County of Los Angeles Public Health

Acute Communicable Disease Control
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SALMONELLOSIS CASE REPORT

DO NOT USE FOR SALMONELLA TYPHI (TYPHOID FEVER)

Reset Form

Group: _____ Serotype: _____ Presumptive: ☐

Census tract: _____ IRIS ID: _____

PATIENT INFORMATION

Patient Name - Last	First	Middle	Date of Birth	Age

Address - Number, Street	City	State	Zip Code

Telephone Number Home	Work	Cell	Email	Country of Birth	Date of Arrival

Patient's current gender identity? (check one)
☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman
☐ Gender Non-Binary, Gender Non-Conforming ☐ Other: _____ ☐ Prefer not to state

Patient's sex at birth? (check one)
☐ Male ☐ Female ☐ Non-Binary or X
☐ Other: _____ ☐ Prefer not to answer

Patient's sexual orientation? (check one)
☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure ☐ Something else: _____
☐ Don't understand the question ☐ Prefer not to answer

Patient's race or ethnicity? (check all that apply)
☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
☐ Some other race; specify: _____ ☐ Refused
If Asian or Native Hawaiian/Other Pacific Islander, specify nationalities/ethnic groups: _____

Occupation, school, and/or volunteer (city/zip code)	Homelessness? ☐ Yes ☐ No	Sensitive Occupation/Situation (S.O.S)? ☐ Yes ☐ No

PRESENT ILLNESS

Did patient have symptoms? ☐ Yes ☐ No ☐ Unknown
If Yes, Onset date: _____ Time: _____
Duration of symptoms (in days): _____
Symptoms of illness (Check all that apply.)

Diarrhea	☐ Yes	☐ No	☐ Unknown
Bloody Diarrhea	☐ Yes	☐ No	☐ Unknown
Nausea	☐ Yes	☐ No	☐ Unknown
Vomiting	☐ Yes	☐ No	☐ Unknown
Fever (≥38° C,100° F)	☐ Yes	☐ No	☐ Unknown
Abdominal cramps	☐ Yes	☐ No	☐ Unknown

Other-Specify. _____

Medical History/Complications ☐ None ☐ Cancer ☐ Diabetes ☐ Immunocompromised
☐ Pre-existing Gastrointestinal Disease ☐ Pregnant: Estimated due date: _____
☐ Renal Disease ☐ Other – Specify. _____

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown
If Yes, Admit date: _____ Discharge date: _____

Facility/Hospital Name

Attending or consulting physician	Telephone number

Transferred to/from another hospital: ☐ Yes ☐ No ☐ Unknown
If Yes, Hospital name: _____ Admit date: _____

Did patient die? ☐ Yes ☐ No ☐ Unknown If Yes, Date of death: _____

DIAGNOSTIC TESTS *(Attach laboratory results if available.)*

Culture confirmed? ☐ Yes ☐ No
If Yes, Source of specimen ☐ Stool ☐ Blood ☐ Urine ☐ None ☐ Other –Specify. _____
Date of collection: _____
Laboratory name: _____ Phone number: _____

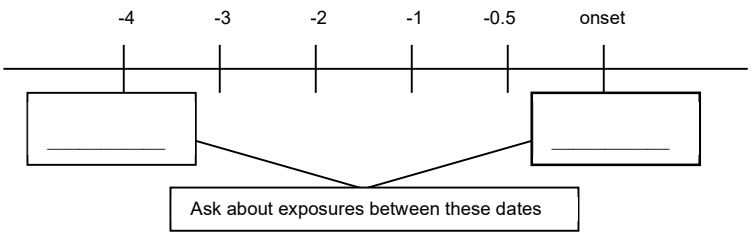
SOURCES OF REPORT

Who reported the case? ☐ Laboratory ☐ Physician ☐ Public Health Laboratory ☐ Infection Control Practitioner ☐ Other –Specify. _____
First reporter name: _____ Phone number: _____ First report date: _____

EPIDEMIOLOGIC RISK FACTORS

CALCULATE EXPOSURE PERIOD

Enter onset date in heavy box at right. Count back 4 days and insert date into the left box to figure out probably exposure period.



Note:
1) Usual communicable period up to 5 weeks, unless treated.
2) Communicable period= time of fecal excretion.
3) Antibiotic therapy may prolong carriage.

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

EPIDEMIOLOGIC RISK FACTORS (Continued)

☐ No risk factors could be identified ☐ Patient could not be interviewed

During the exposure period, was the case:

Associated with a known outbreak? ☐ Yes ☐ No ☐ Unknown If Yes, Outbreak (OB) number? _____

A close contact of a confirmed or presumptive case? ☐ Yes ☐ No ☐ Unknown If Yes, Has the above case been reported? ☐ Yes ☐ Not Yet

Specify nature of contact: ☐ Household ☐ Sexual ☐ Daycare ☐ Other Name of linked case: _____

During the exposure period, did the case have: Medical procedures ☐ Yes ☐ No ☐ Unknown

Alternative medicine procedures (e.g. high colonic enema) ☐ Yes ☐ No ☐ Unknown

In the 4 days prior to onset, did case (>=15 yrs.) have sex with: ☐ Men ☐ Women ☐ Both ☐ None ☐ Refused to Answer

SUSPECT FOODS *(4 days before onset)*				OTHER POTENTIAL SOURCES *(4 days before onset)*			
Yes	No	Unknown	**(if yes, indicate date)**	Yes	No	Unknown	**(if yes, indicate date)**
☐	☐	☐	Rare/raw meat or poultry	☐	☐	☐	Use folk/herbal remedies (e.g. rattlesnake)
☐	☐	☐	Raw/slightly cooked eggs, or in foods (sauces;	☐	☐	☐	Livestock, poultry, or wild birds
			homemade eggnog; ice cream; or mayonnaise)	☐	☐	☐	Pets-including cats, dogs, birds, exotic animals
☐	☐	☐	Goat (e.g. birria)	☐	☐	☐	Reptiles (lizards, snakes, turtles, other _____)
☐	☐	☐	Raw milk, unpasteurized cheese, other raw dairy -	☐	☐	☐	Animal/reptile culture taken? Date._____
			Detail exposure. _____	☐	☐	☐	Persons with diarrheal illness
☐	☐	☐	Raw/unpasteurized juice (brand) _____	☐	☐	☐	Diapered children or adults
☐	☐	☐	Food eaten outside of home (e.g. restaurant, fast	☐	☐	☐	Exposure to human excreta: Specify. _____
			food, food trucks, street vendors)	☐	☐	☐	Overnight visitors from abroad: Where? _____
☐	☐	☐	Food at gatherings (e.g. potlucks, catered, events)	☐	☐	☐	Travel outside the U.S. to _____
☐	☐	☐	Sprouts: Type _____	☐	☐	☐	Travel inside the U.S. to _____
☐	☐	☐	Raw vegetables/fruits: Specify. _____				Travel dates: _____ to _____
☐	☐	☐	Other suspect food. _____				

SENSITIVE OCCUPATION/SITUATION (SOS)

During communicable period (<=5 wks after onset), did case prepare food for any public or private gatherings? ☐ Yes ☐ No ☐ Unknown

If Yes, Provide details here. _____

Does the case or household contact attend daycare or pre-school? ☐ Yes ☐ No ☐ Unknown

If Yes, Is the case/contact in diapers? ☐ Yes ☐ No ☐ Unknown Are other children or staff ill? ☐ Yes ☐ No ☐ Unknown

Is the case or household contact a food handler, a HCW with direct patient contact, or childcare worker? ☐ Yes ☐ No ☐ Unknown

*If **case** attends/works at daycare/foodhandler/HCW:*		*If **contact** attends/works at daycare/foodhandler/HCW:*	
Employer/Situation		Name of contact	
Address		Employer/Situation	Phone
City	Phone	Address	City
Notes:		Notes:	

REMARKS - EXPOSURE DETAILS (Complete for any "Yes" answer – e.g. names of restaurants, market, foods eaten, dates, etc.)

Suspected Source

FOLLOW-UP CHECKLIST: Provide details as appropriate.

☐ Preventive/Education per B-73 ☐ Work or daycare restriction for case per B-73 ☐ FBI filed # _____

☐ Daycare inspection by PHN ☐ Follow-up of other household member(s) ☐ OB opened # _____

Public Health Nurse/Investigator (PHN/PHI) Name (print)	PHN/PHI Signature	Telephone number	Date
PHNS/PHIS Name (print)	PHNS/PHIS Signature		Date

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CONTACT ROSTER FOR SALMONELLA / SHIGELLA (circle one)

Name of case: _____ **Onset date:** _____ **Date of 1st positive culture:** _____

HOUSEHOLD CONTACTS

/	Name Relationship	Age DOB	Occupation -**or**- School & Grade	SOS? ✔	Symptoms? ✔	Onset date	Confirmed? ✔	Presumptive?* ✔	Comments	Specimen Collection Dispensed	Collected	Results
1				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
2				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
3				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
4				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
5				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
6				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				

NON-HOUSEHOLD CONTACTS WITH SIMILAR ILLNESS

/	Name	Age DOB	Address City	Phone number	Onset date	SOS? ✔	Confirmed case? ✔	Presumptive case? * ✔	Referred to: ✔	Comments (e.g. common meal, daycare, etc.)
1						Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ACD ☐ District ☐	
2						Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ACD ☐ District ☐	
3						Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ACD ☐ District ☐	
4						Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ACD ☐ District ☐	

* **Presumptive Case definition:** In a person epi-linked to a confirmed case, diarrhea (> 2 loose/24 hours) and fever **-or-** diarrhea and at least 2 other symptoms (e.g. cramps, vomiting, aches).

~Note: Follow-up for a presumptive case is the same as for a confirmed case. Also, a presumptive case is reportable: Epi-form must be filled out and the case entered into VCMR.