

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

SALMONELLOSIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 38

REMINDER to Local Health Department Staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /	SSN
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NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

GENERAL DIAGNOSTIC INFORMATION

Is/was patient symptomatic for this disease? Y N U If yes, symptom onset date (mm/dd/yyyy): ___/___/___

CLINICAL FINDINGS

Check all that apply:

Fever <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Highest measured temperature: _____ Nausea <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Abdominal pain or cramps <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes, subjective <input type="checkbox"/> No Fever <input type="checkbox"/> Yes, measured <input type="checkbox"/> Unknown Fever onset date (mm/dd/yyyy): _____	Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Check all that apply: <input type="checkbox"/> Bloody <input type="checkbox"/> Non-bloody <input type="checkbox"/> Watery <input type="checkbox"/> Other Maximum # stools 24-hour period: _____	Bacteremia <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Date of positive blood culture: _____ Septicemia/sepsis <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
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REASON FOR TESTING

Why was the patient tested for this condition?

Symptomatic of disease Exposed to organism causing this disease (asymptomatic) Screening of asymptomatic person with reported risk factor(s)

Household / close contact to a person reported with this disease Other, specify _____ Unknown

PREGNANCY/ TREATMENT

Is the patient currently pregnant? Y N U Did the patient take an antibiotic as treatment for this illness? Y N U

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours Y N U (If no, skip to Isolation/Quarantine/Control Measures)

Hospital name: _____	Admit date (mm/dd/yyyy): ___/___/___
City, State: _____	Discharge date (mm/dd/yyyy): ___/___/___
Hospital contact name: _____	Telephone: (____) _____ - _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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ISOLATION/ QUARANTINE MEASURES

Restrictions to movement or freedom of action? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Date control measures issued: ___/___/___
Check all that apply: <input type="checkbox"/> Work <input type="checkbox"/> Sexual behavior	Date control measures ended: ___/___/___
<input type="checkbox"/> Child care <input type="checkbox"/> Blood and body fluid	Did local health director or designee implement additional control measures? (cohort classrooms, special cleaning, active surveillance, etc.)
<input type="checkbox"/> School <input type="checkbox"/> Other, specify: _____	
Was patient compliant with control measures? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U if yes, specify: _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____	Died from this illness? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Survived? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Date of Death: (mm/dd/yyyy) ___/___/___
Died? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	

TRAVEL/IMMIGRATION

The patient is: Resident of NC Resident of another state or US territory None of the above

Did patient have a travel history during the 7 days prior to onset of symptoms? Y N U

From ___/___/___ Until ___/___/___

List dates of travel and destinations:

CHILDCARE/SCHOOL/COLLEGE

Is the patient in child care? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Is the patient a child care worker or volunteer in child care? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Name of care provider: _____	Name of care provider: _____
Address: _____	Address: _____
City: _____ State: _____ Zip code: _____	City: _____ State: _____ Zip code: _____
Contact Name: _____ Telephone: _____	Contact Name: _____ Telephone: _____
Is the patient a parent or primary caregiver of a child in child care? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Patient wears diapers or shares a classroom with diapered children? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Name of care provider: _____	Who wears diapers? <input type="checkbox"/> Patient <input type="checkbox"/> Classmate
Address: _____	List names of all childcare arrangements that involve diapering: _____
City: _____ State: _____ Zip code: _____	
Contact Name: _____ Telephone: _____	

Is patient a student? Y N U

Type of school: NC Public School (pre K-12) NC Private School (pre K-12) Other School (pre K) Community College/University

Other academic institution (trade school, professional school, etc.)

Name of School: _____ Address: _____ City: _____ State: _____

Zip code: _____ County: _____ Telephone: _____

BEHAVIORAL RISK/CONGREGATE LIVING

During the 7 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional, barracks, commune, boarding school, dormitory)? Y N U

Name of facility: _____ Dates of contact: from ___/___/___ to ___/___/___

During the 7 days prior to onset of symptoms, did the patient attend any social gatherings or crowded settings (including weddings, birthday or other parties, conferences, etc.)? Y N U

If yes, specify: _____

OTHER EXPOSURE INFO:

Does the patient know anyone else with similar symptoms? Y N U

If yes, specify: (Include contact name, onset date, if contact was ill prior to or after case)

During the 7 days prior to onset of symptoms did the patient have contact with sewage or human excreta? Y N U

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FOOD AND RISK EXPOSURE

During the 7 days prior to onset of symptoms, did the patient drink any bottled water? Y N U

Specify brand: _____

Describe the source of drinking water used in the patient's home (check all that apply):

- Bottled water supplied by a company Bottled water purchased from a grocery Municipal supply (city water) Well water

Where does the patient/patient's family typically buy groceries? (use back of form for additional stores)

Store Name:	Store Name:
Store City:	Store City:
Store Address/Shopping Center:	Store Address/Shopping Center:

During the 7 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmers market? Y N U Specify: _____

Eat any food items that came from a store or vendor where they do not typically shop for groceries? Y N U Specify: _____

During the 7 days prior to onset of symptoms, was the patient:

Employed as food worker? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Specify job duties: _____
Where employed: _____	What dates did the patient work? From ___/___/___ until ___/___/___
Employed as food worker while symptomatic? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Specify job duties: _____
Where employed: _____	What dates did the patient work? From ___/___/___ until ___/___/___
A non-occupational food worker (e.g., potlucks, receptions)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Specify job duties: _____
Where employed: _____	What dates did the patient work? From ___/___/___ until ___/___/___

DISEASE-SPECIFIC FOOD QUESTIONS

Dairy Products

During the 7 days prior to onset of symptoms, did the patient:

Handle shell eggs? Y N U

Drink unpasteurized milk? Y N U

Specify type of milk: Cow Goat Sheep Unknown Other (specify): _____

Obtained from: Farm: _____ Grocery: _____ Restaurant: _____ Other (specify): _____

Eat any other unpasteurized dairy products? Y N U

Specify type of product: Queso fresco, Queso blanco or other Mexican soft cheese
 Butter Cheese from raw milk (specify): _____
 Food made from raw dairy product (specify): _____
 Other, specify: _____

Obtained from: Farm: _____ Grocery: _____ Restaurant: _____ Other (specify): _____

Juice & Ciders

Drink unpasteurized juices or ciders? Y N U Specify juices or ciders: Apple Orange Other (specify): _____

Beef Products

Eat ground beef or hamburger? Y N U

Brand: _____ Name of source: _____

Was this food rare, undercooked or raw? Y N U

Eat other beef/beef products? Y N U

Specify: Roast Steak Unknown Other (specify): _____

Was this food rare, undercooked or raw? Y N U Brand: _____

Obtained from: Farm: _____ Grocery: _____ Restaurant: _____ Other (specify): _____

Name of source: _____

Poultry Products

Eat any poultry/poultry products? Y N U

Specify: Chicken Turkey Other (specify): _____

Obtained from: Farm: _____ Grocery: _____ Restaurant: _____ Other (specify): _____

Brand: _____ Name of source: _____

Eat eggs or any dish having eggs as an ingredient? Y N U

Obtained from: Farm: _____ Grocery: _____ Restaurant: _____ Other (specify): _____

Brand: _____ Name of source: _____

Taste/eat any uncooked batter (uncooked cake/cookie batter, ice cream containing cookie dough) containing eggs? Y N U

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Pork Products

Eat pork/pork products? Y N U Specify: Sausage Chops Roast Ham Bacon BBQ Other: _____

Was this food rare, undercooked or raw? Y N U Brand: _____

Obtained from: Farm: _____ Grocery: _____ Restaurant: _____ Other (specify): _____

Name of source: _____

Other Meats

Eat wild game meat? Y N U Specify: Deer/Venison Bear Wild Boar/Javelina/Feral Hog Other: _____

FISH AND SEAFOOD

Handle/Eat shellfish (clams, crab, lobster, mussels, oysters, shrimp, crawfish, etc.)? Y N U

Specify shellfish: _____

Obtained from: Caught (fished) Grocery: _____ Restaurant: _____ Other (specify): _____

Was this food rare, undercooked or raw? Y N U

Handle/Eat fresh (not canned) finfish (tuna, mahi-mahi, salmon, sushi, etc.) Y N U

Specify finfish: _____

Obtained from: Caught (fished) Grocery: _____ Restaurant: _____ Other (specify): _____

Was this food rare, undercooked or raw? Y N U

Handle/Eat other seafood (octopus, squid, etc.) or frogs? Y N U

Specify seafood: _____

Obtained from: Caught (fished) Grocery: _____ Restaurant: _____ Other (specify): _____

Was this food rare, undercooked or raw? Y N U

FRUITS AND VEGETABLES

Eat raw fruit? Y N U Specify: apples bananas oranges grapes pears mangoes peaches
 berries (specify): _____ other (specify): _____

Eat raw salads or vegetables other than sprouts? Y N U

Specify raw salad or vegetable:

<input type="checkbox"/> Bagged salad greens without toppings	Type: _____	<input type="checkbox"/> Lettuce	Type: _____
<input type="checkbox"/> Onions	Type: _____	<input type="checkbox"/> Potatoes	Type: _____
<input type="checkbox"/> Salad with toppings	Type: _____	<input type="checkbox"/> Tomatoes	Type: _____
<input type="checkbox"/> Cucumbers	<input type="checkbox"/> Mushrooms	<input type="checkbox"/> Spinach	<input type="checkbox"/> Other _____

Eat sprouts? Y N U Specify sprouts: Alfalfa Bean Clover Other _____ Unknown

Eat fresh herbs? Y N U Specify: Basil Cilantro Cumin Oregano Parsley Rosemary Thyme
 Other _____

DELI MEATS, PRE-PACKAGED FOODS, DRIED AND PROCESSED FOODS

Eat pre-packaged, processed meat/meat products (does not include dried, smoked, or preserved products)? Y N U

Specify: Cold Cuts Bologna Ham Turkey Other _____ Hot dogs

Obtained from: Grocery: _____ Restaurant: _____ Other _____

Eat ready-to-eat dried, preserved, smoked, or traditionally prepared meats (summer sausage, salami, jerky)? Y N U

Specify: Jerky Salami Summer Sausage Other _____

Obtained from: Grocery: _____ Restaurant: _____ Other: _____

Eat deli-sliced (not prepackaged) meat? Y N U Specify: Bologna Chicken Ham Roast Beef Turkey
 Other: _____

Obtained from: Grocery: _____ Restaurant: _____ Other: _____

Eat meat stews or meat pies? Y N U Specify: _____

OTHER FOOD ITEMS

Did the patient ingest infant formula? Y N U Type (powdered, liquid and brand): _____

Did the patient eat commercial baby food? Y N U Type (powdered, liquid and brand): _____

RESTAURANTS AND OTHER FOOD SOURCES AWAY FROM HOME

Eat at a group meal? Y N U Specify (type of group and name): Place of worship: _____ School: _____
 Social function: _____ Other: _____

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RESTAURANTS, ETC. (CONTINUED)

Eat food from a restaurant? Y N U

Name: _____ Location: _____

Name: _____ Location: _____

Name: _____ Location: _____

Name: _____ Location: _____

WATER EXPOSURE

During the 7 days prior to onset of symptoms, did the patient have recreational, occupational or other exposure to water? Y N U

Please describe:

.....

.....

ANIMAL EXPOSURES

During the 7 days prior to onset of symptoms, did the patient have exposure to animals (including animal tissues, animal products or animal excreta)? Y N U

Household pets? Y N U Specify Pets:

Animal Notes (Please note any visits to petting zoos, aquariums, zoos, flea markets, and all pets including reptiles, amphibians and exotic pets):

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Did patient own, work at, or visit a pet store, animal shelter and/or animal breeder / wholesaler / distributor? Y N U

Notes:

.....

Did patient/household contact work at, live on, or visit a farm, ranch or dairy? Y N U

Notes:

.....

CASE INTERVIEWS / INVESTIGATIONS

Was the patient interviewed? Y N U Date of interview: ___/___/___

Were interviews conducted with others? Y N U Who was interviewed? _____

Were healthcare providers consulted? Y N U Who was consulted? _____

Medical record(s) reviewed (including telephone review with provider / office staff)? Y N U

Notes on medical record verification:

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Is the patient part of an outbreak of this disease? Y N U

Case interview notes (Please note any additional food items mentioned, including snack foods, as well as any relevant information regarding the case):

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Salmonellosis (*Salmonella* spp.)

2012 Case Definition

CSTE Position Statement Number: 11-ID-08

Clinical Description

An illness of variable severity commonly manifested by diarrhea, abdominal pain, nausea, and sometimes vomiting. Asymptomatic infections may occur, and the organism may cause extraintestinal infections.

Laboratory Criteria for Diagnosis

Suspect

Detection of *Salmonella* from a clinical specimen using a non-culture based method

Confirmed

Isolation of *Salmonella* from a clinical specimen

Case Classification

Suspect

A case that meets the suspect laboratory criteria for diagnosis.

Probable

A clinically compatible case that is epidemiologically linked to a confirmed case, i.e., a contact of a confirmed case or member of a risk group as defined by public health authorities during an outbreak.

Confirmed

A case that meets the confirmed laboratory criteria for diagnosis. When available, O and H antigen serotype characterization should be reported.

Comment

Both asymptomatic infections and infections at sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.