NC EDSS EVENT ID#  

ATTENTION HEALTH CARE PROVIDERS: Please report relevant clinical findings about this disease event to the local health department.

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.

### NC EDSS PART 2 WIZARD
Communicable Disease

<table>
<thead>
<tr>
<th>Is/was patient symptomatic for this disease?</th>
<th>Y</th>
<th>N</th>
<th>U</th>
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</thead>
<tbody>
<tr>
<td>If yes, symptom onset date (mm/dd/yyyy):</td>
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### CHECK ALL THAT APPLY:

- Head drooping
- Blurred vision or double vision
- Drooping eyelids / ptosis
- Difficulty swallowing (dysphagia)
- Difficulty speaking (dysarthria)
- Loss of facial expression
- Other

### Cranial nerve or bulbar weakness or paralysis

| Onset date (mm/dd/yyyy): | / | / | / |

### Muscle weakness (paresis)

| Y | N | U |

### Muscle paralysis

| Onset date (mm/dd/yyyy): | / | / | / |

### Acute flaccid paralysis

| Onset date (mm/dd/yyyy): | / | / | / |

### EMG performed

| Date performed (mm/dd/yyyy): | / | / | / |

### MRI performed

| Date performed (mm/dd/yyyy): | / | / | / |

### Nerve conduction study performed

| Date performed (mm/dd/yyyy): | / | / | / |

### Head CT performed

| Date performed (mm/dd/yyyy): | / | / | / |

### PREDISPOSING CONDITIONS

**Any immunosuppressive conditions?** Y N U

Specify ______________________________

**Injury/Wound/Break in skin** Y N U

**Recent/Acute injury(ies)** Y N U

**Anatomic site** Y N U

**Was medical care obtained for this injury?** Y N U

**Contaminated** Y N U

**REASON FOR TESTING**

**Why was the patient tested for this condition?**

Y Y N U

- Symptomatic of disease
- Screening of asymptomatic person with reported risk factor(s)
- Exposed to organism causing this disease (asymptomatic)
- Household / close contact to a person reported with this disease
- Other, specify
- Unknown

**ISOLATION/QUARANTINE/CONTROL MEASURES**

**Did local health director or designee implement additional control measures?** Y N

If yes, specify: ________________________________

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**Source:** NC Disease Code: 111

**LAB RESULTS**

Verify if lab results for this event are in NC EDSS. If not present, enter results.

<table>
<thead>
<tr>
<th>Specimen Date</th>
<th>Specimen #</th>
<th>Specimen Source</th>
<th>Type of Test</th>
<th>Test Result(s)</th>
<th>Description (comments)</th>
<th>Result Date</th>
<th>Lab Name—City/State</th>
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</thead>
<tbody>
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</table>

**Specimen**

- / / / 
- / / / 
- / / / 

**Type of Test**

- / / / 
- / / / 
- / / / 

**Result(s)**

- / / / 
- / / / 
- / / / 

**Date performed (mm/dd/yyyy):**

- / / / 
- / / / 
- / / / 

**RESULT**

- / / / 
- / / / 
- / / / 

**Date antitoxin given (mm/dd/yyyy):**

- / / / 

**Other symptoms, signs, clinical findings, or complications consistent with this illness:**

- / / / 

**Reason for testing**

**Was botulism antitoxin given?** Y N U

**Date antitoxin given (mm/dd/yyyy):** / / /

**Time treatment began** AM PM

**Did the patient require mechanical ventilation?** Y N U

If yes, specify: ________________________________

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**Source**: DHHS/EPISWIZARD

**Date**: AUGUST 2011

**Page**: PAGE 1 OF 3
Patient's Last Name                  First                           Middle                         Suffix            Maiden/Other                         Alias
Birthdate (mm/dd/yyyy)               SSN

CLINICAL OUTCOMES
Discharge/Final diagnosis:
Survived?........................................ Y N U
Died?........................................ Y N U
Died from this illness?..................... Y N U
Date of death (mm/dd/yyyy):________/____/____

HOSPITALIZATION INFORMATION
Was patient hospitalized for this illness >24 hours?........... Y N U
Hospital name: ____________________________
City, State: ________________________________
Hospital contact name: ______________________
Telephone: (______) ______ - ___________
Admit date (mm/dd/yyyy): ______/____/____
Discharge date (mm/dd/yyyy): ______/____/____

TRAVEL/IMMIGRATION
The patient is:
☐ Resident of NC
☐ Resident of another state or US territory
☐ Foreign Visitor
☐ Refugee
☐ Recent Immigrant
☐ Foreign Adoptee
☐ None of the above
Did patient have a travel history during the 14 days prior to onset of symptoms?........ Y N U
List travel dates and destinations:
From ______/____/____ to ______/____/____

OTHER EXPOSURE INFORMATION
Does the patient know anyone else with similar symptoms?.............. Y N U
If yes, specify: ___________________________________________________________

BEHAVIORAL RISK & CONGREGATE LIVING
In what setting was the patient most likely exposed?
☐ Restaurant
☐ Home
☐ Work
☐ Child Care
☐ School
☐ University/College
☐ Camp
☐ Doctor’s office/
Outpatient clinic
☐ Hospital In-patient
☐ Hospital Emergency
☐ Department
☐ Laboratory
☐ Long-term care facility
☐ Rest Home
☐ Military
☐ Prison/Jail/Detention Center
☐ Place of Worship
☐ Outdoors, including woods or wilderness
☐ Athletics
☐ Farm
☐ Pool or spa
☐ Pond, lake, river or other body of water
☐ Hotel / motel
☐ Social gathering, other than listed above
☐ Travel conveyance (airplane, ship, etc.)
☐ International
☐ Community
☐ Other (specify)
☐ Unknown

CASE INTERVIEWS/INVESTIGATIONS
Was the patient interviewed?........... Y N U
Date of interview (mm/dd/yyyy): ______/____/____
Were interviews conducted with others?.............. Y N U
Who was interviewed?
Were health care providers consulted?.............. Y N U
Who was consulted?
Medical records reviewed (including telephone review with provider/office staff)?.............. Y N U
Specify reason if medical records were not reviewed:

NOTES ON MEDICAL RECORD VERIFICATION:

In what geographic location was the patient MOST LIKELY exposed?
Specify location:
☐ In NC
☐ City ____________________________
☐ County __________________________
☐ Outside NC, but within US
☐ City __________________________
☐ State __________________________
☐ County __________________________
☐ Outside US
☐ City __________________________
☐ Country __________________________
☐ Unknown

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

Was patient hospitalized for this illness >24 hours?........... Y N U
Hospital name: ____________________________
City, State: ________________________________
Hospital contact name: ______________________
Telephone: (______) ______ - ___________
Admit date (mm/dd/yyyy): ______/____/____
Discharge date (mm/dd/yyyy): ______/____/____

HOSPITALIZATION INFORMATION

OTHER EXPOSURE INFORMATION

BEHAVIORAL RISK & CONGREGATE LIVING

CASE INTERVIEWS/INVESTIGATIONS

NOTES ON MEDICAL RECORD VERIFICATION:

In what geographic location was the patient MOST LIKELY exposed?
Specify location:

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

Was patient hospitalized for this illness >24 hours?........... Y N U
Hospital name: ____________________________
City, State: ________________________________
Hospital contact name: ______________________
Telephone: (______) ______ - ___________
Admit date (mm/dd/yyyy): ______/____/____
Discharge date (mm/dd/yyyy): ______/____/____

HOSPITALIZATION INFORMATION

OTHER EXPOSURE INFORMATION

BEHAVIORAL RISK & CONGREGATE LIVING

CASE INTERVIEWS/INVESTIGATIONS

NOTES ON MEDICAL RECORD VERIFICATION:
Botulism, Wound (Clostridium botulinum)

2011 Case Definition

CSTE Position Statement Number: 10-ID-03

Clinical description

An illness resulting from toxin produced by Clostridium botulinum that has infected a wound. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

Laboratory criteria for diagnosis

- Detection of botulinum toxin in serum, or
- Isolation of Clostridium botulinum from wound

Case classification

Confirmed: A clinically compatible case that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms.

Probable: A clinically compatible case in a patient who has no suspected exposure to contaminated food and who has either a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms.