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

North Carolina Public Health

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

LISTERIOSIS
Confidential Communicable Disease Report—Part 2

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

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

List any specimen from which listeria was isolated

FOR CASES NOT ASSOCIATED WITH PREGNANCY

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/ State	State Public Health Lab Isolate Number
/ /		Blood				/ /		
/ /		CSF				/ /		
/ /		Vagina				/ /		
/ /		Tissue				/ /		
/ /		Stool				/ /		
/ /		Other, specify				/ /		

FOR CASES ASSOCIATED WITH PREGNANCY

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/ State	State Public Health Lab Isolate Number
/ /		Blood from mother				/ /		
/ /		Blood from neonate				/ /		
/ /		CSF from mother				/ /		
/ /		CSF from neonate				/ /		
/ /		Stool from mother				/ /		
/ /		Placenta				/ /		
/ /		Amniotic fluid				/ /		
/ /		Other, specify				/ /		
/ /		Other, specify				/ /		

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐Y ☐N ☐U
☐Yes, subjective ☐No
☐Yes, measured ☐Unknown
Highest measured temperature_____

Fever onset date (mm/dd/yyyy):____/____/____
Shock ☐Y ☐N ☐U
Altered mental status ☐Y ☐N ☐U
Patient displayed (select all that apply)
☐Delirium ☐Coma
Headache ☐Y ☐N ☐U
Meningitis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____

Encephalomyelitis/ meningoencephalitis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____
Febrile gastroenteritis ☐Y ☐N ☐U
Chills ☐Y ☐N ☐U
Muscle aches ☐Y ☐N ☐U
Stiff neck ☐Y ☐N ☐U
Preterm labor ☐Y ☐N ☐U

(CONTINUED NEXT PAGE)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE (CONTINUED)

Arthritis ☐ Y ☐ N ☐ U
Extent: ☐ One joint ☐ Multiple joints
Type: ☐ Septic
Abscess/infected skin lesion (pyoderma) ☐ Y ☐ N ☐ U
Nausea ☐ Y ☐ N ☐ U
Vomiting ☐ Y ☐ N ☐ U
Abdominal pain or cramps ☐ Y ☐ N ☐ U
Diarrhea ☐ Y ☐ N ☐ U
Describe (select all that apply)
☐ Bloody ☐ Watery
☐ Non-bloody ☐ Other
Maximum number of stools in a 24-hour period:_____
Bacteremia ☐ Y ☐ N ☐ U
Date of positive blood culture (mm/dd/yyyy) ____/____/____
Septicemia/sepsis ☐ Y ☐ N ☐ U
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐ Y ☐ N ☐ U
Specify _____

REASON FOR TESTING

Why was the patient tested for this condition?
☐ 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

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U
If yes, specify:

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 70 days prior to onset of symptoms? ☐ Y ☐ N ☐ U
List travel dates and destinations
From ____/____/____ to ____/____/____
_____
_____
Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U
List persons and contact information:
_____
_____
_____

PREGNANCY

Is the patient currently pregnant? ☐ Y ☐ N ☐ U
Estimated delivery date ____/____/____
If pregnant, who is providing prenatal care? ☐ Y ☐ N ☐ U
Name: _____
Address: _____
City:_____State: _____
Zip code: _____
Telephone: (_____) _____ - _____
Number of weeks gestation at onset of illness? ____
Has the patient been pregnant in the last 12 months? ☐ Y ☐ N ☐ U

Outcome of pregnancy (single gestation or Twin 1)	Weeks gestation	Date	Outcome of pregnancy (Twin 2)	Weeks gestation	Date
Still pregnant		/ /			/ /
Fetal death (miscarriage or stillbirth)		/ /			/ /
Induced abortion		/ /			/ /
Delivery (live birth)		/ /			/ /
Other, specify_____		/ /			/ /

Types of illness in mother	Types of illness in Twin 1	Types of illness in Twin 2
☐ Bacteremia/sepsis	☐ Bacteremia/sepsis	☐ Bacteremia/sepsis
☐ Meningitis	☐ Meningitis	☐ Meningitis
☐ Febrile gastroenteritis	☐ Febrile gastroenteritis	☐ Febrile gastroenteritis
☐ Amnionitis	☐ Amnionitis	☐ Amnionitis
☐ Non-specific "flu-like" illness	☐ Non-specific "flu-like" illness	☐ Non-specific "flu-like" illness
☐ Other, specify_____	☐ Other, specify_____	☐ Other, specify_____
☐ Unknown	☐ Unknown	☐ Unknown
☐ None	☐ None	☐ None

Was mother hospitalized for listeriosis?	Was Twin 1 hospitalized for listeriosis?	Was Twin 2 hospitalized for listeriosis?
☐ Yes Admit date ____/____/____ Discharge date ____/____/____ ☐ No ☐ Unknown ☐ Survived ☐ Died ☐ Unknown	☐ Yes Admit date ____/____/____ Discharge date ____/____/____ ☐ No ☐ Unknown ☐ Survived ☐ Died ☐ Unknown	☐ Yes Admit date ____/____/____ Discharge date ____/____/____ ☐ No ☐ Unknown ☐ Survived ☐ Died ☐ Unknown

Mother's outcome	Neonate 1's (twin 1's) outcome	Neonate 2's (twin 2's) outcome
☐ Survived	☐ Survived	☐ Survived
☐ Died	☐ Died	☐ Died
☐ Unknown	☐ Unknown	☐ Unknown

INFANT BIRTH INFORMATION

Infant gestational age at birth:
☐ Full term ☐ Premature ☐ Unknown
Number of weeks gestation _____
Vital status:
☐ Born alive and still alive
☐ Born alive and then died
☐ Stillborn
☐ Unknown
If died, date of child death ____/____/____
Give cause(s) of death from death certificate
_____
Was an autopsy performed? ☐ Y ☐ N ☐ U
Give final anatomical diagnosis_____
_____
Was the case diagnosed while pregnant or within 2 weeks of delivery or miscarriage? ☐ Y ☐ N ☐ U
Indicate outcome of pregnancy:
☐ Normal delivery Date of delivery____/____/____
☐ Stillbirth Date of stillbirth____/____/____
☐ Miscarriage Date of miscarriage___/___/___
☐ On-going Expected date of delivery____/____/____
Was the case a newborn? ☐ Y ☐ N ☐ U

MATERNAL INFORMATION

Did biologic mother have confirmed listeria infection during this pregnancy? ☐ Y ☐ N ☐ U

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

FOOD RISK AND EXPOSURE

During the 70 days prior to onset of symptoms, did the patient eat any raw or undercooked meat or poultry? ☐Y ☐N ☐U

Specify meat/poultry:_____

Specify place of exposure: _____

During the 70 days prior to onset of symptoms, did the patient eat any raw or undercooked seafood or shellfish (i.e., raw oysters, sushi, etc.)? ☐Y ☐N ☐U

Specify type of seafood/shellfish_____

Specify place of exposure_____

Where does the patient/patient's family typically buy groceries?

Store name:_____

Store city: _____

Shopping center name/address:

_____

During the 70 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? ☐Y ☐N ☐U

Specify source: _____

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

Specify source(s): _____

Handle raw meat other than poultry? ☐Y ☐N ☐U

Specify type of meat:
- ☐ Beef (hamburger/steak, etc)
- ☐ Pork (ham, bacon, pork chops, sausage, etc)
- ☐ Lamb/mutton
- ☐ Wild game, specify: _____
- ☐ Other, specify: _____
- ☐ Unknown

Handle raw poultry? ☐Y ☐N ☐U

Specify type of poultry:
- ☐ Chicken
- ☐ Turkey
- ☐ Other, specify: _____
- ☐ Unknown

Drink unpasteurized milk? ☐Y ☐N ☐U

Specify type of milk:
- ☐ Cow
- ☐ Goat
- ☐ Sheep
- ☐ Other, specify: _____
- ☐ Unknown

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: _____

Drink unpasteurized juices or ciders? ☐Y ☐N ☐U

Specify juices or ciders:
- ☐ Apple
- ☐ Orange
- ☐ Other, specify: _____

Eat ground beef/hamburger? ☐Y ☐N ☐U

Eat other beef/beef products? ☐Y ☐N ☐U
- ☐ Roast
- ☐ Steak
- ☐ Other, specify: _____

Eat any poultry/poultry product? ☐Y ☐N ☐U

Eat pork/pork products? ☐Y ☐N ☐U

Specify type of pork/pork product:
- ☐ Sausage
  - ☐ Smoked ☐ Unsmoked
- ☐ Chops
- ☐ Roast
- ☐ Ham
  - ☐ Smoked ☐ Cured ☐ Canned
  - ☐ Other, specify: _____
- ☐ Bacon
- ☐ BBQ
- ☐ Other, specify: _____

Eat wild game meat (deer, bear, wild boar)**?** ☐Y ☐N ☐U

Specify type of wild game meat:
- ☐ Deer/venison
- ☐ Bear
- ☐ Wild boar/javelina/feral hog
- ☐ Other, specify: _____

Eat other meat / meat products (i.e. ostrich, emu, horse)? ☐Y ☐N ☐U

Specify other meat/meat product:
- ☐ Ostrich
- ☐ Emu
- ☐ Horse
- ☐ Other, specify: _____

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)**?** ☐Y ☐N ☐U

Handle/eat finfish (i.e. Tuna, Mackerel, Skip Jack, Amber Jack, Bonito, Mahi-mahi / dorado, Blue fish, Salmon, Puffer fish, Porcupine fish, Ocean sunfish, sushi)**?** ☐Y ☐N ☐U

Specify type of finfish:
- ☐ Tuna
- ☐ Mackerel
- ☐ Skip Jack or Amberjack
- ☐ Bonito
- ☐ Mahi-mahi (dorado/"blue dolphin")
- ☐ Puffer fish
- ☐ Parrot fish
- ☐ Porcupine fish
- ☐ Ocean sunfish (Mola mola)
- ☐ Bluefish
- ☐ Salmon
- ☐ Sushi, unknown type of fish
- ☐ Other: specify _____
- ☐ Unknown

Handle/eat other seafood (i.e. octopus, squid) **or frogs?** ☐Y ☐N ☐U

Specify other seafood:
- ☐ Squid ☐ Octopus ☐ Frog
- ☐ Other, specify:_____

Eat raw fruit? ☐Y ☐N ☐U

Specify raw fruit:
- ☐ Apples
- ☐ Bananas
- ☐ Oranges
- ☐ Grapes, specify:_____
- ☐ Pears
- ☐ Peaches
- ☐ Berries, specify_____
- ☐ Melon,specify_____
- ☐ Mangoes
- ☐ Other, specify: _____

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

Specify raw salad or vegetable:
- ☐ Bagged salad greens without toppings, type: _____
- ☐ Salad with toppings, specify: _____
- ☐ Lettuce, type: _____
- ☐ Spinach
- ☐ Tomatoes, type: _____
- ☐ Cucumbers
- ☐ Mushrooms, type: _____
- ☐ Onions, type: _____
- ☐ Potatoes, type:_____
- ☐ Other, specify: _____

Eat sprouts? ☐Y ☐N ☐U

Specify type of sprouts:
- ☐ Alfalfa ☐ Clover ☐ Bean
- ☐ Other, specify: _____
- ☐ Unknown

Eat fresh herbs? ☐Y ☐N ☐U

Specify:
- ☐ Basil ☐ Thyme
- ☐ Parsley ☐ Cilantro
- ☐ Oregano ☐ Rosemary
- ☐ Cumin
- ☐ Other, specify: _____

Eat prepackaged, processed meat/meat products (does not include dried, smoked, or preserved products)**?** ☐Y ☐N ☐U

Specify type of prepackaged, processed meat/meat product:
- ☐ Hot dogs
- ☐ Cold Cuts
  - ☐ Bologna
  - ☐ Turkey
  - ☐ Ham
  - ☐ Other cold cut, specify _____

Any other ready-to-eat meat? Specify:

Eat ready-to-eat dried, preserved, smoked, or traditionally prepared meat (i.e. summer sausage, salami, jerky)**?** ☐Y ☐N ☐U

Specify type of prepared meat:
- ☐ Summer sausage, specify: _____
- ☐ Salami
- ☐ Jerky
- ☐ Other, specify: _____

Eat deli-sliced (not pre-packaged) **meat?** ☐Y ☐N ☐U

Specify type of meat:
- ☐ Bologna
- ☐ Turkey
- ☐ Ham
- ☐ Roast beef
- ☐ Chicken
- ☐ Other, specify_____

Eat deli-sliced (not pre-packaged) **cheese?** ☐Y ☐N ☐U

Specify type of deli-sliced cheese:
- ☐ Cheddar
- ☐ Swiss
- ☐ American
- ☐ Other cheese, specify: _____

Eat meat stews or meat pies? ☐Y ☐N ☐U

Specify: _____

Eat gravy (i.e. beef, chicken, turkey)**?** ☐Y ☐N ☐U

Specify: _____

Eat potentially hazardous foods (i.e. pastries, custards, salad dressings)**?** ☐Y ☐N ☐U

Specify:
- ☐ Pastries
- ☐ Custards
- ☐ Salad dressings
- ☐ Other: specify _____

Eat commercially-prepared, refrigerated foods (i.e. dips, salsa, sandwiches)? ☐Y ☐N ☐U

Specify type of food:
- ☐ Dips, specify:_____
- ☐ Salsa
- ☐ Sandwiches, Specify: _____
- ☐ Other, Specify: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

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): ____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐Y ☐N ☐U
Check all that apply:
☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and Body Fluid
☐ School ☐ Other
Date control measures issued: ____/____/____
Date control measures ended: ____/____/____
Was patient compliant with control measures? ☐Y ☐N ☐U
Did local health director or designee implement additional control measures? ☐Y ☐N
If yes, specify: _____
Were written isolation orders issued? ☐Y ☐N ☐U
If yes, where was the patient isolated? _____
Date isolation started: ____/____/____
Date isolation ended: ____/____/____
Was the patient compliant with isolation? ☐Y ☐N ☐U

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): _____/_____/_____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐Y ☐N ☐U
Patient a child care worker or volunteer in child care? ☐Y ☐N ☐U
Patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U
Is patient a student? ☐Y ☐N ☐U
Type of school:
Is patient a school WORKER / VOLUNTEER in NC school setting? ☐Y ☐N ☐U
Give details:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 70 days prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐Y ☐N ☐U
Name of facility: _____
Dates of contact: from ___/___/___ until ___/___/___
During the 70 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? ☐Y ☐N ☐U
If yes, specify: _____
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:

GEOGRAPHICAL SITE OF EXPOSURE

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
Notes: