

Salmonellosis Case Report Form

Version 2.2, March 2012

(Please report *Salmonella* Typhi as typhoid fever, not salmonellosis)

This form is designed to aid in completing the Extended Data screen in Merlin for salmonellosis cases

***Blue fields are REQUIRED**

Merlin case #: _____

Date CHD reported to BOE: _____

Date CRF submitted: _____

I. PROFILE DETAIL

SSN: _____

*Last name: _____

First name: _____

Middle: _____

Parent name: _____

*Gender: ☐ Male
☐ Female
☐ Unk

*Birth date: _____ Death date: _____

*Race: ☐ American Indian/Alaska Native
☐ Asian/Pacific Islander
☐ Black
☐ White
☐ Other
☐ Unk

*Ethnicity: ☐ Hispanic
☐ Non-Hispanic
☐ Unk

Address: _____

*Zip: _____ *County: _____

City: _____ *State: _____

Home phone: _____

Other phone: _____

Emer. phone: _____

Profile
specific
notes:

II. CASE INFORMATION

Investigator: _____

CHD ref #: _____

Animal exposure: ☐

*Imported: ☐ Acquired in FL
☐ Acquired in US, not in FL
☐ Acquired outside US
☐ Unk

Origin: _____

*Outbreak: ☐ Outbreak-associated
☐ Sporadic
☐ Unk

Outbreak ID: _____

*Case classification: ☐ Primary
☐ Secondary
☐ Unk

*1st notified by ELR: ☐ Yes
☐ No
☐ Unk

Reporter type: _____

Military base: _____

Reporter's name: _____

III. CLINICAL

*DX status: ☐ Confirmed
☐ Probable
☐ Suspect
☐ Unk

Case definitions: http://www.doh.state.fl.us/Disease_ctrl/epi/surv/CaseDefinitions.html

*Investigated: ☐ Yes
☐ No

Date investigated: _____

Interviewed: ☐ Yes
☐ No

Date interviewed: _____

Symptomatic at
interview: ☐ Yes
☐ No
☐ Unk

Final known outcome: ☐ Died
☐ Ill at time of reporting
☐ Recovered
☐ Unk

ED visit: ☐ Yes
☐ No
☐ Unk

*Inpatient
hospitalization: ☐ Yes
☐ No
☐ Unk

Date admitted: _____

Date discharged: _____

Prophylaxed: ☐ Yes
☐ No
☐ Unk
☐ N/A

Date onset: _____

Date diagnosis: _____

Lab report date: _____

*CHD notified date: _____

Clinical notes
(treatment, etc.)

IV. SENSITIVE EMPLOYMENT/ATTENDANCE INFORMATION

*Day care: ☐ No
☐ Attendee
☐ Staff
☐ Unk

*Occupation: ☐ No or non-sensitive occupation
☐ Healthcare worker
☐ Food handler
☐ Unk

Company: _____

Address: _____

Zip: _____

City: _____ State: _____

Phone: _____ Fax: _____

Last date attended: _____

V. PROVIDER INFORMATION

Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Case-Finding

Did you ask the patient (or patient's proxy, e.g., guardian/caregiver) to identify contacts who were exposed to the patient or a common point-source?

This would include asymptomatic contacts and household contacts, and would typically be completed during the initial case interview. This does not include information gathered in a mailed questionnaire.

☐ Yes, and contacts were identified

Date 1st contact was identified: _____

☐ Yes, but there were no contacts

☐ Yes, but the patient refused to answer

☐ No

Isolation

Did you recommend that the patient be excluded from a sensitive situation (e.g., day care attendee or staff, food handler, or health care worker)?

Exclusion can be based on follow-up testing until patient is negative or excluding until asymptomatic. Exclusion would include re-assigning employees in sensitive situations to job duties that are not sensitive.

☐ Yes

Date patient notified of exclusion recommendation: _____

☐ No, the patient was in a sensitive situation, but was no longer infectious at the time of interview

☐ No, the patient was not in a sensitive situation

☐ No

Education

If the patient was symptomatic at the time of interview, did you provide the patient (or patient's proxy, e.g., guardian/caregiver) with information on preventing disease transmission in order to prevent the patient from infecting others?

This would not include educational materials mailed to the patient.

☐ Yes

☐ No

VII. CASE SYMPTOMS

What symptoms did the patient experience? Check all that apply.

☐ Abdominal pain

☐ Diarrhea

☐ Fever/chills

☐ Nausea

☐ Vomiting

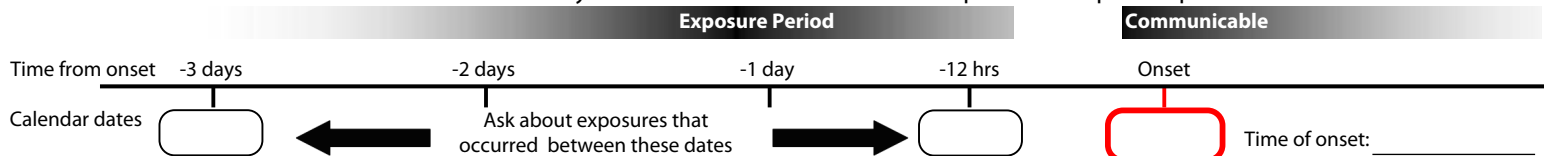
☐ Other, specify: _____

☐ Asymptomatic

If the patient was asymptomatic or the onset date is unknown, [skip to LONG-TERM EXPOSURE QUESTIONS section on page 5.](#)

VIII. EXPOSURE PERIOD CALCULATION

Enter onset date in red box. Count backwards 3 days from onset date to calculate the probable exposure period and enter dates in boxes.



IX. CONTACTS (Optional: contact information on page 6)

1. Were any of the patient's contacts symptomatic in the 3 days before or after this patient's onset?

☐ Yes ☐ No ☐ Unk

a. If yes, were any contacts household members? ☐ Yes ☐ No ☐ Unk

b. If yes, specify (check all that apply):

☐ One or more contacts had onset >24 hours **after** patient's onset (primary case = patient; secondary case = contact)

☐ One or more contacts had onset **within** 24 hours of patient's onset (primary case = patient and contact)

☐ One or more contacts had onset >24 hours **before** patient's onset (primary case = contact; secondary case = patient)

☐ Unknown

If the patient is [known to be a secondary case](#), this form is complete.

If the patient is [not known to be a secondary case](#), please complete the remainder of this form.

X. TRAVEL HISTORY

2. Did the patient travel during the 3 day exposure period?

☐ Yes ☐ No ☐ Unk

a. If yes, was that travel overnight?

☐ Yes ☐ No ☐ Unk

b. If yes, specify type of travel (check all that apply):

☐ In-state

☐ Out-of-state

☐ Out-of-country

c. If yes, specify travel dates and locations:

If the patient's illness was acquired [outside of the U.S.](#), this form is complete.

If the patient's illness may have been acquired [in the U.S.](#), please complete the remainder of form.

3. Did the patient consume food from any restaurant during the 3 day exposure period?

☐ Yes ☐ No ☐ Unk

- a. If yes, specify setting (check all that apply):
- ☐ Fast-food (order at counter)
 - ☐ Sit-down (waiter takes order at table)
 - ☐ Self-serve buffet
 - ☐ Delivery (food delivered to location)
 - ☐ Other: _____

Please note: if a restaurant is suspected as the source of infection, please fill out the **Environmental Health Foodborne Illness Survey/ Complaint Form** (<http://www.myfloridaeh.com/medicine/foods-surveillance/investigation-information.htm>).

- b. If yes, provide details (restaurant names, foods, locations, etc.):

XII. CHILD/INFANT FOOD HISTORY

4. If the patient is <5 years old, did the child consume any of the following during the 3 day exposure period?

If the child is 5 years or older, skip to next page.

Yes No Unk

- ☐ ☐ ☐ a. Breast milk
- ☐ ☐ ☐ b. Baby formula bought as a liquid in a can.
- ☐ ☐ ☐ c. Baby formula bought as a powder
 - i. If yes, specify type of water used to reconstitute formula: _____
 - ii. If yes, was water boiled before using to reconstitute formula? ☐ Yes ☐ No ☐ Unk
- ☐ ☐ ☐ d. Homemade puréed/strained/mashed baby food
- ☐ ☐ ☐ e. Store-bought puréed/strained/mashed baby food

If yes, was any of the milk stored (i.e. pumped)? ☐ Yes ☐ No ☐ Unk

If yes, specify brand: _____

If yes, specify brand: _____

☐ Unfiltered tap water ☐ Bottled water

☐ Filtered tap water ☐ Other: _____

☐ Yes ☐ No ☐ Unk

If yes, specify types: _____

If yes, specify brand/types: _____

XIII. GENERAL FOOD HISTORY (Optional: 72 hour food history on page 7)

5. Did the patient prepare or handle any raw meat during the 3 day exposure period?

☐ Yes ☐ No ☐ Unk

If yes, specify (check all that apply): ☐ Poultry ☐ Beef ☐ Pork ☐ Fish ☐ Shellfish ☐ Other: _____

6. Did the patient consume any of the following during the 3 day exposure period? If yes, provide details (foods, settings, etc.).

Yes No Unk

- ☐ ☐ ☐ a. Poultry _____ If yes, was any of it raw or undercooked? ☐ Yes ☐ No ☐ Unk
- ☐ ☐ ☐ b. Beef _____ If yes, was any of it raw or undercooked? ☐ Yes ☐ No ☐ Unk
- ☐ ☐ ☐ c. Pork _____ If yes, was any of it raw or undercooked? ☐ Yes ☐ No ☐ Unk
- ☐ ☐ ☐ d. Fish _____ If yes, was any of it raw or undercooked? ☐ Yes ☐ No ☐ Unk
- ☐ ☐ ☐ e. Shellfish _____ If yes, was any of it raw or undercooked? ☐ Yes ☐ No ☐ Unk
- ☐ ☐ ☐ f. Eggs _____ If yes, was any of it raw or undercooked? ☐ Yes ☐ No ☐ Unk
- ☐ ☐ ☐ g. Foods with raw eggs (cake mix, salad dressings, etc.) _____
- ☐ ☐ ☐ h. Unpasteurized milk or milk products _____
- ☐ ☐ ☐ i. Raw or unpasteurized cheese (queso blanco, queso fresco, etc.) _____
- ☐ ☐ ☐ j. Peanut butter _____
- ☐ ☐ ☐ k. Nuts _____
- ☐ ☐ ☐ l. Raw produce _____
 - If yes, specify (check all that apply): ☐ Any food from salad bar ☐ Lettuce ☐ Peppers (bell, chile, etc.) ☐ Green onions (scallions)
 - ☐ Sprouts (bean, alfalfa, etc.) ☐ Tomatoes ☐ Cilantro ☐ Cantaloupe
- ☐ ☐ ☐ m. Unpasteurized juice or cider _____
- ☐ ☐ ☐ n. Food from produce stand, roadside vendor, mobile stand, concession stand, or truck _____
- ☐ ☐ ☐ o. Food from specialty butcher/specialty market _____
- ☐ ☐ ☐ p. Home slaughtered/home grown food _____
- ☐ ☐ ☐ q. Food at a group meal (party, wedding, business meeting, potluck, etc.) _____
- ☐ ☐ ☐ r. Food at an outdoor setting (picnic, barbecue, etc.) _____
- ☐ ☐ ☐ s. Drink untreated/unfiltered water _____
 - If yes, specify (check all that apply): ☐ Private well ☐ Shared well
 - ☐ Other (stream, surface water, swimming, etc), specify: _____

7. Did the patient prepare or handle food for any public/private gathering while symptomatic?

☐ Yes ☐ No ☐ Unk

If yes, provide detail: _____

8. Did the patient have any exposure to animals during the 3 day exposure period?

☐ Yes ☐ No ☐ Unk

a. If yes, specify animal (check all that apply):

- | | | |
|---------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Cat | <input type="checkbox"/> Lizard/iguana | <input type="checkbox"/> Caged bird |
| <input type="checkbox"/> Dog | <input type="checkbox"/> Snake | <input type="checkbox"/> Horse |
| <input type="checkbox"/> Turtle | <input type="checkbox"/> Hamster/guinea pig | <input type="checkbox"/> Cow |
| <input type="checkbox"/> Frog | <input type="checkbox"/> Duck/goose | <input type="checkbox"/> Goat/sheep |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Chicken/poultry | <input type="checkbox"/> Other: _____ |

b. If yes, specify setting (check all that apply):

- ☐ Household pet
☐ School or day care pet
☐ Farm
☐ Petting zoo/fair
☐ Wild
☐ Other: _____

Animal history
comments:

9. Are there pets in the household?

☐ Yes ☐ No ☐ Unk

a. If yes, total number of pets: _____

b. If yes, what type of food are pets fed? [Check all that apply.](#)

- ☐ Dry food
☐ Fresh or frozen food
☐ Raw meat, bones, or eggs
☐ Other: _____
☐ Unk

c. If yes, where are pets fed? [Check all that apply.](#)

- ☐ Kitchen
☐ Laundry room
☐ Garage
☐ Other: _____
☐ Unk

d. If yes, how often does the patient clean up the pet's feces, urine, or vomit?

- ☐ Never
☐ On occasion
☐ Weekly
☐ Daily
☐ Unk

XV. OTHER ENVIRONMENTAL EXPOSURES

10. Was the patient exposed to any of the following during the 3 day exposure period? [If yes, provide details.](#)

Yes No Unk
☐ ☐ ☐

a. Outdoor/recreational activities _____

If yes, specify

(check all that apply):

- | | | | |
|------------------------------------|---------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Playing | <input type="checkbox"/> Sports | <input type="checkbox"/> Camping | <input type="checkbox"/> Fishing |
| <input type="checkbox"/> Yard work | <input type="checkbox"/> Hiking | <input type="checkbox"/> Hunting | <input type="checkbox"/> Other: _____ |

☐ ☐ ☐ b. Recreational water (swimming, splashing, wading, etc.) _____

If yes, specify

(check all that apply):

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Pool | <input type="checkbox"/> Spa/hot tub/jacuzzi | <input type="checkbox"/> River/lake/canal/pond |
| <input type="checkbox"/> Kiddie pool | <input type="checkbox"/> Interactive fountain | <input type="checkbox"/> Boating/kayaking/canoeing/fishing |
| <input type="checkbox"/> Wading pool | <input type="checkbox"/> Water park | <input type="checkbox"/> Ocean/Gulf |
| <input type="checkbox"/> Other: _____ | | |

☐ ☐ ☐ c. Close contact with a healthcare worker, daycare worker, or food handler _____

☐ ☐ ☐ d. Contact with a diapered child or adult _____

☐ ☐ ☐ e. Contact with children <5 years old who attend daycare, preschool, Head Start, etc. _____

☐ ☐ ☐ f. Live in an institution (nursing home, jail, group home, etc.) _____

☐ ☐ ☐ g. Occupational exposure to excreta (sewer plant worker, plumbers, septic tank workers, etc.) _____

11. If the patient is <5 years old, answer the following questions for the 3 day exposure period?

[If the patient is 5 years or older, skip to next page.](#)

Yes No Unk

☐ ☐ ☐ a. Was the child in diapers?

☐ ☐ ☐ b. Was the child toilet trained?

☐ ☐ ☐ c. Was the child crawling?

☐ ☐ ☐ d. Was the child walking?

☐ ☐ ☐ e. Was the child teething?

☐ ☐ ☐ f. Did the child use a pacifier or teething toys?

If yes, how are they cleaned?

[Check all that apply.](#)

- | | |
|---|--|
| <input type="checkbox"/> Rinsed with water | <input type="checkbox"/> Sterilized using heat (e.g. microwave or boiling) |
| <input type="checkbox"/> Washed with soap and water | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dishwasher | <input type="checkbox"/> Unk |

☐ ☐ ☐ g. Did the child suck his/her thumb or fingers?

☐ ☐ ☐ h. Did the child use bottles?

If yes, how are they cleaned?

[Check all that apply.](#)

- | | | |
|---|--|------------------------------|
| <input type="checkbox"/> Rinsed with water | <input type="checkbox"/> Dishwasher | <input type="checkbox"/> Unk |
| <input type="checkbox"/> Washed with soap and water | <input type="checkbox"/> Sterilized using heat (e.g. microwave or boiling) | |
| <input type="checkbox"/> Bottle brush | <input type="checkbox"/> Other: _____ | |

☐ ☐ ☐ i. Did the child ride in a grocery cart with meat or poultry?

☐ ☐ ☐ j. Was the child exposed to dirt or sand, either indoors or outdoors?

☐ ☐ ☐ k. Did the child spend time on the floor? If yes, specify approximately how many hours per day:

- | | |
|---------------------------|---------------------------|
| <input type="radio"/> <1 | <input type="radio"/> 7-9 |
| <input type="radio"/> 1-3 | <input type="radio"/> 10+ |
| <input type="radio"/> 4-6 | <input type="radio"/> Unk |

12. In an average day:

- a. How many times does the patient wash or sanitize his/her hands?
- ☐ <1 ☐ 7-9
☐ 1-3 ☐ 10+
☐ 4-6 ☐ Unk
- b. Does the patient use soap or hand sanitizer (e.g. Purell) more often?
- ☐ Never uses either
☐ Soap
☐ Sanitizer
☐ About the same
☐ Unk
- c. How many 8 oz glasses of unheated tap water does the patient drink?
- ☐ <1 ☐ 5-6
☐ 1-2 ☐ 6+
☐ 3-4 ☐ Unk
- d. How many 8 oz drinks **made with** unheated tap water does the patient drink?
- ☐ <1 ☐ 5-6
☐ 1-2 ☐ 6+
☐ 3-4 ☐ Unk

13. In an average week:

- a. How many hours does the patient spend outdoors? This includes playing, gardening/yard work, camping/hiking, sports, running, biking, etc.
- ☐ <1 ☐ 7-9
☐ 1-3 ☐ 10+
☐ 4-6 ☐ Unk
- b. How many frogs, lizards, turtles, or other reptiles/amphibians does the patient see around/outside the residence?
- ☐ <1 ☐ 7-9
☐ 1-3 ☐ 10+
☐ 4-6 ☐ Unk
- c. How often are shoes worn inside the house by residents or visitors?
- ☐ Never
☐ Rarely
☐ Occasionally
☐ Frequently
☐ Always
☐ Unk
- d. How many times is a dishwasher run per week in the patient's household?
- ☐ Never ☐ 4-5
☐ 0-1 ☐ 6+
☐ 2-3 ☐ Unk
- e. How many meals are **prepared** per week in the patient's household?
- ☐ <1 ☐ 7-9
☐ 1-3 ☐ 10+
☐ 4-6 ☐ Unk

14. In an average week, how often is meat (chicken, beef, pork, etc.) prepared in the patient's household (regardless of whether the patient eats the meat)?

- ☐ <1, skip to question 15 ☐ 7-9
☐ 1-3 ☐ 10+
☐ 4-6 ☐ Unk
- a. How is meat thawed before cooking? **Check all that apply.**
- ☐ Meat is never frozen or is cooked frozen
☐ Refrigerator
☐ Microwave
☐ Kitchen/room surface (counter, sink, etc.)
☐ Under running water
☐ Other: _____
☐ Unk
- b. What surfaces in the home are used to prepare meat? **Check all that apply.**
- ☐ Wood cutting board
☐ Plastic or other cutting board
☐ Countertop
☐ Table
☐ Sink
☐ Plate
☐ Other: _____
☐ Unk
- c. How are surfaces cleaned after meat preparation? **Check all that apply.**
- ☐ Surfaces are not cleaned
☐ Rinsed with water
☐ Washed with soap and water
☐ Washed in dishwasher
☐ Disinfected with bleach/other
☐ Wiped with multi-use sponge/cloth
☐ Wiped with single-use sponge/cloth
☐ Other: _____
☐ Unk

15. Regarding the patient's daily household (include patient):

- a. Total # of people: _____
- b. # of people < 5 years old: _____
- c. # of children/adults in diapers: _____
- d. # of toilets: _____

16. List jobs of all working members of household:

- a. Do any of the jobs listed above involve exposure to soil?
- ☐ Yes ☐ No ☐ Unk ☐ No jobs
- b. Do any of the jobs listed above involve exposure to animals?
- ☐ Yes ☐ No ☐ Unk ☐ No jobs

17. Regarding the patient's residence:

- a. Type of residence:
- ☐ Free-standing house
☐ Apartment building
☐ Condo/townhouse/duplex
☐ Mobile home
☐ Other: _____
☐ Unk
- b. Setting of residence:
- ☐ Urban/city
☐ Suburban residential area
☐ Small town
☐ Rural area
☐ Other: _____
☐ Unk
- c. Type of piped water source:
- ☐ Municipal/city/public water
☐ Private well
☐ Community (shared) well
☐ Other: _____
☐ Unk
- d. Type of waste disposal:
- ☐ Septic tank
☐ Public sewer system
☐ Other: _____
☐ Unk
- e. Is water filtered?
- ☐ Yes ☐ No ☐ Unk
- If yes, what type of filter is used?
Check all that apply.
- ☐ Pitcher filter
☐ Faucet-mounted filter
☐ Refrigerator filter
☐ Under-the-sink filter
☐ Whole-house filter
☐ Other: _____
☐ Unk
- f. Is there a separate system of piped water for irrigation purposes only?
- ☐ Yes ☐ No ☐ Unk
- g. Do any immediate neighbors keep poultry/livestock on their property?
- ☐ Yes ☐ No ☐ Unk
- h. Does the patient live near (within 3 miles) any family or industrial farms, meat processing plants, or any other animal husbandry facilities?
- ☐ Yes ☐ No ☐ Unk

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XVII. CONTACT INFORMATION (OPTIONAL)

Obtain the following for all contacts with diarrhea in the 3 days before or after this patient's onset of illness (use contact comments for additional space):

[illegible]

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XVIII. 72 HOUR FOOD HISTORY (OPTIONAL)

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Meal	Date: _____	Date: _____	Date: _____	Date: _____
Breakfast				
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Snacks				
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Lunch				
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Snacks				
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Dinner				
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Snacks				
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten

Food history
comments: