

# Foodborne and Waterborne Diseases

## West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control  
 Infectious Disease Epidemiology Program  
 Phone: 304-558-5358 or 800-423-1271 in West Virginia  
 Fax: 304-558-8736

### Disease Under Investigation

\* indicates required fields

- |  |  |
|--|--|
| <input type="radio"/> <i>Amebiasis</i><br><input type="radio"/> <i>Cholera</i><br><input type="radio"/> <i>Cyclosporiasis</i><br><input type="radio"/> <i>Shiga toxin producing Escherichia Coli (STEC) Serogroup non 0157:H7</i><br><input type="radio"/> <i>Hemolytic Uremic Syndrome, Postdiarrheal</i><br><input type="radio"/> <i>Salmonellosis</i><br><input type="radio"/> <i>Trichinosis</i><br><input type="radio"/> <i>Yersiniosis</i> | <input type="radio"/> <i>Campylobacteriosis</i><br><input type="radio"/> <i>Cryptosporidiosis</i><br><input type="radio"/> <i>Shiga toxin producing Escherichia Coli (STEC) Serogroup 0157:H7</i><br><input type="radio"/> <i>Giardiasis</i><br><input type="radio"/> <i>Listeriosis</i><br><input type="radio"/> <i>Shigellosis</i><br><input type="radio"/> <i>Typhoid Fever</i> |
|--|--|

**Investigation Status\***

- Closed*  
  *Open*  
  *Regional Review*  
  *State Review*  
  *Superseded*  
  *Unassigned*

**Case Status\***

- Confirmed*  
  *Not a Case*  
  *Probable*  
  *Suspect*  
  *Unknown*

### Patient Information

\* indicates required fields

<b>Last Name*</b>	<b>First Name*</b>	<b>Middle Initial</b>	
<b>Street Address</b>			
<b>City</b>	<b>County</b>	<b>State</b> West Virginia	<b>Zip</b>
<b>Is the patient's residence a:</b>			
<input type="radio"/> <i>Correctional Facility (Specify) _____</i>		<input type="radio"/> <i>Long Term Care Facility (Specify) _____</i>	
<input type="radio"/> <i>Shelter or Group Home (Specify) _____</i>		<input type="radio"/> <i>None of the above</i>	
<b>Home Phone</b> ###-###-####	<b>Ext.</b>	<b>Other Phone</b> ###-###-####	<b>Ext.</b>
			<b>Report Date</b> mm/dd/yyyy

### Parent / Guardian Information

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Relationship to Patient</b>
<input type="radio"/> <i>Check if address is same as above; otherwise complete guardian contact information below</i>			
<b>Guardian Street Address</b>			
<b>City</b>	<b>County</b>	<b>State</b> West Virginia	<b>Zip</b>
<b>Home Phone</b> ###-###-####	<b>Ext.</b>	<b>Other Phone</b> ###-###-####	<b>Ext.</b>

## Patient Demographic Information

\* indicates required fields

**Sex**
 Male  Female  Transsexual  Unknown  Failure to report sex/missing sex  Other (Specify) \_\_\_\_\_
**Date of Birth\***

mm/dd/yyyy

**Age****Age Units**
 Days  Weeks  Months  Years
**Ethnicity**
 Hispanic or Latino  Not Hispanic or Latino  Unknown  Failure to report ethnicity/missing ethnicity
**Race**

(Check all that apply)

 American Indian or Alaska Native  Asian  
 Black or African American  Native Hawaiian or Other Pacific Islander \_\_\_\_\_  
 White  Unknown  
 Failure to report race/missing race  Some Other Race \_\_\_\_\_

## Outcome and Clinical Information

**Date of onset of symptoms**

mm/dd/yyyy

**Date of diagnosis**

mm/dd/yyyy

**Was the patient hospitalized for the disease?**
 Yes  No  Unknown
**Name of Hospital****Date of Admission**

mm/dd/yyyy

**Patient outcome from this disease:**
 Died  Survived  Unknown
**Date of Death**

mm/dd/yyyy

## Laboratory Information

Collection Date	Report Date	Specimen Source	Type of test	Test result
mm/dd/yyyy	mm/dd/yyyy	(select one)		

Antibiotic Susceptibility Testing				
Antimicrobial Agent	Susceptibility Method	S/I/R/U Result	Sign **	MIC Value
	A=Agar dilution method B=Broth dilution D=Disk diffusion (Kirby Bauer) S=Strip: Antimicrobial gradient strip (E-test)	Result indicates microorganism's susceptibility to the antimicrobial being tested	Select Sign	(e.g., 0.06 ug/ml)
Ampicillin				
Cefotaxime				
Ceftriaxone				
Ceftizoxime				
Chloramphenicol				
Ciprofloxacin				
Levofloxacin				
Nalidixic Acid				
Trimethoprim/Sulfamethoxazole				
Other 1 (Specify Below)				
Other 2 (Specify Below)				
<b>Record Other Antimicrobial Agent 1</b>		<b>Record Other Antimicrobial Agent 2</b>		
<b>Laboratory Name</b>	<b>Phone</b> ###-###-####	<b>Ext.</b>	<b>Fax Number</b> ###-###-####	
<b>Address</b>	<b>State:</b> West Virginia		<b>Zip:</b>	
<b>Reporting Source</b>				
<b>Last Name</b>	<b>First Name</b>	<b>Phone</b> ###-###-####	<b>Ext.</b>	<b>Fax</b> ###-###-####
<b>Facility</b>		<b>Address</b>		
<b>City</b>	<b>State</b> West Virginia	<b>Zip</b>	<b>E-mail</b>	

### Provider with Further Patient Information

<b>Last Name</b>		<b>First Name</b>	
<b>Phone</b> ###-###-####	<b>Ext.</b>	<b>Fax</b> ###-###-####	
<b>Address</b>			
<b>City</b>	<b>State</b> West Virginia	<b>Zip</b>	

### Public Health Investigation

<b>Name of Person Interviewed</b>		<b>Relationship to Patient</b>		<b>Date reported to public health</b> mm/dd/yyyy	
<b>Investigator</b>	<b>Date public health investigation began</b> mm/dd/yyyy	<b>Health Department</b>		<b>Phone</b> ###-###-####	
<b>Ext.</b>					
<b>Investigation ID</b>	<b>Part of an Outbreak?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<b>Outbreak Name</b>		<b>Lost to follow-up?</b> <input type="radio"/> Yes <input type="radio"/> No	

### Clinical Data

<b>Date of onset</b> mm/dd/yyyy	<b>Time</b>	<input type="radio"/> AM <input type="radio"/> PM	<b>Date well</b> mm/dd/yyyy	<b>Time</b>	<input type="radio"/> AM <input type="radio"/> PM
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Symptoms: Check all that are present and elaborate in the space below:

<b>Symptoms</b> (Check all that apply)	
<input type="checkbox"/> <i>Bloody Stool</i> <input type="checkbox"/> <i>Diarrhea (How Many Times)(Specify)</i> _____ <input type="checkbox"/> <i>Headache</i> <input type="checkbox"/> <i>Vomiting (How Many Times)(Specify)</i> _____	<input type="checkbox"/> <i>Cramps</i> <input type="checkbox"/> <i>Fever (How High-Specify F or C)(Specify)</i> _____ <input type="checkbox"/> <i>Nausea</i>

<b>Elaborate</b>
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## Exposures

Within ( ) hours/days\* prior to onset of illness, did you:

<b>1. Handle raw meat?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<b>2. Have contact with a daycare or a daycare attendee?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
<b>3. Have a household member or sexual partner with similar symptoms?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<b>4. Hike, camp, fish or swim?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<b>5. Drink from a spring or stream?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
<b>6. Travel to another state or country?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<b>7. Have contact with birds or poultry, pets, farm animals, or reptiles?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

If you answered YES to any questions dealing with the above, please explain:

\*Use the incubation period which applies to the agent / disease under investigation: e.g., *Campylobacter* (1-10 days, usually 2-5 days), *Clostridium botulinum* (Botulism)-(12-36 hours), *Cyclospora cayentanensis* (1-11 days), *Cryptosporidium parvum* (1-12 days, average 7 days), *E. coli* O157:H7 (2-8 days, median 3-4 days), *Entamoeba histolytica* (Amebiasis)-(2-3 days to 1-4 Weeks), *Giardiasis* (1-4 Weeks), *Listeriosis* (9-48 hours), *Non-typhoidal Salmonella gastroenteritis* 6-72 hours, usually 12-36 hours), *Norwalk-like virus* (24-48 hours), *Salmonella typhii* (Typhoid fever)-(3 days-1 month, usually 8-14 days), *Shigella* (12-96 hours, usually 1-3 days), *Vibrio cholerae* (few hours-5 days, usually 2-3 days).

## Occupational Risk

**Is this patient a:**

(Check all that apply)

Food Handler  
  Health Care Worker  
  Day Care Worker  
  Student  
  None of Above

**Employer/School Name:**

**Address:**

**Elaborate:**

## Activity History

List all group activities, parties or gatherings (wedding receptions, baby shower, church events, clubs, school events, athletic events, office parties or banquets, festivals, or fairs)attended in the last ( ) hours/days\* prior to onset.

Date	Activity	Location
mm/dd/yyyy		

## Restaurant History

List all restaurants patronized in the last ( ) hours/days\* prior to onset.

Date	Restaurant Name	Street Address	City, State
mm/dd/yyyy			

## Contact Information

If any household member is symptomatic, the member is epi-linked, and therefore is a probable case and should be investigated further. A stool culture, yellow card and disease case report follow-up form should be completed.

Name	Age	Relationship to Case	Symptoms (Y/N)	Date of Onset	Lab Testing	Occupation
			N=No Y=Yes	mm/dd/yyyy		

## Food History

Did the patient eat any of the following within ( ) hours/days\* prior to the onset of symptoms?

**1. Fresh shell eggs:**

Yes  No  Unknown

**If yes, were the eggs cooked well?**

Yes  No  Unknown

**2. Raw eggs in egg nog, Caesar salad, hollandaise sauce, meringue, bearnaise sauce, raw cookie dough, homemade mayonnaise , tiramisu, homemade ice-cream, or other**

Yes  No  Unknown  Other \_\_\_\_\_

**3. Raw or undercooked chicken, turkey, or other fowl**

Yes  No  Unknown

**4. Raw or undercooked wild game**

Yes  No  Unknown

**5. Raw or undercooked hamburger, red meat, pork or pork products**

Yes  No  Unknown

**6. Luncheon meats or wieners**

Yes  No  Unknown

**7. Raw or unpasteurized milk or cheese**

Yes  No  Unknown

**8. Raw or undercooked fish or shellfish, including raw oysters**

Yes  No  Unknown

**9. Unpasteurized juice or cider**

Yes  No  Unknown

**10. Raw fruits or vegetables (includes slaw, salad, sprouts, cantaloupes, tomatoes, etc.)**

Yes  No  Unknown

**Source of Home Water Supply**

Municipal  Well  Cistern  Spring  Other \_\_\_\_\_

**Elaborate**

### Food Purchased

Date	Name	Location	Food Purchased
mm/dd/yyyy			

### Open-ended Food History

Within ( )\* hours/days prior to onset

**Date**  
mm/dd/yyyy

Day 1

Meal	Food/Beverage Consumed	Location
Breakfast		
Dinner		
Lunch		
Other/Snacks		

**Date**  
mm/dd/yyyy

Day 2

Meal	Food/Beverage Consumed	Location
Breakfast		
Dinner		
Lunch		
Other/Snacks		

**Date**  
mm/dd/yyyy

Day 3

Meal	Food/Beverage Consumed	Location
Breakfast		
Dinner		
Lunch		
Other/Snacks		

## Open-ended Food History cont.

**Date**

mm/dd/yyyy

Day 4

Meal	Food/Beverage Consumed	Location
Breakfast		
Dinner		
Lunch		
Other/Snacks		

**Date**

mm/dd/yyyy

Day 5

Meal	Food/Beverage Consumed	Location
Breakfast		
Dinner		
Lunch		
Other/Snacks		

## Public Health Laboratory Investigation (OLS)

Date Collected	Date Reported	Specimen Source	Serotype	PFGE State Code
mm/dd/yyyy	mm/dd/yyyy	(select one)		

## Public Health Action Taken

**Describe public health action taken**