WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Botulism, Infant

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address (mailing): _____ _____
Address (physical): _____
City/State/Zip: _____
Phone (home): _____ **Phone** (work/cell) : _____

Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
Name: _____ *Phone:* _____

***Birth date**: __ / __ / ____ **Age**: ____
***Gender**: ☐Male ☐Female ☐Unk
***Ethnicity**: ☐Not Hispanic or Latino
☐Hispanic or Latino ☐Unk

***Race**: ☐White ☐Black/Afr. Amer.
(Mark all that apply) ☐Native HI/Other PI
☐Am. Ind/AK Native
☐Asian ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigation Start Date: __ / __ / ____
Earliest date reported to LHD: __ / __ / ____
Earliest date reported to State: __ / __ / ____

Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐Private Provider ☐Public Health Agency ☐Other
Reporter Name: _____ **Reporter Phone** : _____
Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __ / __ / ____ **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

Clinical Findings

Y	N	U	
☐	☐	☐	Poor feeding
☐	☐	☐	Constipation
☐	☐	☐	Floppy or weak baby
☐	☐	☐	Head drooping
☐	☐	☐	Eyelids drooping (ptosis)
☐	☐	☐	Cry weak or altered
☐	☐	☐	Breathing difficulty or shortness of breath
☐	☐	☐	Diarrhea
☐	☐	☐	Failure to thrive
☐	☐	☐	Sepsis syndrome
☐	☐	☐	Altered mental status
☐	☐	☐	Mechanical ventilation or intubation required
☐	☐	☐	Paralysis or weakness

☐Acute flaccid paralysis ☐ Asymetric
☐Symmeteric ☐Ascending ☐Descending

*Hospitalization

Y	N	U	
☐	☐	☐	Hospitalized for this illness

Hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

*Death

Y	N	U	
☐	☐	☐	Died due to this illness

Date of death: __ / __ / ____

TREATMENT

Y	N	U	
☐	☐	☐	*Botulinum antitoxin given

Date/time given: ___/___/_____ _____ AM/PM

LABORATORY (Please submit copies of all labs associated with this illness to DIDE)

Specimen source: ☐ Serum ☐Stool Collection date: __ / __ / ____

Y	N	U	
☐	☐	☐	Botulinum toxin detection (serum or stool)
☐	☐	☐	C. botulinum isolation (stool)
☐	☐	☐	Food specimen submitted for testing

Toxin type: ☐ A ☐B ☐C ☐ D ☐ E ☐F ☐ G ☐ Unknown

Notes(clinical/laboratory)

Y=Yes N=No U=Unknown NA=Not applicable
*required surveillance indicator

INFECTION TIMELINE

Instructions:
Enter onset date in grey box. Count backward to determine probable exposure period

	Exposure period		Onset date
***Days** from onset*	***-30** (Max Incubation)*	***-3** (Min Incubation)*	
Calendar dates:	__ / __ / ____	__ / __ / ____	__ / __ / ____

EPIDEMIOLOGIC EXPOSURES

Y N U

☐ ☐ ☐ *Honey (e.g. honey-filled pacifier, honey water)
☐ ☐ ☐ Corn syrup
☐ ☐ ☐ If infant, breast fed
☐ ☐ ☐ Infant formula Brand and Type: _____
☐ ☐ ☐ Comercial baby food Brand: _____
☐ ☐ ☐ Home canned food
☐ ☐ ☐ Dried, preserved, or traditionally prepared meat (e.g. sausage, jerky, salami)
☐ ☐ ☐ Preserved, smoked, or traditionally prepared fish
☐ ☐ ☐ Known contaminated food product Specify:_____
☐ ☐ ☐ Travel out of the state, country or outside of usual routine

If yes, dates/locations:

Date	Location

PUBLIC HEALTH ISSUES

Y N NA

☐ ☐ ☐ Antitoxin needed
☐ ☐ ☐ Commercial product possibly implicated
☐ ☐ ☐ Case is part of an outbreak

Outbreak Name: _____

PUBLIC HEALTH ACTIONS

Y N NA

☐ ☐ ☐ Disease/Transmission Education Provided
☐ ☐ ☐ Contacted state to arrange for antitoxin
☐ ☐ ☐ Patient is lost to follow up
☐ ☐ ☐ Other:_____

NOTES