

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

BOTULISM CASE REPORT

Check one: ☐ Foodborne ☐ Wound ☐ Other (specify): _____

THIS FORM SHOULD NOT BE USED FOR INFANT BOTULISM

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	
Address Number & Street – Residence			Apartment / Unit Number		
City / Town			State	Zip Code	
Census Tract	County of Residence		Country of Residence		
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone / Pager		Work / School Telephone	
E-mail Address		Other Electronic Contact Information			
Work / School Location		Work / School Contact			
Gender <input type="checkbox"/> Female <input type="checkbox"/> Trans female / transwoman <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Trans male/ transman <input type="checkbox"/> Identity not listed <input type="checkbox"/> Declined to answer					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes, Est. Delivery Date (mm/dd/yyyy)			
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 11)		Other Describe/Specify			
Occupation (see list on page 11)		Other Describe/Specify			
Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown					
Race(s) (check all that apply, race descriptions on page 10) The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.					
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply, see list on page 10) <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Indonesian <input type="checkbox"/> Japanese <input type="checkbox"/> Other: _____ </div> <div> <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Malaysian <input type="checkbox"/> Pakistani <input type="checkbox"/> Sri Lankan <input type="checkbox"/> Taiwanese <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____ </div> </div> <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 10) <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Fijian <input type="checkbox"/> Guamanian <input type="checkbox"/> Other: _____ </div> <div> <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan <input type="checkbox"/> Other: _____ </div> </div> <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown					
ADDITIONAL PATIENT DEMOGRAPHICS					
Sex Assigned at Birth <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Declined to answer		Sexual Orientation <input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Questioning, unsure, or patient doesn't know <input type="checkbox"/> Declined to answer <input type="checkbox"/> Gay, lesbian, or same-gender loving <input type="checkbox"/> Orientation not listed <input type="checkbox"/> Unknown <input type="checkbox"/> Bisexual			

First three letters of
patient's last name:

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CLINICAL INFORMATION

Physician 1	Last Name		First Name	
	Specialty <input type="checkbox"/> Infectious diseases <input type="checkbox"/> Neurologist <input type="checkbox"/> Other (specify): _____		Telephone Number	Fax Number
Physician 2	Last Name		First Name	
	Specialty <input type="checkbox"/> Infectious diseases <input type="checkbox"/> Neurologist <input type="checkbox"/> Other (specify): _____		Telephone Number	Fax Number

SIGNS AND SYMPTOMS

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Onset Date (mm/dd/yyyy)	Onset Time (hh:mm)	Specify AM/PM
Date of First Neurologic Symptoms (mm/dd/yyyy)		Date First Sought Medical Care (mm/dd/yyyy)	
Signs and Symptoms	Yes	No	Unk
Nausea			
Vomiting			
Abdominal pain			
Diarrhea			
Constipation			
Diplopia (double vision) / blurred vision			
Dizziness			
Slurred speech			
Thick tongue			
Other signs / symptoms (specify)			

PHYSICAL EXAM FINDINGS

Observation	Yes	No	Unk	If Yes, Specify as Noted
Alert and oriented				
Extraocular palsy				Is it bilateral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Ptosis				Is it bilateral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pupil abnormality				Abnormality <input type="checkbox"/> Dilated <input type="checkbox"/> Constricted <input type="checkbox"/> Non-reactive Is it bilateral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Facial paralysis				Is it bilateral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Palatal weakness				Is it bilateral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Impaired gag reflex				
Sensory deficit(s)				Specify

(continued on page 3)

First three letters of
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PHYSICAL EXAM FINDINGS (continued)

Observation	Yes	No	Unk	If Yes, Specify as Noted
Muscle weakness and / or paralysis				<i>Progression of weakness / paralysis</i> <input type="checkbox"/> Ascending, ending with cranial nerves <input type="checkbox"/> Descending, beginning with cranial nerves <input type="checkbox"/> Other (specify): _____
Ataxia				<i>Is it bilateral?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Abnormal deep tendon reflexes				<i>Describe</i>
<i>Other signs / symptoms (specify)</i>				

MUSCLE STRENGTH EXAM

<i>Proximal Upper Extremity</i> Right: ____ / 5 Left: ____ / 5	<i>Distal Upper Extremity</i> Right: ____ / 5 Left: ____ / 5	Scale: 0 = no evidence of contractility 1 = slight contractility, no movement 2 = full range of motion, gravity eliminated 3 = full range of motion with gravity 4 = full range of motion against gravity, some resistance 5 = full range of motion against gravity, full resistance 9 = unknown
<i>Proximal Lower Extremity</i> Right: ____ / 5 Left: ____ / 5	<i>Distal Lower Extremity</i> Right: ____ / 5 Left: ____ / 5	

CLINICAL TESTS

Type of Test	Yes	No	Unk	If Yes, Specify as Noted
Lumbar puncture (CSF analysis)				<i>WBC count (highest)</i> <i>RBC count</i> <i>Opening pressure</i>
				<i>Protein (highest)</i> <i>Glucose</i> <i>Date (mm/dd/yyyy)</i>
EMG (If copy of EMG test report is available, please attach copy.)				<i>Result</i> <input type="checkbox"/> Suggestive of / consistent with botulism <input type="checkbox"/> Not consistent with botulism <input type="checkbox"/> Unknown
				<i>Was EMG done with rapid stimulation?</i> <i>If Yes, what Hertz?</i> <i>Date (mm/dd/yyyy)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Edrophonium (Tensilon)				<i>Describe results</i> <i>Date (mm/dd/yyyy)</i>
CT or MRI scan				<i>Describe results</i> <i>Date (mm/dd/yyyy)</i>

PAST MEDICAL HISTORY

<i>Prior botulism diagnosis?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If Yes, specify prior diagnosis date (mm/dd/yyyy)</i>
<i>Prior neurological impairment?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If Yes, describe impairment</i>
<i>Allergy to equine products?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If Yes, describe</i>
<i>Immunocompromised?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If Yes, specify condition</i>
<i>Other (specify)</i>	

DID PATIENT USE ANY DRUGS THAT COULD CAUSE MUSCULAR PARALYSIS WITHIN 30 DAYS BEFORE ILLNESS ONSET?

<i>Myobloc (toxin-type B)?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>Botox (toxin-type A)?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>Aminoglycoside (gentamicin, tobramycin)?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>Anticholinergic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>Other (specify)</i>			

First three letters of
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HOSPITALIZATION

Did patient visit emergency room for illness?

☐ Yes ☐ No ☐ Unknown

Was patient hospitalized?

☐ Yes ☐ No ☐ Unknown

If Yes, how many total hospital nights?

If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION – DETAILS

Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis
Hospital Name 2	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

TREATMENT / MANAGEMENT

Was antitoxin released / authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of Antitoxin Release (mm/dd/yyyy)		Time of Antitoxin Release (HH:MM AM/PM)			
	Officer Releasing Antitoxin - Last Name, First Name					
	Name of Hospital / Pharmacy that Received Antitoxin		Pharmacy Phone Number			
Received botulinum antitoxin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of Doses Used	Antitoxin Type - First Dose <input type="checkbox"/> Cangene heptavalent <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____		Date Administered (mm/dd/yyyy)		
		Antitoxin Type - Second Dose <input type="checkbox"/> Cangene heptavalent <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____		Date Administered (mm/dd/yyyy)		
Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Admit Date (mm/dd/yyyy)					
Intubated and placed on ventilator? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Intubation Date (mm/dd/yyyy)					

OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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ADDITIONAL COMMENTS

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First three letters of
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LABORATORY INFORMATION**CLINICAL SPECIMENS - DIRECT TOXIN TESTING**

Specimen Type 1 <input type="checkbox"/> Gastric aspirate <input type="checkbox"/> Serum (pre-toxin) <input type="checkbox"/> Serum (post-toxin) <input type="checkbox"/> Stool	Result <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No botulinum toxin detected <input type="checkbox"/> Botulinum toxin detected </div> <div> <input type="checkbox"/> Other or unknown toxin detected <input type="checkbox"/> Insufficient or unsatisfactory sample </div> <div> <input type="checkbox"/> Test cancelled <input type="checkbox"/> Unknown </div> </div>		
	Type of Toxin Detected <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type ABE <input type="checkbox"/> Type C <input type="checkbox"/> Type D <input type="checkbox"/> Type E <input type="checkbox"/> Type F <input type="checkbox"/> Type G <input type="checkbox"/> Untypeable <input type="checkbox"/> Unk		
	Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number

Specimen Type 2 <input type="checkbox"/> Gastric aspirate <input type="checkbox"/> Serum (pre-toxin) <input type="checkbox"/> Serum (post-toxin) <input type="checkbox"/> Stool	Result <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No botulinum toxin detected <input type="checkbox"/> Botulinum toxin detected </div> <div> <input type="checkbox"/> Other or unknown toxin detected <input type="checkbox"/> Insufficient or unsatisfactory sample </div> <div> <input type="checkbox"/> Test cancelled <input type="checkbox"/> Unknown </div> </div>		
	Type of Toxin Detected <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type ABE <input type="checkbox"/> Type C <input type="checkbox"/> Type D <input type="checkbox"/> Type E <input type="checkbox"/> Type F <input type="checkbox"/> Type G <input type="checkbox"/> Untypeable <input type="checkbox"/> Unk		
	Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number

CLINICAL SPECIMENS - CULTURE TESTING

Specimen Type 1 <input type="checkbox"/> Gastric aspirate <input type="checkbox"/> Stool <input type="checkbox"/> Wound or abscess (specify site): _____ <input type="checkbox"/> Other (specify): _____	Result <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No <i>Clostridium</i> organism isolated <input type="checkbox"/> <i>Clostridium botulinum</i> organism isolated <input type="checkbox"/> <i>Clostridium baratii</i> organism isolated </div> <div> <input type="checkbox"/> <i>Clostridium butyricum</i> organism isolated <input type="checkbox"/> Other clostridial species <input type="checkbox"/> Insufficient or unsatisfactory sample </div> <div> <input type="checkbox"/> Test cancelled <input type="checkbox"/> Unknown </div> </div>		
	Type of Toxin Produced by Organism <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type ABE <input type="checkbox"/> Type C <input type="checkbox"/> Type D <input type="checkbox"/> Type E <input type="checkbox"/> Type F <input type="checkbox"/> Type G <input type="checkbox"/> None <input type="checkbox"/> Untypeable <input type="checkbox"/> Unknown		
	Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number

Specimen Type 2 <input type="checkbox"/> Gastric aspirate <input type="checkbox"/> Stool <input type="checkbox"/> Wound or abscess (specify site): _____ <input type="checkbox"/> Other (specify): _____	Result <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No <i>Clostridium</i> organism isolated <input type="checkbox"/> <i>Clostridium botulinum</i> organism isolated <input type="checkbox"/> <i>Clostridium baratii</i> organism isolated </div> <div> <input type="checkbox"/> <i>Clostridium butyricum</i> organism isolated <input type="checkbox"/> Other clostridial species <input type="checkbox"/> Insufficient or unsatisfactory sample </div> <div> <input type="checkbox"/> Test cancelled <input type="checkbox"/> Unknown </div> </div>		
	Type of Toxin Produced by Organism <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type ABE <input type="checkbox"/> Type C <input type="checkbox"/> Type D <input type="checkbox"/> Type E <input type="checkbox"/> Type F <input type="checkbox"/> Type G <input type="checkbox"/> None <input type="checkbox"/> Untypeable <input type="checkbox"/> Unk		
	Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number

FOOD SPECIMENS

Type of Food Item 1 (specify)	Food Identification #	Did the patient eat this item in the week before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did anyone else eat this item in the week before patient's illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Direct Toxin Testing Results <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No botulinum toxin detected <input type="checkbox"/> Botulinum toxin detected </div> <div> <input type="checkbox"/> Other or unknown toxin detected <input type="checkbox"/> Insufficient or unsatisfactory sample </div> <div> <input type="checkbox"/> Test cancelled <input type="checkbox"/> Unknown </div> </div>		
	Type of Toxin Detected <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type ABE <input type="checkbox"/> Type C <input type="checkbox"/> Type D <input type="checkbox"/> Type E <input type="checkbox"/> Type F <input type="checkbox"/> Type G <input type="checkbox"/> Untypeable <input type="checkbox"/> Unk		
	Culture Testing Results <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No <i>Clostridium</i> organism isolated <input type="checkbox"/> <i>Clostridium botulinum</i> organism isolated <input type="checkbox"/> <i>Clostridium baratii</i> organism isolated </div> <div> <input type="checkbox"/> <i>Clostridium butyricum</i> organism isolated <input type="checkbox"/> Other clostridial species <input type="checkbox"/> Insufficient or unsatisfactory sample </div> <div> <input type="checkbox"/> Test cancelled <input type="checkbox"/> Unknown </div> </div>		
	Type of Toxin Produced by Organism <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type ABE <input type="checkbox"/> Type C <input type="checkbox"/> Type D <input type="checkbox"/> Type E <input type="checkbox"/> Type F <input type="checkbox"/> Type G <input type="checkbox"/> None <input type="checkbox"/> Untypeable <input type="checkbox"/> Unk		
	Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number

First three letters of
patient's last name:

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FOOD SPECIMENS (continued)

Type of Food Item 2 (specify)	Food Identification #	Did the patient eat this item in the week before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did anyone else eat this item in the week before patient's illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Direct Toxin Testing Results <input type="checkbox"/> No botulinum toxin detected <input type="checkbox"/> Other or unknown toxin detected <input type="checkbox"/> Test cancelled <input type="checkbox"/> Botulinum toxin detected <input type="checkbox"/> Insufficient or unsatisfactory sample <input type="checkbox"/> Unknown		
	Type of Toxin Detected <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type ABE <input type="checkbox"/> Type C <input type="checkbox"/> Type D <input type="checkbox"/> Type E <input type="checkbox"/> Type F <input type="checkbox"/> Type G <input type="checkbox"/> Untypeable <input type="checkbox"/> Unk		
	Culture Testing Results <input type="checkbox"/> No <i>Clostridium</i> organism isolated <input type="checkbox"/> <i>Clostridium butyricum</i> organism isolated <input type="checkbox"/> Test cancelled <input type="checkbox"/> <i>Clostridium botulinum</i> organism isolated <input type="checkbox"/> Other clostridial species <input type="checkbox"/> Unknown <input type="checkbox"/> <i>Clostridium baratii</i> organism isolated <input type="checkbox"/> Insufficient or unsatisfactory sample		
	Type of Toxin Produced by Organism <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type ABE <input type="checkbox"/> Type C <input type="checkbox"/> Type D <input type="checkbox"/> Type E <input type="checkbox"/> Type F <input type="checkbox"/> Type G <input type="checkbox"/> None <input type="checkbox"/> Untypeable <input type="checkbox"/> Unk		
	Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number

ADDITIONAL INFORMATION

If post-antitoxin test was performed and was positive, describe circumstances.	Additional antitoxin given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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EPIDEMIOLOGIC INFORMATION**EXPOSURES / RISK FACTORS - WOUND AND DRUG USE**

Provide information regarding the patient's wound and drug use below.

Wound / Drug Use	Yes	No	Unk	If Yes, Specify as Noted
Wound or abscess				Date of injury (mm/dd/yyyy) Location(s)
				Description
				How wound occurred Did / does wound appear infected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injects black tar heroin (chiba)				Date last used (mm/dd/yyyy) Injection method <input type="checkbox"/> Intravenous <input type="checkbox"/> Subcutaneous (skin-pop) <input type="checkbox"/> Unknown <input type="checkbox"/> Intramuscular <input type="checkbox"/> Other: _____
Injects other drugs				Drugs injected <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
				Injection method <input type="checkbox"/> Intravenous <input type="checkbox"/> Subcutaneous (skin-pop) <input type="checkbox"/> Unknown <input type="checkbox"/> Intramuscular <input type="checkbox"/> Other: _____
Sniffs / snorts drugs				Drugs sniffed / snorted <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
Other drug use				Describe type of use and drugs

First three letters of
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EXPOSURES / RISK FACTORS - POTENTIAL HIGH RISK PRODUCTS

ASK ABOUT HIGH RISK FOODS EVEN IF WOUND BOTULISM IS SUSPECTED
(SUCH AS HOME CANNED OR SUSPICIOUS COMMERCIAL OR RESTAURANT FOODS)

Provide information regarding potential high-risk products consumed one week prior to illness onset.

Food Product	Yes	No	Unk	If Yes, Describe
Home canned, jarred, or preserved food products				Describe
Fermented food products				Describe
Dried or smoked fish products				Describe
Marinated food products				Describe
Suspicious commercial products (i.e., bulging lids or cans, recalled products, "off-odor" food items)				Describe

EXPOSURES / RISK FACTORS - SPECIFIC FOOD ITEMS

Provide information regarding any suspected food item consumed one week prior to illness onset.

Suspect Food Item 1	Food Item	Date Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM)
	Type of Food <input type="checkbox"/> Homemade <input type="checkbox"/> Restaurant associated <input type="checkbox"/> Commercial product <input type="checkbox"/> Unk		If commercial product, specify Brand: _____ Lot: _____
	How was food stored? <input type="checkbox"/> Unrefrigerated <input type="checkbox"/> Refrigerated <input type="checkbox"/> Frozen <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
	How was food preserved? <input type="checkbox"/> Canned <input type="checkbox"/> Dried <input type="checkbox"/> Fermented <input type="checkbox"/> Salted <input type="checkbox"/> Pickled <input type="checkbox"/> No preservation method <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
	How was food item served? <input type="checkbox"/> Unheated <input type="checkbox"/> Only warmed <input type="checkbox"/> Microwaved <input type="checkbox"/> Heated <input type="checkbox"/> Boiled <input type="checkbox"/> Fried <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
	Number of Persons who Shared the Food Item	Number of Persons Ill	
	Samples of food item available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Samples submitted for botulism testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Foods of same batch / lot recovered or recalled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Suspect Food Item 2	Food Item	Date Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM)
	Type of Food <input type="checkbox"/> Homemade <input type="checkbox"/> Restaurant associated <input type="checkbox"/> Commercial product <input type="checkbox"/> Unk		If commercial product, specify Brand: _____ Lot: _____
	How was food stored? <input type="checkbox"/> Unrefrigerated <input type="checkbox"/> Refrigerated <input type="checkbox"/> Frozen <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
	How was food preserved? <input type="checkbox"/> Canned <input type="checkbox"/> Dried <input type="checkbox"/> Fermented <input type="checkbox"/> Salted <input type="checkbox"/> Pickled <input type="checkbox"/> No preservation method <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
	How was food item served? <input type="checkbox"/> Unheated <input type="checkbox"/> Only warmed <input type="checkbox"/> Microwaved <input type="checkbox"/> Heated <input type="checkbox"/> Boiled <input type="checkbox"/> Fried <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
	Number of Persons who Shared the Food Item	Number of Persons Ill	
	Samples of food item available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Samples submitted for botulism testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Foods of same batch / lot recovered or recalled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

EXPOSURES / RISK FACTORS - OTHER POTENTIAL EXPOSURES OF INTEREST

Exposure 1	Describe
Exposure 2	Describe

First three letters of
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TRAVEL HISTORY (INCUBATION PERIOD IS 7 DAYS PRIOR TO ILLNESS ONSET)Did patient travel **outside county of residence** during the **incubation period**?☐ Yes ☐ No ☐ Unknown

If Yes, specify all locations and dates below.

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					

CONTACTS / OTHER ILL PERSONS

Any contacts with similar illness?

☐ Yes ☐ No ☐ Unk

If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	
Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	

NOTES / REMARKS**REPORTING AGENCY**

Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
Date First Reported to Public Health (mm/dd/yyyy)		First Reported by <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____	

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Contact Name / Case Number
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DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)

☐ Confirmed ☐ Probable ☐ Suspect

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OUTBREAK*Part of known outbreak?*☐ Yes ☐ No ☐ Unknown*If Yes, extent of outbreak:*☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other: _____*Vehicle of Outbreak**Pattern 1 ID number**Pattern 2 ID number***STATE USE ONLY***State Case Classification*☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Need additional information**CASE DEFINITION****BOTULISM, FOODBORNE (2011)****CLINICAL DESCRIPTION**

Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

LABORATORY CRITERIA FOR DIAGNOSIS

- Detection of botulinum toxin in serum, stool, or patient's food, or
- Isolation of *Clostridium botulinum* from stool

CASE CLASSIFICATION

Probable: a clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours)

Confirmed: a clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory confirmed botulism

BOTULISM, WOUND (2011)**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

Probable: a clinically compatible case 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

Confirmed: a clinically compatible case that is laboratory confirmed 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

BOTULISM, OTHER (2011)**CLINICAL DESCRIPTION**

See Botulism, Foodborne.

LABORATORY CRITERIA FOR DIAGNOSIS

- Detection of botulinum toxin in clinical specimen, or
- Isolation of *Clostridium botulinum* from clinical specimen

CASE CLASSIFICATION

Confirmed: a clinically compatible case that is laboratory confirmed in a patient aged greater than or equal to 1 year who has no history of ingestion of suspect food and has no wounds

First three letters of
patient's last name:

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RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
ASIAN GROUPS	
<ul style="list-style-type: none"> Bangladeshi Bhutanese Burmese Cambodian Chinese 	<ul style="list-style-type: none"> Filipino Hmong Indian Indonesian Iwo Jiman
<ul style="list-style-type: none"> Japanese Korean Laotian Madagascar Malaysian 	<ul style="list-style-type: none"> Maldivian Nepalese Okinawan Pakistani Singaporean
<ul style="list-style-type: none"> Sri Lankan Taiwanese Thai Vietnamese 	
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS	
<ul style="list-style-type: none"> Carolinian Chamorro Chuukese Fijian Guamanian 	<ul style="list-style-type: none"> Kiribati Kosraean Mariana Islander Marshallese Melanesian
<ul style="list-style-type: none"> Micronesia Native Hawaiian New Hebrides Palau Papua New Guinean 	<ul style="list-style-type: none"> Pohnpeian Polynesian Saipanese Samoan Solomon Islander
<ul style="list-style-type: none"> Tahitian Tokelauan Tongan Yapese 	

First three letters of
patient's last name:

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OCCUPATION SETTING

- | | |
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| <ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other | <ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other |
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OCCUPATION

- | | |
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| <ul style="list-style-type: none"> • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - waiter or waitress • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker | <ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - registered nurse • Medical - other/unknown • Military - officer • Military - recruit or trainee • Protective service - police officer • Protective service - other • Professional, technical, or related profession • Retired • Sex worker • Student - preschool or kindergarten • Student - elementary or middle school • Student - high (secondary) school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high (secondary) school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Other • Refused • Unknown |
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