

Gastroenteritis Case Report Form

Maryland Department of Health

INSTRUCTIONS: Complete Section I for all pathogens; additionally, complete Section II for *Campylobacter*, *Salmonella*, and STEC cases. See **Interviewer Instructions** for more information. Submit completed forms to MDH FoodNet at fax #410-225-7615 or mdh.FoodNet@maryland.gov (*must be encrypted*).

Use this form for:	Complete Sections
<input type="checkbox"/> <i>Campylobacter</i>	I and II
<input type="checkbox"/> <i>Cryptosporidium</i>	I only
<input type="checkbox"/> <i>Salmonella</i> (non-Typhi)	I and II
<input type="checkbox"/> Shiga-toxin producing <i>E. coli</i>	I and II
<input type="checkbox"/> <i>Shigella</i>	I only
<input type="checkbox"/> <i>Yersinia</i>	I only
<input type="checkbox"/> Other:	I only

SECTION I (Complete for all pathogens)

Investigation Data

INVESTIGATOR	INVESTIGATOR PHONE	NEDSS CASE ID#	INVESTIGATION ID# CAS
INVESTIGATOR EMAIL	LAB REPORT DATE	REPORT RECEIVED DATE	INTERVIEW DATE
CASE STATUS <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Unknown	CASE INVESTIGATED AS PART OF AN OUTBREAK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	OUTBREAK/CLUSTER ID	

Patient Data

LAST	FIRST	DATE OF BIRTH	AGE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Other
STREET ADDRESS		CITY	GENDER IDENTITY <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Transgender <input type="checkbox"/> Non-binary <input type="checkbox"/> Genderqueer/Gender nonconforming <input type="checkbox"/> Declined <input type="checkbox"/> Something else:	
STATE	ZIP CODE	COUNTY	HOMELESS <input type="checkbox"/> Yes <input type="checkbox"/> NO	
TELEPHONE		MOBILE	EMAIL	
ETHNICITY (Hispanic, Latino, or Spanish Origin?) <input type="checkbox"/> Yes <input type="checkbox"/> Mexican, Mexican American, Chicano <input type="checkbox"/> No <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Unknown <input type="checkbox"/> Cuban <input type="checkbox"/> Declined		RACE (Check all that apply) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> Declined <input type="checkbox"/> Other		
OCCUPATION, STUDENT (Include Employer, school, etc.)		HIGH RISK <input type="checkbox"/> Food <input type="checkbox"/> Healthcare <input type="checkbox"/> Daycare	RESTRICTION <input type="checkbox"/> Yes <input type="checkbox"/> No	

Clinical Data

SYMPTOMS <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever (°F) <input type="checkbox"/> Vomiting <input type="checkbox"/> Chills <input type="checkbox"/> Other: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Bloody diarrhea <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Nausea <input type="checkbox"/> Muscle aches <input type="checkbox"/> Other:				
ONSET: DATE	TIME	DURATION <input type="checkbox"/> still ill	OUTCOME <input type="checkbox"/> Died, date: <input type="checkbox"/> Survived <input type="checkbox"/> Unknown	
HOSPITALIZED <input type="checkbox"/> No <input type="checkbox"/> Yes →	ADMIT DATE	DISCHARGE DATE	HOSPITAL	ICU? <input type="checkbox"/> No <input type="checkbox"/> Yes
TRANSFERRED <input type="checkbox"/> No <input type="checkbox"/> Yes →	TRANSFER DATE	DISCHARGE DATE	TRANSFER HOSPITAL	STEC ONLY: HAVE HUS? <input type="checkbox"/> No <input type="checkbox"/> Yes
TREATED WITH ANTIBIOTICS <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown →		Name(s) of all antibiotics:		

Laboratory Data ☐ ELR ☐ Epi-linked, no testing done

COLLECTION DATE	LABORATORY NAME	SPECIMEN TESTED <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Other: <input type="checkbox"/> Urine
Test Type <input type="checkbox"/> Culture <input type="checkbox"/> Non-culture, specify: <input type="checkbox"/> Unknown (<input type="checkbox"/> EIA <input type="checkbox"/> PCR <input type="checkbox"/> Other)	AGENT IDENTIFIED	SPECIMEN SENT TO MDH <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History						
In the <u>30 days</u> before illness, from _____ to _____, did [you/your child]:						
Medication Exposures	YES	NO	UNK	If yes, specify name(s) or type(s):		
1. Take antacids or other medications to block acid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Take any antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. Take any probiotics?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4. Take any immunosuppressive medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
In the <u>6 months</u> before illness, from _____ to _____, were [you/your child]:						
Comorbidities	YES	NO	UNK			
1. Diagnosed or treated for cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Diagnosed or treated for diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. Have abdominal surgery (e.g., removal of appendix or gallbladder, any stomach or intestinal surgery)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Environmental Exposures						
In the <u>7 days</u> before illness, from _____ to _____, did [you/your child]:						
WATER-RELATED EXPOSURES	YES	NO	UNK	If yes, details:		
1. Live in a home with a septic system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Primarily use water from a well for drinking water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Treatment:</i>		
3. Drink any untreated water (pond, lake, river, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4. Swim or wade in untreated water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Where?</i>		
5. Swim or wade in treated water (pool, hot tub, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Where?</i>		
ANIMAL CONTACT	YES	NO	UNK			
1. Have contact with an animal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, did [you/your child] have contact with a:				If yes, details:		
a. Dog?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Food/Treat Brand:</i>		
b. Cat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Food/Treat Brand:</i>		
c. Reptile or amphibian (frog, snake, turtle, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify:</i>		
d. Live poultry (chicken, turkey, hen, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
e. Pet bird (not live poultry)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
f. Cattle, goat, or sheep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify:</i>		
g. Pig?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
h. Other animal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify:</i>		
i. Pet with diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Visit, work, or live on a farm, ranch, or petting zoo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify:</i>		
Travel						
In the <u>7 days</u> before illness, from _____ to _____, did [you/your child]:				YES	NO	UNK
1. Travel to another <u>state</u> or <u>country</u> outside of your normal routine? (<i>Specify below</i>)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the <u>6 months</u> before illness, from _____ to _____, did [you/your child]:				YES	NO	UNK
2. Travel to another <u>country</u> ? (<i>Specify below</i>)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Location:		From:		To:		
b. Location:		From:		To:		
c. Location:		From:		To:		
List Hotels/Resorts stayed at:						

Contacts										
In the 7 days before illness, did [you/your child]:				YES	NO	UNK	If yes, details:			
1. Have exposure to a daycare or nursery?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name:			
2. Have a household member or close contact with diarrhea?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
In the 6 months before illness, did:				YES	NO	UNK	If yes, what countries:			
1. Any member(s) of your household travel outside the U.S.?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
[List all household contacts (ill or not ill), and any ill close contacts regardless of where they live (i.e., caregivers, boy/girlfriends, relatives, etc.). For all, indicate if high risk; if symptomatic, give onset and testing information.]										
Name	Age	High Risk			Symptoms		Onset Date	Lab Testing: Y/N, coll. date, result	Relationship to Case	
		Day care	Health care	Food Svc.	Yes	No				
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Food Sources										
In the 7 days before illness, from _____ to _____, did [you/your child]:								YES	NO	UNK
1. Attend any events where food was served? (If yes, list below)								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Event</u>		<u>Date</u>		<u>Location</u>			<u>Foods Eaten</u>			
a.										
b.										
c.										
2. Eat at any restaurants? (If yes, list below)								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Name</u>		<u>Date</u>		<u>Location</u>			<u>Foods Eaten</u>			
a.										
b.										
c.										
d.										
3. List all stores where food eaten prior to illness were purchased (e.g. grocery stores, ethnic markets, farm stands)										
<u>Name</u>				<u>Location</u>				<u>Shoppers Card Number</u>		
a.										
b.										
c.										
d.										
Complete Food History (next page) for ALL cases and Food Exposures (Section II) for ALL <u>Campylobacter</u> , non-Typhi <u>Salmonella</u> , and <u>STEC</u> cases.										
Notes and Summary of Investigation										

Food History (For all cases, complete for the **7 days** before illness. If case was asymptomatic or the onset is unknown, complete for the **7 days** before collection. If the case is an infant or young child that is predominately breast-fed, formula-fed, or has limited food exposures, the following sections should also include responses from the individual who spends the **MOST** time with the case.)

Date							
Morning / Breakfast							
Afternoon / Lunch							
Evening / Dinner							
Snacks / Other							

SECTION II

Food Exposures				
Instructions: Complete for all <i>Campylobacter</i>, non-<i>Typhi Salmonella</i>, and STEC cases. Ask for the 7 day period prior to onset of illness. If unknown or asymptomatic, the 7 days prior to collection date. Use the space on the right to provide additional details, such as the specific type of food and where food was purchased or eaten.				
Respondent was: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Caretaker <input type="checkbox"/> Other (Specify):				
[Infants Only]: <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula-fed (Brand):				
If the case is an infant or young child that is predominately breast-fed, formula-fed, or has limited food exposures, the following sections should also include responses from the individual who spends the MOST time with the case.				
	YES	NO	UNK	<i>If yes, details:</i>
1 Do you follow any special diet (e.g. vegan, kosher, gluten-free)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2 Do you have any food allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3 Do you take any dietary supplements, herbal supplements, protein powders, or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>In the 7 days before illness, from _____ to _____, did [you/your child] eat or drink any:</i>				
	YES	NO	UNK	<i>If yes, food details:</i>
1 Chicken or foods containing chicken?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>If yes, a. Chicken prepared outside the home?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Where?</i>
<i>b. Chicken at home?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Which part(s):</i>
2 Turkey or foods containing turkey?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>a. Ground turkey?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3 Beef or foods containing beef?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>If yes, a. Beef prepared outside the home?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Where?</i>
<i>b. Ground beef?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>If yes, i. Undercooked or raw ground beef?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4 Any veal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5 Pork or foods containing pork?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6 Lamb or mutton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7 Goat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8 Liver (including pate)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>If yes, a. Undercooked or raw liver?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9 Fish or fish products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>a. Undercooked or raw fish (e.g., sushi)?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10 Seafood (e.g., crab, shrimp, oysters, clams)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify:</i>
<i>a. Undercooked or raw seafood?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Which?</i>
11 Any other meat, poultry, or deli meats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify:</i>
12 Frozen meals (e.g., pizza, soup, entrée)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify:</i>
13 Dairy products (e.g., milk, yogurt, cheese, ice cream)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>If yes, a. Pasteurized cow's or goat's milk?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>b. Unpasteurized milk or other dairy?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>From where?</i>
<i>c. Soft cheese (e.g., queso fresco)?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14 Non-dairy milk (e.g., oat, almond, soy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Food Exposures (continued)				
In the 7 days before illness, from	to			, did [you/your child] <u>eat</u> or <u>drink</u> any:
	YES	NO	UNK	If yes, food details:
15 Eggs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, a. Eggs prepared outside the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Where?
b. Eggs that were runny, raw, or uncooked foods made with raw eggs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	From where?
16 Fresh cantaloupe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17 Fresh watermelon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18 Fresh (unfrozen) berries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
19 Unpasteurized, not from concentrate juice (sold at an orchard or farm, or commercially with label)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	From where?
20 Fresh (uncooked) onions (e.g., red, white, yellow)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
21 Fresh green onion or scallions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22 Fresh cucumber?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23 Fresh, raw tomatoes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type(s):
24 Fresh peppers (e.g., bell, hot, sweet)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
25 Fresh, raw lettuce?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify loose (<input type="checkbox"/>) or pre-packaged (<input type="checkbox"/>)
26 Fresh (unfrozen), raw spinach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify loose (<input type="checkbox"/>) or pre-packaged (<input type="checkbox"/>)
27 Sprouts (e.g., mung bean, alfalfa)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
28 Other fresh fruits or vegetables eaten raw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
29 Fresh (not dried) herbs (e.g., basil, cilantro)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
30 Nuts or seeds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
31 Peanut Butter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32 Other nut butter or alternative (e.g. sunflower)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
33 Hummus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34 Other dips or spreads?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
35 Foods purchased online?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, a. Grocery Delivery (Amazon Fresh, Peapod)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Where?
b. Meal Kit Delivery (Blue Apron, Meals on Wheels)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:
36 Foods purchased from someone's home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37 Food from a food truck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38 Food from a farmers' market?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Where?

[Click in box to type any additional notes.]