Gastroenteritis Case Report Form

Maryland Department of Health & Mental Hygiene
Epidemiology & Disease Control Program

Case Reported by: ____________________

Report Date: ___/___/___ **Rec'd Date:** ___/___/___

Disease
☐ Salmonellosis ☐ Campylobacteriosis ☐ Unknown
☐ Shigellosis ☐ Other ____________

Status
☐ Sporadic Case ☐ Outbreak ☐ Unknown

Patient Data

Name Last ____ First ____

Telephone Home ____ Work ____

Address Street ____
County ____ City ____ State ____ Zip ____

Age ____ **Date of Birth** ___/___/___ **Sex** ☐ Male ☐ Female

Are you Hispanic or Latino? ☐ Yes ☐ No

Race: Select one or more. If multiracial, select all that apply.
☐ American Indian or Alaska Native ☐ Native Hawiian or other Pacific Islander
☐ Asian ☐ White
☐ Black or African American ☐ Other ☐ Unknown

Occupation, Student, or Situation

Name of Employer, School, or Day Care

Clinical Data

Date of Onset ___/___/___ **Time** ______ am or pm

☐ Diarrhea ☐ Headache ☐ Cramps
☐ Bloody Stool ☐ Nausea ☐ Muscle Aches
☐ Fever ____°F ☐ Vomiting ☐ Other ____________

Duration ________ **Pregnant at time of onset?** ☐ Yes ☐ No ☐ Unknown

Physician Visit ☐ Yes ☐ No If Yes, Physician Name ____________
Address ____________ Phone # ________

Hospitalized ☐ Yes ☐ No **Pt. ID. #** ________

Hospital Name

Date Admitted ___/___/___ Date Discharged ___/___/___

Transferred to another hospital? ☐ Yes ☐ No

Transfer Hospital Name ____________

Specimen submitted when case was: ☐ Hospitalized ☐ Out Patient ☐ Unknown

Outcome: ☐ Survived ☐ Unknown
☐ Died Date of Death ___/___/___

Laboratory Data

Date of Collection ___/___/___

Specimen Submitted:
☐ Stool ☐ Blood ☐ Urine ☐ None ☐ Other (Specify) ________

Test Type: ☐ Culture ☐ Ova and Parasite ☐ Serological ☐ Other

Agent Identified:
☐ Salmonella Group ______ Serotype ________
☐ Shigella Serotype ________
☐ Campylobacter Serotype ________
☐ Other ________

Originating Lab Name ____________
Specimen Accession ID # ________ Phone # ________

Was the isolate sent to the State Lab for serotyping or confirmation?
☐ Yes ☐ No ☐ Unknown

Travel

Did patient travel to another state or country in the 2 weeks prior to onset of symptoms? ☐ Yes ☐ No

Where ____________ When ____________

Animal Contact

Did patient have direct or indirect contact with any animals such as: dogs, cats, birds, farm animals, turtles, lizards, snakes, rodents, etc. ( ) hours/days* prior to onset of symptoms? ☐ Yes ☐ No

If yes, list ____________

Food History

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

	Yes	No	Unknown
1. Eggs			
a. Cooked eggs: scrambled, fried, other ______	☐	☐	☐
b. Undercooked eggs: poached, soft scrambled, sunny side up, other ______	☐	☐	☐
c. Raw eggs: egg nog, Caesar salad, hollandaise sauce, meringue, bearnaise, other ______	☐	☐	☐
2. Raw or undercooked poultry (chicken, turkey)	☐	☐	☐
3. Raw or undercooked red meat	☐	☐	☐
4. Raw (unpasteurized) milk	☐	☐	☐
5. Homemade/unpasteurized cheese	☐	☐	☐
6. Raw or undercooked fish/shellfish	☐	☐	☐

Other Exposures

Within ( ) hours/days* prior to onset of symptoms did patient:

	Yes	No	Unknown
1. Handle raw meat?	☐	☐	☐
2. Handle raw poultry?	☐	☐	☐
3. Have exposure to a day care or nursery?	☐	☐	☐
4. Have a household member or sexual partner with similar symptoms?	☐	☐	☐
5. Hike, camp, fish, or swim?	☐	☐	☐
6. Drink from a spring, stream, or lake?	☐	☐	☐
7. Take antibiotics in month prior to onset of illness?	☐	☐	☐

Disposition

Work or school restrictions? ☐ Yes ☐ No

If yes, specify ____________

Was patient advised of appropriate precautions?
☐ Yes ☐ No

If yes, how?
☐ Telephone ☐ Fact Sheet ☐ In Person ☐ In Writing

Food History. List the foods eaten within (   ) hours/days* prior to onset of symptoms:

Date:	___/___/___	___/___/___	___/___/___	___/___/___
Breakfast				
Lunch				
Dinner				

Please use additional paper if necessary

Household Members. List all household contacts, even if asymptomatic; give onset if symptomatic:

Name	Age	Relationship to Case	Symptoms Y/N?	Onset of Symptoms	Lab Testing (Date Collected and Result)	Occupation/Employer, School/Grade, Day Care

Summary of Investigation. List actions taken on patients and contacts and outcome:

____

____

____

____

Name of person completing form ______________________ Date of interview ______________________

*Use the incubation period which applies to the agent/disease under investigation: e.g., ***Bacillus cereus*** (1-24 hours), ***Campylobacter*** (1-10 days, usually 2-5 days), ***Cryptosporidium parvum*** (1-12 days), ***Cydospora*** (usually 7 days), ***E. coli*** O157:H7 (3-8 days, usually 3-4 days), ***Listeria*** (variable incubation), ***Salmonella*** (6-72 hours, usually 12-36 hours), ***Shigella*** (12-96 hours, usually 1-3 days), ***Staphylococcus*** (30 min.- 8 hours, usually 2-4 hours), ***Vibrio cholerae*** (few hours - 5 days, usually 2-3 days), ***Vibrio parahaemolyticus*** (4-30 hours, usually 12-24 hours), ***Viral agent*** (24-72 hours), ***Yersinia*** (3-7 days).

For State Health Department use:	Case Control Study	Identified by Audit	Case Report Complete
	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Please mail a copy of the completed form to the State Health Department