State of California—Health and Human Services Agency

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

Local ID Number _____

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)

☐Preliminary ☐Final

SALMONELLOSIS CASE REPORT

***Please note**: Prompt, standardized interview of all cases of salmonellosis is strongly encouraged to improve the accuracy of recall of possible vehicles of infection. Jurisdictions that choose to use this form should maintain the form at the local jurisdiction to be provided to the State's Infectious Diseases Branch staff if the patient is identified as part of a cluster or outbreak investigation. For jurisdictions participating in CalREDIE, entry into the CalREDIE form or scanning and uploading into the CalREDIE filing cabinet will facilitate cluster investigations and surveillance analysis. Please do not fax or send hard copy of the forms to the State unless requested.*

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐*Years* ☐*Months* ☐*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
☐Male ☐Female ☐Other: _____

Pregnant? ☐Yes ☐No ☐Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 8)	*Other Describe/Specify*

Occupation (see list on page 8)	*Other Describe/Specify*

Primary Language
☐English
☐Spanish
☐Other:_____

Ethnicity (check one)
☐Hispanic/Latino
☐Non-Hispanic/Non-Latino
☐Unk

*Race**
(check all that apply, race descriptions on page 8)
☐African-American/Black
☐American Indian or Alaska Native
☐Asian *(check all that apply)*
- ☐Asian Indian ☐Japanese
- ☐Cambodian ☐Korean
- ☐Chinese ☐Laotian
- ☐Filipino ☐Thai
- ☐Hmong ☐Vietnamese
- ☐Other:_____

☐Pacific Islander *(check all that apply)*
- ☐Native Hawaiian ☐Samoan
- ☐Guamanian
- ☐Other:_____

☐White
☐Other:_____
☐Unk

*Comment: self-identity or self-reporting
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.

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

GROUP SETTING

Attend child care or preschool? ☐Yes ☐No ☐Unk	*Location / Other Details of Child Care, Preschool, or Skilled Nursing Facility*
Live in skilled nursing facility? ☐Yes ☐No ☐Unk	

First three letters of patient's last name: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐Yes ☐No ☐Unk	Onset Date (mm/dd/yyyy)	Onset Time (hh:mm)	Specify AM/PM ☐AM ☐PM	Duration of Acute Symptoms (days)

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted	
Diarrhea				Max. number of stools in 24-hr period	Onset date of diarrhea (mm/dd/yyyy)
Bloody diarrhea					
Fever				Highest temperature (specify °F/°C)	
Vomiting					
Abdominal cramps					
Chills					

Other signs / symptoms (specify)

PAST MEDICAL HISTORY

Did the patient take antibiotics in the month prior to onset? ☐Yes ☐No ☐Unk	If Yes, specify antibiotic(s)
Does the patient take any medications regularly? ☐Yes ☐No ☐Unk	If Yes, specify medication(s)
Does the patient have any medical conditions? (i.e., renal disease, diabetes, immune compromising conditions) ☐Yes ☐No ☐Unk	If Yes, specify medical condition(s)

HOSPITALIZATION

Did patient visit emergency room for illness? ☐Yes ☐No ☐Unk	Was patient hospitalized? ☐Yes ☐No ☐Unk	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

Received treatment? ☐Yes ☐No ☐Unk	If Yes, specify the treatments below.

TREATMENT / MANAGEMENT DETAILS

Treatment Type 1 ☐Antibiotic ☐Other	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Treatment Type 2 ☐Antibiotic ☐Other	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)

First three letters of patient's last name: | | | |

OUTCOME

Outcome? ☐Survived ☐Died ☐Unk	If Survived, Survived as of _____(mm/dd/yyyy)	Date of Death (mm/dd/yyyy)

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 ☐Stool ☐Blood ☐Urine ☐Other (specify): _____ _____	Collection Date (mm/dd/yyyy)	Laboratory Name		Telephone Number
	Was result confirmed by local public health lab? ☐Yes ☐No ☐Unk		Result (including subtype)	Local Lab ID Number
	Was isolate sent to state lab for serotyping confirmation? ☐Yes ☐No ☐Unk		Result (including serotype)	State Lab ID Number
	Was PFGE requested? ☐Yes ☐No ☐Unk	Xbal Pattern #	BinI Pattern #	CDC Cluster ID #
Specimen Type 2 ☐Stool ☐Blood ☐Urine ☐Other (specify): _____ _____	Collection Date (mm/dd/yyyy)	Laboratory Name		Telephone Number
	Was result confirmed by local public health lab? ☐Yes ☐No ☐Unk		Result (including subtype)	Local Lab ID Number
	Was isolate sent to state lab for serotyping confirmation? ☐Yes ☐No ☐Unk		Result (including serotype)	State Lab ID Number
	Was PFGE requested? ☐Yes ☐No ☐Unk	Xbal Pattern #	BinI Pattern #	CDC Cluster ID #

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 7 DAYS PRIOR TO ILLNESS ONSET

FOOD HISTORY

DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?

Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Eggs				Eaten undercooked or raw? ☐Yes ☐No ☐Unk		Where purchased
Food made with raw eggs (e.g., eggnog, Caesar salad dressing, cookie dough, homemade mayonnaise)				Food items		Where purchased
Raw (unpasteurized) milk				Type(s)	Brand(s)	Where purchased
Raw milk products				Type(s)	Brand(s)	Where purchased
Mexican-style fresh cheese (queso fresco) or cheese from a street vendor				Unpasteurized? ☐Yes ☐No ☐Unk Type(s)	Brand(s)	Where purchased
Ground beef				Eaten undercooked or raw? ☐Yes ☐No ☐Unk		Where purchased
Poultry				Type(s)	Eaten undercooked or raw? ☐Yes ☐No ☐Unk	Where purchased
Other meat (e.g., pork, lamb, goat, etc.)				Type(s)	Eaten undercooked or raw? ☐Yes ☐No ☐Unk	Where purchased
Raw nuts				Type(s)		Where purchased
Tomatoes				Type(s)		Where purchased

(continued on page 4)

First three letters of patient's last name: | | | |

FOOD HISTORY (continued)						
Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Lettuce				*Type(s)*		*Where purchased*
Cilantro				*Where purchased*		
Green onions				*Where purchased*		
Bean sprouts				*Where purchased*		
Alfalfa sprouts				*Where purchased*		
Other raw vegetables				*Type(s)*		*Where purchased*
Fresh salsa				*Where purchased*		
Cantaloupe				*Where purchased*		
Other raw fresh fruit				*Type(s)*		*Where purchased*
Raw (unpasteurized) juices, ciders, smoothies				*Type(s)*	*Brand(s)*	*Where purchased*
Other food exposures of interest				*Food item(s)*		*Where purchased*

FOOD HISTORY - GROCERIES		
WHERE DID PATIENT SHOP FOR GROCERIES? (INCLUDE FARMER'S MARKETS, DELIS, SWAP MEETS, ETC.)		
Store / Location 1	*Address / Cross-streets*	
	City	*State*
Store / Location 2	*Address / Cross-streets*	
	City	*State*
Store / Location 3	*Address / Cross-streets*	
	City	*State*

FOOD HISTORY - OUTSIDE HOME	
Did patient consume food or drink prepared outside of the home during the incubation period? ☐Yes ☐No ☐Unk	*If Yes, specify name of place (e.g., restaurant, concession stand, friend's house, etc.), location, date, and items consumed below.*

FOOD HISTORY - OUTSIDE HOME - DETAILS		
Name of Place 1	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	
Name of Place 2	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	

(continued on page 5)

First three letters of patient's last name: | | | |

FOOD HISTORY - OUTSIDE HOME - DETAILS

Name of Place 3	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	
Name of Place 4	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	

ANIMAL EXPOSURES

DID THE PATIENT HAVE ANY OF THE FOLLOWING ANIMAL EXPOSURES DURING THE INCUBATION PERIOD?

Animal Exposures	Yes	No	Unk	Type(s) of Animals	Animal ill?	Setting/Location	Date (mm/dd/yyyy)
Birds					☐Yes ☐No ☐Unk		
Reptiles					☐Yes ☐No ☐Unk		
Other pet					☐Yes ☐No ☐Unk		
Livestock (e.g., cows, pigs, sheep, goats)					☐Yes ☐No ☐Unk		
Farms					☐Yes ☐No ☐Unk		
Animal exhibits (e.g., petting zoos, fairs)					☐Yes ☐No ☐Unk		
Other animal exposures of interest					☐Yes ☐No ☐Unk		

WATER EXPOSURES

DID THE PATIENT HAVE ANY OF THE FOLLOWING WATER EXPOSURES DURING THE INCUBATION PERIOD?

Water Source	Yes	No	Unk	Activity	Location	Date (mm/dd/yyyy)
Natural: rivers, lakes, oceans, etc.						
Artificial: swimming pools, water parks, fountains, etc.						
Other water exposures of interest						

TRAVEL HISTORY

*Did patient travel **outside county of residence** during the incubation period?* ☐Yes ☐No ☐Unk	*If Yes, specify all locations and dates below.*

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

First three letters of patient's last name: | | | |

HOUSEHOLD CONTACTS

How many people besides the case, live in the household?	Please provide details below.

HOUSEHOLD CONTACTS - DETAILS

Name 1	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? ☐Yes ☐No ☐Unk
	Telephone Number	Similar illness? ☐Yes ☐No ☐Unk		Onset Date (mm/dd/yyyy)	Comment
Name 2	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? ☐Yes ☐No ☐Unk
	Telephone Number	Similar illness? ☐Yes ☐No ☐Unk		Onset Date (mm/dd/yyyy)	Comment
Name 3	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? ☐Yes ☐No ☐Unk
	Telephone Number	Similar illness? ☐Yes ☐No ☐Unk		Onset Date (mm/dd/yyyy)	Comment
Name 4	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? ☐Yes ☐No ☐Unk
	Telephone Number	Similar illness? ☐Yes ☐No ☐Unk		Onset Date (mm/dd/yyyy)	Comment

ILL CONTACTS

Any contacts with similar illness (including household contacts)? ☐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	Occupation	Sensitive occupation / situation? ☐Yes ☐No ☐Unk
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	Occupation	Sensitive occupation / situation? ☐Yes ☐No ☐Unk

NOTES / REMARKS

First three letters of patient's last name: | | | |

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*

First Reported By	*Health education provided?*	*Restriction / clearance needed?*
☐Clinician ☐Laboratory ☐Other (specify):_____	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case?	*Contact Name / Case Number*
☐Yes ☐No ☐Unk	

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐Confirmed ☐Probable ☐Suspect

OUTBREAK

Part of known outbreak?	*If Yes, extent of outbreak:*
☐Yes ☐No ☐Unk	☐One CA jurisdiction ☐Multiple CA jurisdictions ☐Multistate ☐International ☐Unk ☐Other (specify):_____

Mode of Transmission	*Vehicle of Outbreak*	*Pattern 1 ID number*	*Pattern 2 ID number*
☐Point source ☐Person-to-person ☐Unk ☐Other:_____			

STATE USE ONLY

State Case Classification
☐Confirmed ☐Probable ☐Suspect ☐Not a case ☐Need additional information

CASE DEFINITION

SALMONELLOSIS (2010)

CLINICAL DESCRIPTION: An illness of variable severity commonly manifested by diarrhea, abdominal pain, nausea, and sometimes vomiting. Asymptomatic infections may occur, and the organism may cause extraintestinal infections.

LABORATORY CRITERIA FOR DIAGNOSIS: Isolation of *Salmonella* from a clinical specimen.

CASE CLASSIFICATION
- **Confirmed**: a case that meets the laboratory criteria for diagnosis. When available, O and H antigen serotype characterization should be reported.
- **Probable**: a clinically compatible case that is epidemiologically linked to a confirmed case.

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.

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Adult film actor/actress
- 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 - server
- 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
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - nurse
- Medical - other/unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent/guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Volunteer
- Other
- Refused
- Unknown