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

TYPHOID AND PARATYPHOID FEVER CASE REPORT

Please complete this form only for new, symptomatic, culture-proven cases of typhoid or paratyphoid fever.

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 6)	*Other Describe/Specify*

Occupation (see list on page 6)	*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 6)
☐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*

SIGNS AND SYMPTOMS

Was the patient ill with symptoms of typhoid or paratyphoid fever (sustained fever, headache, anorexia, relative bradycardia, constipation or diarrhea, etc.)? ☐Yes ☐No ☐Unk	*If Yes, onset date of symptoms (mm/dd/yyyy)*
	Date First Sought Medical Care (mm/dd/yyyy)

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

PAST MEDICAL HISTORY

Did the patient receive typhoid vaccination (primary series or booster) within five years before onset of illness? ☐Yes ☐No ☐Unk	*If Yes, indicate type of vaccine and year received below.*	
	Oral Ty21a or Vivotif (Berna) four pill series? ☐Yes ☐No ☐Unk	*Year Received (yyyy)*
	ViCPS or Typhin Vi shot (Pasteur Merieux)? ☐Yes ☐No ☐Unk	*Year Received (yyyy)*

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)*

OUTCOME

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

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY - FIRST ISOLATION

Date Salmonella First Isolated (mm/dd/yyyy)	*Site(s) of Isolation:* ☐Blood ☐Stool ☐Gall bladder ☐Unk ☐Other (specify):_____
State Lab Isolate ID Number	*Serotype* ☐*S.* Typhi ☐*S.* Paratyphi A ☐*S.* Paratyphi B ☐*S.* Paratyphi C ☐Unk

Was antibiotic sensitivity testing performed on the (these) isolate(s) at the laboratory? ☐Yes ☐No ☐Unk

If Yes, specify if the organism was resistant to the antibiotics listed below.

Ampicillin? ☐Yes ☐No ☐Not tested ☐Unk	*Chloramphenicol?* ☐Yes ☐No ☐Not tested ☐Unk	*Trimethoprim-sulfamethoxazole?* ☐Yes ☐No ☐Not tested ☐Unk	*Fluoroquinolones (e.g. Ciprofloxacin)?* ☐Yes ☐No ☐Not tested ☐Unk

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

LABORATORY RESULTS SUMMARY - ADDITIONAL TESTS

Specimen Type 1 ☐Blood ☐Stool ☐Gall bladder ☐Unk ☐Other:_____	*Type of Test*	*Collection Date (mm/dd/yyyy)*	*Results*
	Laboratory Name		*Telephone Number*
Specimen Type 2 ☐Blood ☐Stool ☐Gall bladder ☐Unk ☐Other:_____	*Type of Test*	*Collection Date (mm/dd/yyyy)*	*Results*
	Laboratory Name		*Telephone Number*
Specimen Type 3 ☐Blood ☐Stool ☐Gall bladder ☐Unk ☐Other:_____	*Type of Test*	*Collection Date (mm/dd/yyyy)*	*Results*
	Laboratory Name		*Telephone Number*
Specimen Type 4 ☐Blood ☐Stool ☐Gall bladder ☐Unk ☐Other:_____	*Type of Test*	*Collection Date (mm/dd/yyyy)*	*Results*
	Laboratory Name		*Telephone Number*

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 30 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY

Did patient travel or live outside the United States during the incubation period? ☐Yes ☐No ☐Unk	*If Yes, date of most recent return or entry to the United States (mm/dd/yyyy)*	
	If No, is patient a close personal contact of a person who traveled internationally? ☐Yes ☐No ☐Unk	*Describe*

Did patient travel outside the county of residence during the incubation period?
☐Yes ☐No ☐Unk

If Yes, to either of the above travel questions, specify all locations and dates in the Travel History - Details table.

TRAVEL HISTORY - DETAILS

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

EXPOSURES / RISK FACTORS

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, friends house, etc.), location, date, and items consumed below.*

EXPOSURES / RISK FACTOR - DETAILS

Name of Place 1	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	

(continued on page 4)

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

EXPOSURES / RISK FACTOR - DETAILS (continued)

Name of Place 2	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	
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	

ILL CONTACTS

Was the case traced to a typhoid carrier? ☐Yes ☐No ☐Unk	*If Yes, was the carrier previously known to the health department?* ☐Yes ☐No ☐Unk
Any contact with similar illness? ☐Yes ☐No ☐Unk	*If there are any ill contacts or contacts who are typhoid carriers, list in the contact section 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
☐Clinician ☐Laboratory ☐Other (specify):_____

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case?
☐Yes ☐No ☐Unk

DISEASE CASE CLASSIFICATION

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

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 ☐Not a case ☐Need additional information

CASE DEFINITION

TYPHOID FEVER (2010)

CLINICAL DESCRIPTION

An illness caused by *Salmonella* Typhi that is often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and nonproductive cough. However, many mild and atypical infections occur. Carriage of *S.* Typhi may be prolonged.

LABORATORY CRITERIA FOR DIAGNOSIS

Isolation of *S*. Typhi from blood, stool, or other clinical specimen

CASE CLASSIFICATION

- **Probable:** a clinically compatible case that is epidemiologically linked to a confirmed case in an outbreak

- **Confirmed**: a clinically compatible case that is laboratory confirmed

COMMENT

Isolation of the organism is required for confirmation. Serologic evidence alone is not sufficient for diagnosis. Asymptomatic carriage should not be reported as typhoid fever. Isolates of S. Typhi are reported to the Foodborne and Diarrheal Diseases Branch, Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC, through the Public Health Laboratory Information System.

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