



Typhoid and Paratyphoid Fever Patient Demographics

Please complete this information for all cases of typhoid or paratyphoid fever in addition to CDC's Typhoid and Paratyphoid Fever Surveillance Report. Please fax both forms to DSHS Central Office, Attn: Foodborne Illness Team, at 512-458-7616.

Patient's name: _____	DOB: ____/____/____	Age: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk
Patient's address: _____ _____	Race (Check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Phone number: (h) () _____ (w) () _____			



TYPHOID AND PARATYPHOID FEVER SURVEILLANCE REPORT

CDC NO.: STATE LAB ISOLATE ID NO. **Instructions:****- Please complete this form only for new, symptomatic, culture-proven cases of typhoid or paratyphoid fever. -** Form Approved OMB No. 0920-0009**DEMOGRAPHIC DATA**

1. Reporting State: <input type="text"/>	2. First three letters of patient's last name: <input type="text"/>	3. Date of birth: <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Yr. or Age: (in years) <input type="text"/>
4. Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	5. Does the patient work as a foodhandler? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	6. Citizenship: (21) U.S. <input type="checkbox"/> Other: <input type="text"/> Unk. <input type="checkbox"/>

CLINICAL DATA

7. Was the patient ill with typhoid or paratyphoid fever? (fever, abdominal pain, headache, etc) Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	If Yes, give date of onset of symptoms: <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Yr.	8. Was the patient hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	If Yes, how many days was the patient hospitalized? <input type="text"/> Days	9. Outcome of case: Recovered <input type="checkbox"/> Died <input type="checkbox"/> Unk. <input type="checkbox"/>
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LABORATORY DATA

10. Date <i>Salmonella</i> first isolated: <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Yr.	Site(s) of isolation: (check all that apply) Blood <input type="checkbox"/> Stool <input type="checkbox"/> Gall bladder <input type="checkbox"/> Other (specify): <input type="text"/>
Serotype: S. Typhi <input type="checkbox"/> S. Paratyphi A <input type="checkbox"/> S. Paratyphi B <input type="checkbox"/> S. Paratyphi C <input type="checkbox"/>	
11. Was antibiotic sensitivity testing performed on this (these) isolate(s) at the laboratory? (Please contact the clinical laboratory for this information) Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	If Yes, was the organism resistant to:
<ul style="list-style-type: none"> • Ampicillin: Yes <input type="checkbox"/> No <input type="checkbox"/> Not tested <input type="checkbox"/> • Chloramphenicol: Yes <input type="checkbox"/> No <input type="checkbox"/> Not tested <input type="checkbox"/> • Trimethoprim-sulfamethoxazole: Yes <input type="checkbox"/> No <input type="checkbox"/> Not tested <input type="checkbox"/> • Fluoroquinolones (e.g., Ciprofloxacin): Yes <input type="checkbox"/> No <input type="checkbox"/> Not tested <input type="checkbox"/> 	

EPIDEMIOLOGIC DATA

12. Did this case occur as part of an outbreak? (two or more cases of typhoid or paratyphoid fever associated by time and place) Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	
13. Did the patient receive typhoid vaccination (primary series or booster) within five years before onset of illness? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	If Yes, indicate type of vaccine received: <ul style="list-style-type: none"> • Oral Ty21a or Vivotif (Berna) four pill series: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="text"/> • ViCPS or Typhim Vi shot (Pasteur Merieux): Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="text"/>
14. Did the patient travel or live outside the United States during the 30 days before the illness began? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	If Yes, please list in order the countries visited during the 30 days before the illness began: (other than the United States) <ol style="list-style-type: none"> 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>
Date of most recent return or entry to the United States: <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Yr.	
15. Was the purpose of the international travel:	
a.) Business? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	d.) Immigration to U.S.? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>
b.) Tourism? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	e.) Other? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>
c.) Visiting relatives or friends? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	(if other, specify): <input type="text"/>
16. Was the case traced to a typhoid or paratyphoid carrier? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	If Yes, was the carrier previously known to the health department? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>
17. Comments: <input type="text"/>	

18. Name of Person Completing Form: <input type="text"/>
Address: <input type="text"/>
Telephone: <input type="text"/>
Date: <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Yr.

- THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM -

Please send a copy to your STATE EPIDEMIOLOGY OFFICE **and** the
 FOODBORNE AND DIARRHEAL DISEASES BRANCH, CENTERS FOR DISEASE CONTROL AND PREVENTION,
 Mailstop A-38, Atlanta, Georgia, 30333. • Fax: (404) 639-2205

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).