



**Foodborne Botulism Alert Summary**  
 Texas Department of State Health Services  
 Infectious Disease Surveillance and Epidemiology Branch  
 Mailcode 1960  
 PO Box 149347  
 Austin, TX 78714-9347  
 (512) 458-7676 (512) 458-7616 fax

1. Name of patient: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Sex: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ H=Hispanic or Latino; N=not Hispanic or Latino; U=Unknown  
 Race: \_\_\_\_\_ W=White; B=Black/African American; N=American Indian/Alaska Native; P=Native Hawaiian/Pacific Islander; A=Asian; O=Other; U=Unknown  
 Patient address: \_\_\_\_\_ Patient phone number: (\_\_\_\_) \_\_\_\_\_  
 Hospital: \_\_\_\_\_ Hospital phone number: (\_\_\_\_) \_\_\_\_\_  
 Physician: \_\_\_\_\_ Physician phone number: (\_\_\_\_) \_\_\_\_\_  
 Physician Address: \_\_\_\_\_

2. Onset of symptoms: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hour: \_\_\_\_\_ AM / PM

3. Symptoms (* are typical):	YES	NO	UNK		YES	NO	UNK
a) Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	k) Dyspnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	l) Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	m) Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Diarrhea (especially type E)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	n) Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) *Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	o) Urinary retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Diplopia (double vision)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	p) Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Photophobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	q) Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) *Dysphagia (difficulty swallowing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	r) Paresthesia (not typical)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) *Dysphonia (difficulty speaking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	where: _____			
j) *Muscle weakness				s) Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1) *upper extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	t) Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
3) *symmetrical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
4) where started: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

4. SIGNS (*are typical):	YES	NO	UNK		YES	NO	UNK
a) *Ptosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i) Sensory findings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Extraocular palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____			
c) Pupils				j) Ataxia			
1) *dilated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1) symmetrical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) constricted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	k) Nystagmus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) *mid-position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	l) Reflexes			
4) reactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1) *normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) *non-reactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2) *hypoactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Decreased corneal reflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3) hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Facial paralysis				4) *symmetrical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1) symmetrical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	m) *Respiratory impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) *Decreased gag reflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	n) Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Decreased ability to protrude tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	o) Vital capacity: _____ cc			
h) *Weakness or paralysis of extremity(ies)				p) Abnormal mental status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1) upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	q) Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
3) *symmetrical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

5. Does patient have a wound?  Yes  No If yes, where? \_\_\_\_\_  
 How treated: \_\_\_\_\_

6. Did patient take antibiotics, anticholinergics, or phenothizaines during the last week?  Yes  No  
 If yes, which drug: \_\_\_\_\_

7. Laboratory results: a) Spinal tap  Yes  No (Normal in botulism, myasthenia gravis; protein may be elevated in Guillain-Barré)

(Normal range)	(0)	(<10)	(15-45 mg%)	(50-70 mg%)	Other
Date	RBC's	WBC's	Protein	Glucose	
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

b) Tensilon test: [Negative in botulism and Guillain-Barré, positive in myasthenia gravis. After administration of Tensilon (edrophonium chloride) the patient's eye signs (ptosis & extraocular abnormalities) markedly decrease.]

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Positive  Negative  Not done

Comments: \_\_\_\_\_

c) EMG results (electromyography): (Botulism: action potential diminished after a single supramaximal stimulus, facilitation with repetitive stimuli at 20-50/sec) (Myasthenia gravis: similar to botulism) (In Guillain-Barré: slowed nerve conduction, whereas there is normal conduction in botulism)

Date	Nerve Stimulated	Stimulated Frequency	Amplitude (Circle One) increase / decrease	Facilitation <input type="checkbox"/> Yes <input type="checkbox"/> No
____/____/____	_____	_____	_____	_____
____/____/____	_____	_____	_____	_____

d) Brain scan Comments: \_\_\_\_\_

e) CT scan (Should be unremarkable) Comments: \_\_\_\_\_

8.a) Indicate date laboratory specimens collected:	DATE	RESULTS
Serum from 20 mL whole blood	____/____/____	_____
Gastric aspirate	____/____/____	_____
5 gm foods	____/____/____	_____
Wound tissue	____/____/____	_____
Wound aspirate	____/____/____	_____

b) Samples: Serum and stool should be sent on cold packs to: (Please do not freeze the serum and stool. If cold packs are unavailable, ship on wet ice. Specify that an overnight courier will be used. Instruct persons shipping samples to call (512) 458-7582 and identify what courier was used.)

LABORATORY SERVICES SECTION  
 TEXAS DEPARTMENT OF STATE HEALTH SERVICES  
 1100 WEST 49<sup>TH</sup> STREET  
 AUSTIN, TX 78756  
 ATTN: Rahsaan Drumgoole, Biothreat Team

9. Suspect Food(s)	Brand name	Lot #	Where Purchased
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. Describe method of preparation of item(s) for serving: \_\_\_\_\_

If home-canned, describe technique of canning: \_\_\_\_\_

11. Incubation Period: (usually 18 to 36 hours) \_\_\_\_\_

12. CDC notified? [24/7 CDC Emergency Operations Center: (770) 488-7100]  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

DSHS Lab Biothreat Team notified? [Day: (512) 458-7111 x7185, x3781, or x7582]  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

DSHS Foods Group notified? [Day: (512) 834-6670]  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

DSHS Food Establishment Group notified? [Day: (512) 834-6753]  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

13. Date antitoxin given: \_\_\_\_/\_\_\_\_/\_\_\_\_

14. Comments: \_\_\_\_\_

Frequency of signs & symptoms of foodborne botulism:

Blurred vision	90-100%	Dry mouth	70-100%	Dysphagia	75-90%	Dysphonia	60-80%
Muscle weakness	80-100%	Dilated, fixed pupils	93%	Ptosis	60-80%		

Quarantine station – Los Angeles (310) 215-2365

Antitoxin: (1) dose given by IV

Four cardinal clinical features of botulism:

1. Neurologic manifestations are symmetric and descending.
2. Mental processes are generally clear.
3. No sensory disturbances, numbness, or decreased perception of touch or paresthesia.
4. Fever is absent early in the disease.

Reported by: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Date Reported: \_\_\_\_/\_\_\_\_/\_\_\_\_

Investigated by: \_\_\_\_\_ Investigation Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Agency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_