Listeriosis

COUNTY

FOR STATE USE ONLY #

___/___/___ case report ☐ confirmed ☐ presumptive

___/___/___ interstate ☐ suspect

Date investigation initiated: ____ /____ /____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

e-mail address_____ language spoken _____

ALTERNATIVE CONTACT: ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT *(check all that apply)*

☐ Lab ☐ Infection Control Practitioner

☐ Physician ☐ _____

Name _____

Phone _____ Date ___/___/___
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient? ☐

DEMOGRAPHICS

SEX

☐ female ☐ male

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____

HISPANIC ☐ yes ☐ no ☐ unknown

RACE

☐ White ☐ American Indian

☐ Black ☐ Asian/Pacific Islander

☐ unknown ☐ refused to answer

☐ other _____

Worksites/school/day care center_____

_____

Occupations/grade_____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic: ☐ yes ☐ no ☐ unk *if yes*, ONSET on ____/____/____
m d y

Hospitalized: ☐ yes ☐ no ☐ unk

name of hospital _____

date of admission ____/____/____ date of discharge ____/____/____
m d y m d y

Transferred to another hospital: ☐ yes ☐ no ☐ unk

transfer hospital name _____

Outcome: ☐ survived ☐ died ☐ unk date of death ____/____/____
m d y

Indicate if patient had:

septicemia	☐ yes	☐ no	☐ unk
meningitis	☐ yes	☐ no	☐ unk
amniotis	☐ yes	☐ no	☐ unk
no symptoms	☐ yes	☐ no	☐ unk

other _____

Indicate if patient was:

pregnant	☐ yes	☐ no	☐ unk
immunocompromised	☐ yes	☐ no	☐ unk

If pregnant, what was the outcome of the pregnancy?

still pregnant	☐ yes	☐ no	☐ unk
miscarriage	☐ yes	☐ no	☐ unk
stillbirth	☐ yes	☐ no	☐ unk
perterm delivery (live)	☐ yes	☐ no	☐ unk
term delivery (live)	☐ yes	☐ no	☐ unk

other _____

Did the fetus or neonate (<1 month of age) have culture-confirmed listeriosis?
☐ yes ☐ no ☐ unk

If yes, what infection did the child have?

meningitis	☐ yes	☐ no	☐ unk
bacterima/sepsis	☐ yes	☐ no	☐ unk
granulomatosis infantisepticum	☐ yes	☐ no	☐ unk

other _____

Child's outcome: ☐ unknown

☐ survived date of birth ____/____/____
m d y

☐ died date of death ____/____/____
m d y

LABORATORY DATA

Culture confirmed: ☐ yes ☐ no

if yes, Lab _____

Source of case specimen:
☐ CSF ☐ blood
☐ meconium ☐ other_____

Date specimen collected____/____/____
m d y

Isolate submitted to PHL? ☐ yes ☐ no ☐ unk

PHL specimen # _____

Serotype _____

If pregnancy-associated case, was a specimen collected on the child? ☐ yes ☐ no ☐ unk

Source of child's specimen:
☐ CSF ☐ blood
☐ placenta ☐ other_____

Date specimen collected____/____/____
m d y

Isolate submitted to PHL? ☐ yes ☐ no ☐ unk

PHL specimen # _____

Serotype _____

EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak? ☐ yes ☐ no ☐ unk
a close contact of a *confirmed* or *presumptive* case? ☐ yes ☐ no ☐ unk

Has the above case been reported? ☐ yes ☐ not yet

Specify nature of contact:

☐ household ☐ sexual ☐ daycare ☐ _____

if yes to any question, specify relevant names, dates, places, etc:

Does the case know about anyone else with a similar illness? ☐ yes ☐ no ☐ could not be interviewed

if yes, give names, onset dates, contact information, and other details.

name	age	occupation	onset date	comments

C

ADMINISTRATION

Remember to copy patient's name to the top of this page.

Case report sent to OHS on ____/____/____

Completed by _____ Date _____ Phone _____ Investigation sent to OHS on ____/____/____