

Demographic and Contact Information

Patient Surname:		First Name:	PHN:
Birthdate: (e.g. 15/Dec/07)	Sex: F <input type="checkbox"/> M <input type="checkbox"/>	Parent or Guardian: <input type="checkbox"/> Respondent is case	
Address: (street, city, postal code)		Home phone: _____	
E-mail:		Work: _____	
		Cell: _____	
Physician:		Physician Phone:	

Case Notification/Assignment

Report Received at HU: (e.g. 15/Dec/07)	
Contact attempts (date and time)	Interview?
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>
Interviewer: <input type="checkbox"/> Not located	

Clinical Information

Serotype	Specimen type	Lab Report Date: (e.g. 15/Dec/07)	Reporting lab:
Onset of Earliest Symptom (e.g. 15/Dec/07) Time: _____ am/pm	Earliest Symptom:	Hospitalized: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Name of Hospital:
Other Symptoms: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Muscle aches <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Headache <input type="checkbox"/> Bacteremia <input type="checkbox"/> Fever <input type="checkbox"/> Meningitis <input type="checkbox"/> Chills <input type="checkbox"/> UTI <input type="checkbox"/> Asymptomatic Other: _____		Date of Admission (e.g. 15/Dec/07)	Date of Discharge (e.g. 15/Dec/07):
If pregnant, outcome (check one): <input type="checkbox"/> Still pregnant <input type="checkbox"/> Fetal death (miscarriage/stillbirth) <input type="checkbox"/> Induced abortion <input type="checkbox"/> Live birth No. weeks gestation: _____		Deceased: <input type="checkbox"/> Y <input type="checkbox"/> N	
If live birth, illness in infant: <input type="checkbox"/> None <input type="checkbox"/> Meningitis <input type="checkbox"/> Bacteremia <input type="checkbox"/> Febrile gastroenteritis <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
If live birth, status of neonate at time of interview <input type="checkbox"/> recovered <input type="checkbox"/> still ill <input type="checkbox"/> deceased			
Underlying conditions or medications that suppress the immune system (e.g. diabetes, cancer, steroids)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK			
If yes, specify:			

Exposure Period



Travel

Infection acquired during travel: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes: <input type="checkbox"/> Within BC <input type="checkbox"/> Within Canada <input type="checkbox"/> Outside Canada
Departure (e.g. 15/Dec/07):
Return (e.g. 15/Dec/07):
Destination(s) (e.g. city, mode of travel):
Foods brought back?:

Animal Contact

Farm, Petting Zoo, Agricultural Fair, Wildlife: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Pets (incl reptiles) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Pet treats or Raw food diet (circle): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Details (e.g. dates, location, type of animals):

Food Exposures

Vegetarian? <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies/Avoidances/special diet? <input type="checkbox"/> Y <input type="checkbox"/> N Details:
Social Gatherings (e.g. parties, weddings, showers, potlucks, community event): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Details:
Restaurants (including: take-out, cafeteria, bakery, deli, kiosk): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK

BC Listeriosis Follow-up Form

Details:

Usual sources of groceries (including grocery stores, specialty/ethnic stores and markets):

Store Name _____ Location _____ Details (e.g. items purchased, date of visit, if known) _____

Specific High Risk Foods/Activities

<i>Risk factor</i>	<i>Eaten</i>	<i>Details</i> Please specify type/ brand where possible	<i>Risk factor</i>	<i>Eaten</i>	<i>Details</i> Please specify type/ brand where possible
Cold cuts/deli meats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Humous	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Pate	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Mussels	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Hot dogs/frankfurters/sausages	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Oysters	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Brie/camembert	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Raw fish (e.g., sushi)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Feta	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Smoked salmon/fish	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Goat cheese	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Shrimp	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Blue/gorgonzola	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Crab	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Other soft cheese	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Melons	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Hard cheese	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Lettuce (bagged or whole)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Unpasteurized milk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Fresh herbs	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Butter	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Fresh mushrooms	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Other dairy (pasteurized)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Sprouts (e.g., alfalfa, bean)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Tuna salad	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Fresh berries	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Cole slaw	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Fresh fruit or vegetable juice	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Other salad (e.g., potato, pasta, bean, fruit, seafood)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Contact with hospital/LTCF	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	

Contacts

people in household:

<i>Name</i>	<i>Date ill?</i>	<i>Nature of contact*</i>	<i>Occupation/Details</i>	<i>Contact phone</i>	<i>^Excluded?</i>

*Household, sexual, close contacts.

^ Please complete Contact Exclusion Form for each contact excluded.

Occupation and Exclusion

Occupation:	Facility name:
Sensitive Setting (check if applicable):	
<input type="checkbox"/> Work/volunteer or attend day care <input type="checkbox"/> Work/volunteer in a health care setting <input type="checkbox"/> Work/volunteer as a food handler <input type="checkbox"/> Other (e.g. pool): _____	
Excluded <input type="checkbox"/> Y <input type="checkbox"/> N Effective date (e.g. 15/Dec/07):	
Details:	
Symptom end date (e.g. 15/Dec/07):	
Exclusion lifted: (e.g. 15/Dec/07):	
MHO:	

Interventions

	Details
<input type="checkbox"/> Referred for Inspection	
<input type="checkbox"/> Referred to another HA	
<input type="checkbox"/> Hygiene Education Provided	
<input type="checkbox"/> Health File Sent	
<input type="checkbox"/> Other	

Notes

Date	Comment	Initials

When completed please fax to Marsha Taylor (604) 707-2516. Thank you.