BC Typhoid/Paratyphoid Fever Follow-up Form*

Demographic and Contact Information

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

Case Notification/Assignment

Report Received at HU: (e.g. 15/Dec/07)

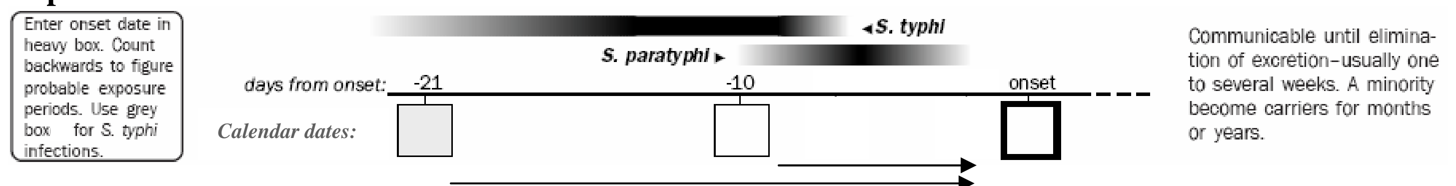
Contact attempts (date and time)	Interview?
1.	☐
2.	☐
3.	☐
4.	☐

Interviewer: ☐ Not located

Clinical Information

Serotype ☐ Typhi ☐ Paratyphi	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: ☐Y ☐N ☐DK	Name of Hospital:
Other Symptoms: ☐ Diarrhea ☐ Bloody Diarrhea ☐ Vomiting ☐ Abdominal cramps ☐ Nausea ☐ Fever Other: _________ Other: _________		Date of Admission (e.g. 15/Dec/07)	Date of Discharge (e.g.15/Dec/07):
		Deceased: ☐Y ☐N	Antibiotic Use: ☐Y ☐N ☐DK

Exposure Period



Disease Acquisition

Travel and Vaccination Status^

Infection acquired during travel: ☐Y ☐N ☐DK

If yes: ☐ Within BC ☐ Within Canada ☐ 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?:

Oral typhoid vaccine within 5 years: ☐Y ☐N ☐DK

IV typhoid vaccine within 2 years: ☐Y ☐N ☐DK

Local Exposures Prior to Case Onset

Contact with international visitor or person recently abroad: ☐Y ☐N ☐DK

Contact with any symptomatic person: ☐Y ☐N ☐DK

If yes to any of the above:

Relationship to case	Ill?	Date(s) of contact	Details

Any imported foods consumed? ☐Y ☐N ☐DK

Details:

If no to all of the above:

Any social gatherings attended? ☐Y ☐N ☐DK

Details:

Any restaurants visited? ☐Y ☐N ☐DK

Details:

^ If case not travel-related, please notify local MHO and BCCDC

* for cases of *S.* Paratyphi B Java, use standard Salmonellosis form

December, 2007

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Disease Transmission

Case Occupation and Exclusion

Occupation:

Sensitive Setting (check if applicable):

- ☐ Work/volunteer or attend day care
- ☐ Work/volunteer in a health care setting
- ☐ Work/volunteer as a food handler
- ☐ Other (e.g. pool): ___________________________________

Facility name:

Excluded ☐Y ☐N Effective from (E.G. 15/DEC/07):

Details:

Symptom end date (e.g. 15/Dec/07):

Exclusion lifted: (E.G. 15/DEC/07):

MHO:

Case Exclusion Worksheet†

Antibiotic Use: ☐Y ☐N ☐DK Specify: __________________________

Length of treatment: _______ days

Date of Discontinuation (E.G. 15/DEC/07):

Sample Number	Sample type (stool/urine)	Date (e.g. 15/Dec/07)	Result
1			☐ Pos ☐ Neg
2			☐ Pos ☐ Neg
3			☐ Pos ☐ Neg
4			☐ Pos ☐ Neg
5			☐ Pos ☐ Neg
6			☐ Pos ☐ Neg

† Refer to CD Control Guidelines on Exclusion of Enteric Cases and their Contacts from High Risk Settings

Contacts at risk of acquiring disease*

people in household:

Name	*Date Ill?*	*Nature of contact**	*Occupation/Details*	*Contact phone*	*Sample requested?*	*^Excluded?*

*Household, sexual, close contacts

^ Please complete an S. Typhi/Paratyphi Contact Exclusion Form for each contact excluded

Interventions

	Details		Details
☐ Referred for Inspection		☐ Referred to another HA	
☐ Hygiene Education Provided		☐ Health file sent	
☐ Case excluded	As above	☐ Contact excluded	
☐ Other			

Notes

Date	Comment	Initials

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