BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Salmonellosis Case Report Form

Confidential when completed

PERSON REPORTING	
Health Authority:	☐ FHA ☐ IHA ☐ VIHA ☐ NHA ☐ VCH
Name:	*Last* *First*
Phone:	( ) - ext.
Email:	

Date Report Received at HU (YYYY/MM/DD): _____

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

Interviewer: ☐ *Not located*

A. CLIENT INFORMATION

Name: *Last* *First* *Middle* Alternate Name(s):

PHN: | Date of Birth: *YYYY / MM / DD* | Sex: ☐ Male ☐ Female

Home Address: *Unit #* *Street #* *Street Name* | City:

Postal code: | Province: | Phone number (home/office/cell) ( ) - ext.

Email: | Physician Name *Last* *First* | Physician Phone Number:

Interview conducted with:

B. ABORIGINAL INFORMATION

Do you wish to self-identify as an Aboriginal Person?
☐ Asked, not provided ☐ No
☐ Not asked ☐ Yes

Aboriginal Identity:
☐ Asked, but unknown ☐ Asked, not provided ☐ First Nations
☐ First Nations and Inuit ☐ First Nations and Métis ☐ First Nations, Inuit and Métis ☐ Inuit
☐ Inuit and Métis ☐ Métis ☐ Not asked

First Nations Status:
☐ Asked, but unknown ☐ Asked, not provided ☐ Non-Status Indian
☐ Not Asked ☐ Status Indian

C. CLINICAL INFORMATION

Date of onset of symptoms: _____ *YYYY / MM / DD* Onset time: _____ AM / PM

Signs and Symptoms

☐ Abdominal discomfort ☐ Diarrhea ☐ Bloody diarrhea ☐ Other: _____
☐ Fever ☐ Nausea ☐ Vomiting

Hospitalization

Admitted to hospital: ☐ Yes ☐ No ☐ DK Hospital name: _____

Admission date: _____ *YYYY / MM / DD* Discharge date: _____ *YYYY / MM / DD*

Outcome

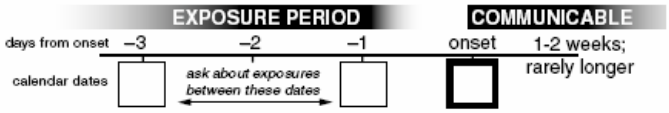
Death: ☐ Yes ☐ No ☐ DK *If yes*, death date: _____ *YYYY / MM / DD* Antibiotic use: ☐ Yes ☐ No ☐ DK

D. LABORATORY INFORMATION

Specimen type	Reporting lab	Collection date	Reported date	Results
		YYYY / MM / DD	*YYYY / MM / DD*	Serotype:

E. RISK FACTORS AND EXPOSURE INFORMATION

Enter onset date in heavy box. Count back to figure the probable exposure period.



NOTE: If Salmonella was isolated from blood or urine, exposure period should be adjusted to reflect most likely onset of initial enteric symptoms.

Travel

Travel during exposure period: ☐ Yes ☐ No ☐ DK If Yes: ☐ within BC ☐ outside BC but within Canada ☐ outside Canada

Was travel confirmed as the most likely source of infection? ☐ Yes

Dates: DEPARTURE	Dates: RETURN	Locations (e.g., city, country, resort)	Mode of travel	Foods brought back
YYYY / MM / DD	*YYYY / MM / DD*			

Animal Contact

In the 3 days prior to onset…	Response	Details (include location, type or frequency of contact)	Was animal ill with vomiting/diarrhea?
Did you have contact with any animals (e.g., reptiles, rodents, farm animals, pets)?	☐ Yes ☐ No ☐ DK		
Cat(s)?	☐ Yes ☐ No ☐ DK		☐ Yes ☐ No ☐ DK
Dog(s)?	☐ Yes ☐ No ☐ DK		☐ Yes ☐ No ☐ DK
Other pets (e.g., reptile, rodent, birds) **Type:** _____	☐ Yes ☐ No ☐ DK		
Poultry (e.g., chicks, goslings, ducklings, turkeys)? **Type:** _____	☐ Yes ☐ No ☐ DK		
Other farm animals (e.g. cow, pig, goat, sheep, lamb, horse), or wildlife? **Type:** _____	☐ Yes ☐ No ☐ DK		
Did you have contact with or visit a farm/petting zoo/agricultural facility?	☐ Yes ☐ No ☐ DK		
Did you have contact with any animal foods or treats?	☐ Yes ☐ No ☐ DK		
Raw pet food (store bought or homemade)?	☐ Yes ☐ No ☐ DK		
Treats derived from animal parts (e.g., pig ears, rawhide, cow hooves)?	☐ Yes ☐ No ☐ DK		
Do you feed your animal(s) eggs or chicken?	☐ Yes ☐ No ☐ DK		

E. RISK FACTORS AND EXPOSURE INFORMATION *continued*

Food Exposures

Vegetarian? ☐ Yes ☐ No ☐ DK Food allergies / avoidances / special diet? ☐ Yes ☐ No ☐ DK

If Yes, Details: _____

In the 3 days prior to onset did you eat…	Response	Details (E.g., where consumed, type, brand, location)
Any chicken meat?	☐ Yes ☐ No ☐ DK	
If yes, type of chicken consumed and details* *If the same chicken exposures (E.g., whole/pieces) is reported multiple times in the 3 day period please record additional exposures in comments/notes		
Any whole chicken pieces/parts (e.g. whole chicken, breasts, wings, thighs, in soups, or as part of a dish, not including deli-meat) If yes, Was it raw/undercooked/pink?	☐ Yes ☐ No ☐ DK ☐ Yes ☐ No ☐ DK	**If yes,** ☐ In home **Purchase location:** **Brand:** ☐ Outside of home **Exposure date:** **Location:**
Ground chicken If yes, Was it raw/undercooked/pink?	☐ Yes ☐ No ☐ DK ☐ Yes ☐ No ☐ DK	**If yes,** ☐ In home **Purchase location:** **Brand:** ☐ Outside of home **Exposure date:** **Location:**
Breaded chicken (e.g. chicken nuggets, strips or burgers) If yes, Was it raw/undercooked/pink?	☐ Yes ☐ No ☐ DK ☐ Yes ☐ No ☐ DK	**If yes,** ☐ In home **Purchase location:** **Brand:** ☐ Outside of home **Exposure date:** **Location:**

E. RISK FACTORS AND EXPOSURE INFORMATION *continued*

Food Exposures *continued*

In the 3 days prior to onset did you eat…	Response	Details (E.g., where consumed, type, brand, location)
Any pre-cooked chicken (e.g., deli rotisserie chicken) If yes, Was it raw/undercooked/pink?	☐ Yes ☐ No ☐ DK ☐ Yes ☐ No ☐ DK	**If yes,** ☐ In home **Purchase location:** **Brand:** ☐ Outside of home **Exposure date:** **Location:**
Other poultry meat (e.g., turkey, quail, etc.)	☐ Yes ☐ No ☐ DK	
Did you handle or prepare any raw chicken?	☐ Yes ☐ No ☐ DK	
Any eggs?	☐ Yes ☐ No ☐ DK	
If yes, Any eggs **at home**? Were the eggs raw/soft/undercooked?	☐ Yes ☐ No ☐ DK ☐ Yes ☐ No ☐ DK	**Type**: ☐ Chicken eggs ☐ Other bird species, specify: _____ **Variety:** ☐ White ☐ Brown ☐ Organic ☐ Free range ☐ Liquid ☐ Other, specify: _____ **Brand**: _____ **How were they prepared?** **Where were the eggs purchased:** ☐ Grocery store:_____ ☐ Farmer's market:_____ ☐ Farm/laneway ☐ Other specify:_____
If yes (to any eggs), Any eggs **outside of the home?** Were the eggs raw/soft/undercooked?	☐ Yes ☐ No ☐ DK ☐ Yes ☐ No ☐ DK	**Location:** **How eaten:**
Did you handle/ prepare any eggs or foods containing raw eggs?	☐ Yes ☐ No ☐ DK	
Foods or beverages that contain raw, soft, undercooked eggs (raw cookie dough, desserts, drinks, dressings, stir fry, hot pot)?	☐ Yes ☐ No ☐ DK	

E. RISK FACTORS AND EXPOSURE INFORMATION *continued*

Food Exposures *continued*

In the 3 days prior to onset did you eat…	Response	Details (E.g., where consumed, type, brand, location)
Pork, including sausage	☐ Yes ☐ No ☐ DK	
Beef, including hamburger patties, other ground beef (meatballs, chilli, spaghetti sauce), steak, roast, donair	☐ Yes ☐ No ☐ DK	
Seafood, including fish or shellfish (eaten cooked / raw / smoked)	☐ Yes ☐ No ☐ DK	
Sprouts (e.g. bean or alfalfa or any other kind), including any sprouts on a sandwich or salads	☐ Yes ☐ No ☐ DK	
Lettuce or leafy greens (including pre-packaged greens)	☐ Yes ☐ No ☐ DK	
Cucumbers	☐ Yes ☐ No ☐ DK	
Tomatoes	☐ Yes ☐ No ☐ DK	
Cantaloupe	☐ Yes ☐ No ☐ DK	
Fresh herbs (e.g., cilantro, parsley, basil)	☐ Yes ☐ No ☐ DK	
Nuts, (either on their own, in granola bar, as a garnish or as part of a dish)	☐ Yes ☐ No ☐ DK	
Peanut butter or other nut butter or spread	☐ Yes ☐ No ☐ DK	
Seeds (e.g., sunflower, sesame, chia, flax, hemp, sprouted seeds)	☐ Yes ☐ No ☐ DK	
Tahini, halva, or other products made from sesame seeds	☐ Yes ☐ No ☐ DK	
Cheese made with unpasteurized (raw) milk	☐ Yes ☐ No ☐ DK	

In the 3 days prior to onset…

Event/Social gathering	Location	Date *(YYYY/MM/DD)*	Foods Eaten
Restaurants (including: take-out, cafeteria, bakery, deli, kiosk)	**Location**	**Date *(YYYY/MM/DD)***	**Foods Eaten**
Grocery stores for food consumed during the incubation period	**Location**	**Foods Purchased**	**Brands/Other details**

F. CONTACTS

people in household:

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

**Household, sexual, close contacts*
^ Please complete Contact Exclusion Form for each contact excluded.

G. INTERVENTIONS

Type	Implemented	Details
Referred for Inspection	☐	
Hygiene Education	☐	
Referred to another HA	☐	
Health File Sent	☐	
Other:	☐	

H. OCCUPATION AND EXCLUSION

Occupation:

(Prompt for agricultural/animal contact and working in food service industry and specify)

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 date (YYYY/MM/DD):

Details:

Symptom end date (YYYY/MM/DD):

Exclusion lifted: (YYYY/MM/DD): MHO:

I. NOTES

Date	Comment	Initials