

RiverStone Health Case Report Form

Reported By
 Lab Infection Control Practitioner Physician Self Other _____
 Name _____ Phone _____ Date ___/___/___

Case Classification
 Confirmed – laboratory confirmed
 Probable – a clinically compatible case that is epidemiologically linked to another
 Suspected – a person whose diagnosis is thought likely to be a particular disease or condition with suspected diagnosis based on signs and symptoms, laboratory evidence, or both
 Complaint – symptomatic, no epidemiological linkage at this time

Patient Information
 Name _____ Date of Birth ___/___/___ Sex _____
 Parent's Name (if child<18) _____
 Address _____ City _____ State _____ Zip _____
 Telephone _____ Alternate Telephone _____
 Hispanic: Yes No Unknown
 Race: White Black Asian/Pacific Islander Native American Other Unknown
 Pregnant: Yes No Underlying Immunodeficiency: Yes No If yes, specify _____
 Employer/school/daycare center _____
 Address _____ Occupation/school _____

Laboratory Data
 Has a lab been completed? Yes No
 If no, ask for a sample to be taken. If yes, complete the information below.
If Confirmed: Lab _____ Date ___/___/___
 Culture: Yes No If yes: Specimen source _____ Date collected: ___/___/___
 Results: Positive Negative Unsatisfactory Species isolated: _____
CHECK TO SEE IF DISEASE SPECIFIC FORM NEEDS TO BE COMPLETED

Provider Information
 Physician/Care Provider: _____ City: _____
 Contact for more info: _____

Present Illness
 Hospitalized? Yes No Hospital name _____ Telephone _____
 Admission date ___/___/___ Discharge date ___/___/___ Discharged to _____
 Specific antibiotic therapy _____ First dose ___/___/___ Last dose ___/___/___

Signs and Symptoms		
Nausea Yes No Vomiting Yes No Diarrhea Yes No max # stools/24 hrs _____ Blood in Stool? Yes No Cramps Yes No Headache Yes No	Fever Yes No Highest Temp _____ Chills Yes No Fatigue Yes No Muscle Aches Yes No Other symptoms _____ _____ _____	What was the first symptom? _____ Date of onset ___/___/___ Time of onset _____ Date of diarrhea onset (if not first): ___/___/___ Time of diarrhea onset _____ Symptoms currently present? Yes No If no, date of recovery ___/___/___ Time of recovery _____

Possible Sources of Infection During Exposure Period (*Exposure Period is typically within 10 days of illness onset*)

Eat or drink any of the following in the 2 weeks prior to illness?

			Description/source	Date
Unpasteurized milk/juice	Y	N	_____	___/___/___
Unpasteurized milk products	Y	N	_____	___/___/___
Raw/rare undercooked poultry	Y	N	_____	___/___/___
Raw/rare meat	Y	N	_____	___/___/___
Raw/rare seafood	Y	N	_____	___/___/___

Exposure to any of the following in the 2 weeks prior to illness?

Untreated/well water	Y	N	_____	___/___/___
Recreational water exposure	Y	N	_____	___/___/___
Septic system failure	Y	N	_____	___/___/___
Handling of poultry carcass	Y	N	_____	___/___/___

Contact with any of the following animals

Puppies /kittens	Y	N	_____	___/___/___
Reptiles	Y	N	_____	___/___/___
Livestock	Y	N	_____	___/___/___
Poultry	Y	N	_____	___/___/___
Other animals	Y	N	_____	___/___/___
Persons with diarrheal illness	Y	N	_____	___/___/___
Diapered children	Y	N	_____	___/___/___
Travel outside Montana	Y	N	_____	___/___/___
Travel outside US	Y	N	_____	___/___/___

Attend any large gatherings where food was served (e.g. weddings, reunions, banquets etc.) in week prior to illness? Yes No

If yes: Where? _____ When? ___/___/___

What was eaten? _____

Other relevant information:

Eat in any restaurants in the 2 weeks prior to illness? Yes No *If yes: Complete table:*

Date	Name of Restaurant	Location	Time of Meal	Foods/Drinks Consumed

Case Management Information

Is the case a food handler? Yes No

Is the case a healthcare worker with direct patient contact? Yes No

Is the case a daycare/childcare worker? Yes No

If yes to any of the above: Provide details about site, job description, dates worked during communicable period, etc.

Does the case live in assisted living, long-term care, or group home? Yes No

If yes: Name of location: _____

Contact person/phone number for location: _____

Did the case live there while symptomatic? Yes No

Is the case in diapers? Yes No

Are other residents or staff ill? Yes No *If yes:* Provide as much information as possible below.

Other relevant information:

Does the case attend daycare or preschool? Yes No

If yes: Name of school: _____

Contact person/phone number for school: _____

Did the case attend while symptomatic? Yes No

Is the case in diapers? Yes No

Are other children or staff ill? Yes No *If yes:* Provide as much information as possible below.

Other relevant information:

Additional Information

Similar Illness in Household Member or Close Contact? Yes No Unknown

If yes, complete below:

Name	Relationship	Phone Number	Onset date

Additional Remarks:

Completion Information

Name of person completing form: _____

Date: _____