

BOTULISM CASE REPORT

REPORTING AGENCY

Officer Releasing Antitoxin		Health Agency		Telephone Number	Today's Date / /
Date of First Report / /	First Reported By		State Contact (if applicable)		
Treating Physician/Contact for H-BAT Release Name- <small>Last Name, First Name</small>		Telephone Number	Fax Number	Specialty <input type="checkbox"/> Internist <input type="checkbox"/> Intensivist <input type="checkbox"/> Neurologist <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Pediatrician <input type="checkbox"/> Other _____	
Attending Physician Name - Last Name, First Name		Telephone Number	Fax Number	Specialty <input type="checkbox"/> Internist <input type="checkbox"/> Intensivist <input type="checkbox"/> Neurologist <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Pediatrician <input type="checkbox"/> Other _____	
			Email		
			Email		

DEMOGRAPHIC INFORMATION

Patient Name - Last Name, First Name, Middle Initial:		Patient's Telephone Number	Patient's E-mail Address		
Patient's Street Address		City	State	Zip Code	
Date of Birth / /	Age <input type="checkbox"/> Months <input type="checkbox"/> Years	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown	Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> African-American/Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Unknown	

CLINICAL INFORMATION

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset Date of First Botulism Symptom / /	Onset Hour (military) : :	Onset Date of Neurologic Symptoms / /	Date First Sought Medical Care / /	Currently Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If yes, Admit date / /
Hospital Name		City	State	Zip Code	Telephone Numbers	
Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, date / /		Placed on Ventilator? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, date / /		Additional Hospital Phone Numbers (e.g., Pharmacy and ICU)		

CLINICAL PRESENTATION

Vital Signs (upon presentation)
 Temperature (°F) _____ Blood Pressure (mmHg) ____/____ Heart Rate (beats/min.) _____ Respiration Rate (breaths/min.) _____

Symptoms	Symptoms			Physical Exam Findings	Physical Exam Findings		
	Yes	No	Unk		Yes	No	Unk
Nausea				Alert and Oriented			
Vomiting				Extraocular Palsy (paralysis of eye muscles)			
Abdominal Pain				If yes, is it bilateral?			
Diarrhea				If bilateral, is it symmetric?			
Constipation				Ptosis (drooping eyelids)			
Blurred Vision				If yes, is it bilateral?			
Diplopia (double vision)				If bilateral, is it symmetric?			
Dizziness				Pupils dilated (mm=)			
Slurred Speech				If yes, is it bilateral?			
Thick tongue				Pupils constricted (mm=)			
Change in sound of voice				If yes, is it bilateral?			
Hoarseness				Pupils non-reactive			
Dry mouth				If yes, is it bilateral?			
Dysphagia (difficulty swallowing)				Facial Paralysis			
Shortness of breath				If yes, is it bilateral?			
Subjective weakness				If bilateral, is it symmetric?			
Fatigue				Palatal weakness			
Paresthesia (abnormal sensation, e.g. numbness)				If yes, is it bilateral?			
Urinary Retention				Impaired gag reflex			
Other Symptoms (specify):				Sensory deficit(s) If yes, specify			
				Other (specify):			

Comments / Remarks:

Musculoskeletal Exam: (0=no evidence of contractility; 1=slight contractility, no movement; 2=full range of motion, gravity eliminated; 3=full range of motion w/ gravity; 4=full range of motion against gravity, some resistance; 5=full range of motion against gravity, full resistance)

Proximal Upper Extremity R: ___/5 Distal Upper Extremity R: ___/5 Proximal Lower Extremity R: ___/5 Distal Lower Extremity R: ___/5
 L: ___/5 L: ___/5 L: ___/5 L: ___/5
Unk Unk Unk U

Deep Tendon Reflexes: (0=No response; 1=sluggish or diminished; 2=active or expected response; 3=more brisk than expected, slightly hyperactive; 4=brisk, hyperactive, with intermittent or transient clonus)

Biceps/Triceps R: ___/4 Brachial R: ___/4 Patellar R: ___/4 Ankle R: ___/4
 L: ___/4 L: ___/4 L: ___/4 L: ___/4
Unk Unk Unk Unk

If muscle weakness/paralysis present, describe progression.

Ascending, ending with cranial nerves Descending, beginning with cranial nerves Other: _____

Clinical Tests Yes No Unk If yes, specify as noted

Lumbar puncture CSF analysis			Date ___/___/___	Repeat Lumbar puncture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, specify as noted	Date ___/___/___
			WBC count _____		WBC count _____
			RBC _____		RBC _____
			Glucose _____		Glucose _____
			Protein _____		Protein _____
EMG			Date ___/___/___ Done with rapid, repetitive stimulation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If yes, at what hertz? _____
			Check one: <input type="checkbox"/> Suggestive of/consistent with botulism <input type="checkbox"/> Not consistent with botulism <input type="checkbox"/> Unk		
Edrophonium (Tensilon)			Date ___/___/___		Describe test results: _____
CT scan or MRI scan			<input type="checkbox"/> Head <input type="checkbox"/> Spine <input type="checkbox"/> Other _____		Suggestive of diagnosis other than botulism <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
			Describe: _____		

Past Medical History

Prior Botulism Diagnosis? Yes No Unk If yes, date ___/___/___

Medications that could cause neuromuscular paralysis used within 30 days before illness onset (check all that apply):
Myobloc (toxin type B) Aminoglycoside (e.g. gentamicin, tobramycin) Other _____
Botox (toxin type A) Anticholinergic Other _____

Prior Neurologic Impairment? Yes No Unk If yes, specify _____

Does the patient have an allergy to equine products? Yes No Unk If yes, describe _____

Differential Diagnosis per attending MD (Please place a 1 for the most likely diagnosis, 2 for the second most likely, and 3 for the third most likely)

___ Botulism ___ Tick paralysis ___ Paralytic shellfish poisoning
 ___ Myasthenia gravis ___ Eaton-Lambert syndrome ___ Other _____
 ___ Guillain-Barré syndrome ___ Stroke or central nervous system mass or lesion ___ Other _____

EPIDEMIOLOGIC INFORMATION

Travel History

Did patient travel **outside county of residence** within 15 days prior to illness onset? Yes No Unk

If yes, specify all locations and dates below.

Location (city, county, state, country)	Dates of Travel
_____	___/___/___ to ___/___/___
_____	___/___/___ to ___/___/___
_____	___/___/___ to ___/___/___

Contacts/ Other Ill Persons

Any contacts with similar illness? Yes No Unk If yes, complete table below.

Name	Age	City, State	Onset Date	Relationship
			___/___/___	
	Sex	Telephone Number	Date Reported to Public Health	Nature of Contact
	()	()	___/___/___	
Name	Age	City, State	Onset Date	Relationship
			___/___/___	
	Sex	Telephone Number	Date Reported to Public Health	Nature of Contact
	()	()	___/___/___	

Comments / Remarks:

Exposures / Risk Factors

Provide information about the patient's wound and drug use in the table below.

	Yes	No	Unk	If yes, specify as noted
Wound or Abscess				Location(s): Description: Date of injury: ___/___/___ How wound occurred: Did/does wound appear infected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Injects Black Tar Heroin (Chiba)				Date last used: ___/___/___ Injection method (check all that apply): <input type="checkbox"/> Intravenous <input type="checkbox"/> Intramuscular <input type="checkbox"/> Subcutaneous (skin-pop) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
Injects other drugs				Drugs injected (check all that apply): <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk Injection method (check all that apply): <input type="checkbox"/> Intravenous <input type="checkbox"/> Intramuscular <input type="checkbox"/> Subcutaneous (skin-pop) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
Sniffs/snorts drugs				Drugs sniffed/snorted (check all that apply): <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
Uses other drugs				Types:

Provide information regarding any suspect food items consumed prior to illness in the table below. If more than three items, append pages; please ask about high risk foods even if wound botulism is suspected. Please pay special attention to fish or seafood exposures.

	Suspect Food 1	Suspect Food 2	Suspect Food 3
Food item			
Date and time eaten	Date: ___/___/___ Time: ___:___ am/pm	Date: ___/___/___ Time: ___:___ am/pm	Date: ___/___/___ Time: ___:___ am/pm
Type of item (check one)	<input type="checkbox"/> Homemade <input type="checkbox"/> Commercial product • Brand: _____ • Lot number: _____ <input type="checkbox"/> Restaurant-associated <input type="checkbox"/> Unk	<input type="checkbox"/> Homemade <input type="checkbox"/> Commercial product • Brand: _____ • Lot number: _____ <input type="checkbox"/> Restaurant-associated <input type="checkbox"/> Unk	<input type="checkbox"/> Homemade <input type="checkbox"/> Commercial product • Brand: _____ • Lot number: _____ <input type="checkbox"/> Restaurant-associated <input type="checkbox"/> Unk
How item preserved	<input type="checkbox"/> Canned <input type="checkbox"/> Dried <input type="checkbox"/> Fermented <input type="checkbox"/> Salted <input type="checkbox"/> Pickled <input type="checkbox"/> No preservation <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk	<input type="checkbox"/> Canned <input type="checkbox"/> Dried <input type="checkbox"/> Fermented <input type="checkbox"/> Salted <input type="checkbox"/> Pickled <input type="checkbox"/> No preservation <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk	<input type="checkbox"/> Canned <input type="checkbox"/> Dried <input type="checkbox"/> Fermented <input type="checkbox"/> Salted <input type="checkbox"/> Pickled <input type="checkbox"/> No preservation <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
How item stored	<input type="checkbox"/> Unrefrigerated <input type="checkbox"/> Refrigerated <input type="checkbox"/> Frozen <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	<input type="checkbox"/> Unrefrigerated <input type="checkbox"/> Refrigerated <input type="checkbox"/> Frozen <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	<input type="checkbox"/> Unrefrigerated <input type="checkbox"/> Refrigerated <input type="checkbox"/> Frozen <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____
How item served	<input type="checkbox"/> Heated <input type="checkbox"/> Only warmed <input type="checkbox"/> Unheated <input type="checkbox"/> Fried <input type="checkbox"/> Boiled <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk	<input type="checkbox"/> Heated <input type="checkbox"/> Only warmed <input type="checkbox"/> Unheated <input type="checkbox"/> Fried <input type="checkbox"/> Boiled <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk	<input type="checkbox"/> Heated <input type="checkbox"/> Only warmed <input type="checkbox"/> Unheated <input type="checkbox"/> Fried <input type="checkbox"/> Boiled <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
# persons sharing item			
# persons ill			
Samples of food available	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Samples submitted for botulism testing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Foods of same lot/batch recovered or recalled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Provide information regarding any other exposures of interest in the table below.

Exposure	Description