Centers for Disease Control and Prevention
1600 Clifton Road, MS C09
Atlanta, GA 30333
Fax: 404-639-2205

Clinical Outcome Report*

Please include copy of discharge summary

Please complete upon discharge or death and fax to 907-563-7868 ATTN: Botulism Surveillance

REPORTING AGENCY

Treating Physician - Last Name, First Name	*Telephone Number*	*Fax Number*	*Today'sDate* ___ ___ _____
Attending Physician Name - Last Name, First Name	*Telephone Number*	*Fax Number*	*Speciality*
Hospital Name	*City*	*State*	*Zip Code*

DEMOGRAPHIC INFORMATION

Patient Name - Last Name, First Name, Middle Initial	*City*	*State*	*Zip Code*

Date of Birth ___ ___ _____

Sex
□Male
□Female

CLINICAL OUTCOME INFORMATION

How many days was patient hospitalized? _____days

How many days was patient in intensive care? _____days

Did patient require mechanical ventilation? □Yes □No □Unk

If yes, how many days was patient on a ventilator? _____days

Did patient require a a tracheostomy? □Yes □No □Unk

If yes, when was the tracheostomy done? ___ ___ _____

Did the patient develop pneumonia? □Yes □No □Unk

What was the final diagnosis? (*please check one)*

□Botulism
□Tick paralysis
□Paralytic shellfish poisoning
□Myasthenia gravis
□Eaton-Lambert syndrome
□Other_____
□Guillain-Barre syndrome
□Stroke or central nervous system mass or lesion

Was treatment given for any of the above diagnosis (even if it wasn't the final diagnosis)? □Yes □No □Unk

If yes, specify type
□Botulism Antitoxin □Plasmapheresis □Neostigmine/Physostigmine □Other Immunoglobulin therapy_____

Did the patient develop an adverse event after botulism antitoxin administration? □Yes □No □Unk

If yes, specify adverse event _____

Did the patient die? □Yes □No □Unk

If yes,

When did patient die? ___ ___ _____

What was the cause of death? _____

If no,

Where was patient discharged?
□Home □Nursing home □ Physical therapy/rehabilitation facility □Other (specify)_____

Did patient have residual disability upon discharge? □Yes □No □Unk

If yes, please specify types below (check as many as apply)

□Proximal Upper Extremity Weakness
□Diminshed deep tendon reflexes
□Other_____
□Distal Upper Extremity Weakness
□Fatigue
□Other_____
□Proximal Lower Extremity Weakness
□Stroke or central nervous system mass or lesion
□Distal Lower Extremity Weakness
□Other_____

ADDITIONAL INFORMATION

Comments / Remarks: