Massachusetts Department of Public Health
Bureau of Infectious Disease and Laboratory Sciences
Office of Integrated Surveillance and Informatics Services
305 South Street, Jamaica Plain MA 02130
*Phone: **617-983-6801** Confidential Fax: **617-983-6813***

Received in ISIS:

ENTERIC DISEASE REPORTING FORM

For assistance filling out this form, call (617) 983-6800

CONFIDENTIAL CASE REPORT

DEMOGRAPHIC INFORMATION

Last Name: First Name: MI:

Address: Apt. #:

City: State: Zip:

Unique Address Condition: ☐ Incarcerated ☐ School/University/College ☐ Drug/Alcohol Recovery Facility
☐ Homeless Shelter ☐ Long Term Care Facility ☐ Chronic/Long Term Hospital ☐ Hotel/Motel ☐ Military Base ☐ Homeless

Contact phone: (____) _____-_____ Occupation:

Birth date: _____/_____/_____ Place of birth (e.g. specific country):

Age: _____ ☐ Years ☐ Months ☐ Weeks ☐ Days ☐ Unk

Sex: ☐ Female ☐ Male ☐ Transgender ☐ Unk

Race *(check all that apply):*
☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unk

Hispanic: ☐ Yes ☐ No ☐ Unk

CLINICAL INFORMATION

First date contact with case (not provider) was attempted: _____/_____/_____

Diagnosis date: _____/_____/_____

Did case have any symptoms? ☐ Yes ☐ No ☐ Unk Symptom onset date: _____/_____/_____

Duration of symptoms: _____ ☐ days ☐ weeks ☐ months

Abdominal cramps	☐ Yes	☐ No	☐ Unk	Abdominal pain	☐ Yes	☐ No	☐ Unk
Anorexia	☐ Yes	☐ No	☐ Unk	Bloating/Gas	☐ Yes	☐ No	☐ Unk
Bloody Stool	☐ Yes	☐ No	☐ Unk	Diarrhea	☐ Yes	☐ No	☐ Unk
Fatigue	☐ Yes	☐ No	☐ Unk				
Fever	☐ Yes (highest temp: ____°F/°C)		☐ No	☐ Unk			
Headache	☐ Yes	☐ No	☐ Unk	Joint aches	☐ Yes	☐ No	☐ Unk
Malaise	☐ Yes	☐ No	☐ Unk	Muscle aches	☐ Yes	☐ No	☐ Unk
Nausea	☐ Yes	☐ No	☐ Unk	Stool with mucus	☐ Yes	☐ No	☐ Unk
Vomiting	☐ Yes	☐ No	☐ Unk	Weight loss	☐ Yes	☐ No	☐ Unk

Other (*specify):*_____

Case hospitalized? ☐ Yes ☐ No ☐ Unk Date hospitalized: _____/_____/_____

Hospital name: Date discharged: _____/_____/_____

Outcome: ☐ Died ☐ Recovered ☐ Unk Date of death: _____/_____/_____

Clinician name and address:

Clinician phone: (_____) _____-_____ Patient record/ chart #:

In the month prior to illness, did the case take antibiotics? ☐ Yes ☐ No ☐ Unk

If yes, what antibiotic(s)? _____ Start date ____/____/____ End date: ____/____/____

DIAGNOSTIC LABORATORY TEST INFORMATION

Organism	Usual incubation (range)	Organism	Usual incubation (range)
☐ *Cryptosporidium*	7 days (1-12 days)	☐ *Giardia*	7-10 days (3-25 days)
☐ *Cyclospora*	7 days (1-2wks)	☐ *Norovirus*	1-2 days (10-72 hours)
☐ *Entamoeba histolytica*	1-4 wks (variable)	☐ *Shigella*	1-3 days (12-96 hours)
☐ *E. coli* O157:H7	3-4 days (1-10 days)	☐ *Yersinia*	3-7 days (1-10 days)

Other (*specify*): _____

Please complete page 2. Include additional laboratory information if available.

INFORMATION RELEVANT TO EXPOSURE, CONTROL AND PREVENTION

Suspect food or drink	Place (store/restaurant) & location	Date/time consumed

Did the case travel during the incubation period? ☐ Yes ☐ No ☐ Unk
If **yes**, specify when: _____/_____/_____ to _____/_____/_____
If **yes**, specify where: City: _____ State: _____ Country :_____

Any outdoor activities such as swimming, hiking, etc.?: ☐ Yes ☐ No ☐ Unk If yes, specify:_____

Any animal contact? (include pets, reptiles, other animals) ☐ Yes ☐ No ☐ Unk
If **yes**, specify animal type, where & when:_____

Did the case consume any high-risk animal products during incubation period? ☐ Yes ☐ No ☐ Unk
If **yes:** Specify: ☐ Raw meat ☐ Raw milk/milk products ☐ Soft cheeses ☐ Undercooked meat
☐ Other (specify:_____)
When purchased: _____/_____/_____ When consumed: _____/_____/_____
Where purchased/obtained: _____
Type of location where purchased: ☐ At a friend's house ☐ CSA ☐ Dairy farm ☐ Farm stand ☐ Farmer's market
☐ Friend ☐ Home delivery ☐ Ordered through the internet ☐ Restaurant ☐ Retail store
☐ Other (specify: _____)
Contact name/Address/Phone number: _____
Where consumed: _____
Where did product originate from: _____
Did any dining partners consume the same seafood? _____

Any other people share the above exposures? ☐ Yes ☐ No ☐ Unk # of people exposed:____ # of people ill:____

Was the case enrolled or employed in a supervised care setting (daycare)? ☐ Yes ☐ No ☐ Unk
If **yes:** **N**ame and location of daycare:_____ Telephone #:_____
Are any of the staff/children at the facility ill with similar symptoms? ☐ Yes ☐ No ☐ Unk
How many? #ill staff: _____ #ill children: _____

Foodhandler: *a person directly preparing or handling food, including preparing trays of food, feeding other persons, administering oral medications, or giving mouth/denture care (see 105 CMR 300.000)*

Is the case a foodhandler? ☐ Yes ☐ No ☐ Unk
If **yes**: Name/address of employment: _____
Was the case removed from work? ☐ Yes ☐ No ☐ Unk
When was the foodhandler removed from work? ____/____/____
If the foodhandler is back at work, when were the back-to-work criteria met (per 105 CMR 300.000)? ____/____/____
When was the Board of Health of the case's place of employment notified? _____/_____/_____
Dates worked during infectious period: _____

CLOSE CONTACTS

Any household or other close contacts ill? ☐ Yes ☐ No ☐ Unk
If **yes:** # ill:____ of total #: _____ Earliest contact symptom onset date: _____/_____/_____

Is a household contact of the case enrolled or employed in a supervised care setting (daycare)? ☐ Yes ☐ No ☐ Unk
If **yes**: Is contact symptomatic? ☐ Yes ☐ No ☐ Unk Contact name: _____
Name and location of daycare: _____
Are any of the staff/children at the facility ill with similar symptoms? ☐ Yes ☐ No ☐ Unk
How many? #ill staff: _____ #ill children: _____

Is a household or close contact of the case a foodhandler? ☐ Yes ☐ No ☐ Unk
If **yes**: Is the contact symptomatic? ☐ Yes ☐ No ☐ Unk
Contact name: _____ Name/address of employment:_____

ADMINISTRATIVE INFORMATION

Comments:_____
_____
Investigator's name: _____ Phone: (____) _____ - _____
Agency: _____ Fax: (____) _____ - _____
Date first reported to you: ____/____/____ Date investigation started: ____/____/____ Date form completed: ____/____/____