# Typhoid and Paratyphoid Fever Investigation Form

## PAGE 1 -- FOR LOCAL USE ONLY

Name of person completing form: _____

Phone: _____Email: _____

Island: _____

---

**Patient's name:** _____ **DOB: ____/____/____ Age: _____** **Sex:** ☐M ☐F ☐Unk

**Patient's address:**

_____

_____

Phone number:

(h) (  ) _____ (w) (  ) _____

**Race (Check all that apply):**
☐ White
☐ Black/African American
☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific
☐ Islander Asian
☐ Other
☐ Unknown

**Ethnicity:**
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Reset Form

# TYPHOID AND PARATYPHOID FEVER SURVEILLANCE REPORT

CDC NO.: ☐☐☐☐☐

STATE LAB ISOLATE ID NO. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

***Instructions:***

**– Please complete this form only for new, symptomatic, culture-proven cases of typhoid or paratyphoid fever. –** Form Approved OMB No. 0920-0009

## DEMOGRAPHIC DATA

**1.** Reporting State: ☐☐

**2.** First three letters of patient's last name: ☐☐☐

**3.** Date of birth: ☐☐ Mo. ☐☐ Day ☐☐☐☐ Yr. ***or*** Age: (in years) ☐☐

**4.** Sex: ☐ Male ☐ Female

**5.** Does the patient work as a foodhandler? ☐ Yes ☐ No ☐ Unk.

**6.** Citizenship: (21) ☐ U.S. ☐ Other: _____ ☐ Unk.

## CLINICAL DATA

**7.** Was the patient ill with typhoid or paratyphoid fever? (fever, abdominal pain, headache, etc) ☐ Yes ☐ No ☐ Unk.

*If Yes,* give date of onset of symptoms: ☐☐ Mo. ☐☐ Day ☐☐ Yr.

**8.** Was the patient hospitalized? ☐ Yes ☐ No ☐ Unk.

*If Yes,* how many days was the patient hospitalized? ☐☐ Days

**9.** Outcome of case: ☐ Recovered ☐ Died ☐ Unk.

## LABORATORY DATA

**10.** Date *Salmonella* first isolated: ☐☐ Mo. ☐☐ Day ☐☐ Yr.

Site(s) of isolation: *(check all that apply)*

☐ Blood ☐ Stool ☐ Gall bladder ☐ Other (specify): _____

Serotype:

☐ *S.* Typhi ☐ *S.* Paratyphi A ☐ *S.* Paratyphi B ☐ *S.* Paratyphi C

**11.** Was **antibiotic sensitivity testing** performed on this (these) isolate(s) at the laboratory? *(Please contact the clinical laboratory for this information)* ☐ Yes ☐ No ☐ Unk.

*If Yes,* was the organism **resistant** to:

| | | | |
|---|---|---|---|
| • Ampicillin: ..... | ☐ Yes | ☐ No | ☐ Not tested |
| • Chloramphenicol: ..... | ☐ Yes | ☐ No | ☐ Not tested |
| • Trimethoprim-sulfamethoxazole: ..... | ☐ Yes | ☐ No | ☐ Not tested |
| • Fluoroquinolones (e.g., Ciprofloxacin):..... | ☐ Yes | ☐ No | ☐ Not tested |

## EPIDEMIOLOGIC DATA

**12.** Did this case occur as part of an outbreak? (two or more cases of typhoid or paratyphoid fever associated by time and place) ☐ Yes ☐ No ☐ Unk.

**13.** Did the patient receive typhoid vaccination (primary series or booster) within **five years** before onset of illness? ☐ Yes ☐ No ☐ Unk.

*If Yes,* indicate type of vaccine received:

| | | | | Year received: |
|---|---|---|---|---|
| • Oral Ty21a or Vivotif (Berna) four pill series:..... | ☐ Yes | ☐ No | ☐ Unk. | ☐☐ |
| • ViCPS or Typhim Vi shot (Pasteur Merieux): .... | ☐ Yes | ☐ No | ☐ Unk. | ☐☐ |

**14.** Did the patient travel or live outside the United States during the 30 days before the illness began? ☐ Yes ☐ No ☐ Unk.

*If Yes,* please list in order the countries visited during the 30 days before the illness began: (other than the United States)

1. _____ 3. _____

2. _____ 4. _____

Date of most recent return or entry to the United States: ☐☐ Mo. ☐☐ Day ☐☐ Yr.

**15.** Was the purpose of the international travel:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **a.**) Business? ..... | ☐ Yes | ☐ No | ☐ Unk. | **d.**) Immigration to U.S.? ..... | ☐ Yes | ☐ No | ☐ Unk. |
| **b.**) Tourism? ..... | ☐ Yes | ☐ No | ☐ Unk. | **e.**) Other?..... | ☐ Yes | ☐ No | ☐ Unk. |
| **c.**) Visiting relatives or friends? ..... | ☐ Yes | ☐ No | ☐ Unk. | (if other, specify): _____ | | | |

**16.** Was the case traced to a typhoid or paratyphoid carrier? ..... ☐ Yes ☐ No ☐ Unk.

*If Yes,* was the carrier **previously known** to the health department?..... ☐ Yes ☐ No ☐ Unk.

**17.** Comments:

**18.** Name of Person Completing Form: _____

Address: _____

Telephone: _____ Date: _____ Mo. Day Yr.

***– THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM –***

*Please send a copy to your* STATE EPIDEMIOLOGY OFFICE ***and*** the FOODBORNE AND DIARRHEAL DISEASES BRANCH, CENTERS FOR DISEASE CONTROL AND PREVENTION, Mailstop A-38, Atlanta, Georgia, 30333. • Fax: (404) 639-2205





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