

BOTULISM CASE REPORT

Wound Foodborne

Patient name—last		first	middle initial	Date of birth	Age	Sex
Address—number, street			City	State	County	ZIP code

RACE (check one) **ETHNICITY** (check one)

African-American/Black White Native American Asian/Pacific Islander Other _____

Hispanic/Latino Non-Hispanic/Non-Latino

If Asian/Pacific Islander, please check one: Asian Indian Cambodian Chinese Filipino Guamanian Hawaiian

Japanese Korean Laotian Samoan Vietnamese Other _____

Onset date	Onset hour	Attending physician			Telephone number ()
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Admit date	Discharge date	Hospital name	Medical record number	Telephone number ()

SIGNS AND SYMPTOMS (check all that apply)

<input type="checkbox"/> Ptosis/droopy eyelids	<input type="checkbox"/> Vomiting	<input type="checkbox"/> General weakness	<input type="checkbox"/> Paresthesia
<input type="checkbox"/> Double or blurry vision	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Alert and oriented	<input type="checkbox"/> Reduced sensation to touch, vibration, etc.
<input type="checkbox"/> Speech difficulty	<input type="checkbox"/> Constipation	<input type="checkbox"/> Ataxia	
<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Breathing trouble	<input type="checkbox"/> Diminished or absent deep tendon reflexes	

Date of first neurologic symptoms	Date first consulted medical care	Date that clinical diagnosis of botulism was made
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Specify details and progression of muscle weakness or paralysis.

Bilateral Symmetrical Descending, beginning with cranial nerves Ascending, ending with cranial nerves

CONTACTS—Are there any close contacts with a similar illness? Yes No Did ill contacts share food or inject drugs with the index patient? Yes No

If yes, describe: _____

If yes, describe: _____

LABORATORY TEST RESULTS

CSF Findings: WBC count (highest) _____	EMG* Test Result: <input type="checkbox"/> Suggestive of/consistent with botulism	DIETROPONIUM (TENSILON) Test Result:
Protein (highest) _____	<input type="checkbox"/> Not consistent with botulism	
Opening pressure _____	<input type="checkbox"/> Not done	

*Encourage repetitive nerve stimulation.

<p>If FOODBORNE BOTULISM is suspected:</p> <p>Suspected food item: _____</p> <p><input type="checkbox"/> Home canned <input type="checkbox"/> Commercial product <input type="checkbox"/> Restaurant associated</p> <p>Specify item _____ Brand and lot number _____</p> <p>How was food served? <input type="checkbox"/> Unheated <input type="checkbox"/> Only warmed <input type="checkbox"/> Boiled</p> <p><input type="checkbox"/> Baked <input type="checkbox"/> Fried</p> <p>Eaten: Date _____ Hour _____</p> <p>Number of persons eating same food: _____ Number ill: _____</p> <p>Were samples of implicated food available? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were samples submitted for botulism testing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have contaminated foods of same batch/lot been recovered/recalled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If WOUND BOTULISM is suspected:</p> <p>Site of wound and how it happened: _____</p> <p>_____</p> <p>Date of injury: _____</p> <p>Did/Does wound appear infected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Not stated</p> <p>Illicit drug user? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, specify drugs usually injected: _____ or sniffed (snorted): _____</p> <p>If injector: <input type="checkbox"/> Intramuscular <input type="checkbox"/> Intravenous <input type="checkbox"/> Skin popper</p> <p>If HEROIN, location where purchased: _____</p> <p>If HEROIN, was it called "BLACK TAR" (or "Chiba")? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>LABORATORY TEST RESULTS FOR C. botulinum AND ITS TOXINS</p> <ul style="list-style-type: none"> • Pretreatment serum toxin: _____ • Gastric aspirate, for anaerobic culture and toxin: _____ • Stool, for anaerobic culture and toxin: _____ • Food item, for anaerobic culture and toxin: _____ • Wound aspirate for anaerobic culture and toxin: _____ (specify SITE of wound) _____ • Biopsy of abscess for anaerobic culture and toxin: _____ • Post-Rx serum toxin (for wound botulism cases only) _____ 	<p>TREATMENT</p> <p>Treated with botulinum antitoxin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date treatment started _____ Number vials used _____</p> <p>Intubated and placed on ventilator? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Current status (as of ____/____/____) <input type="checkbox"/> Survived <input type="checkbox"/> Died</p> <p>If died, specify date: _____</p>
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Investigator name (print)	Date	Telephone number ()
Agency name		