

### Botulism Case Report Form

Case is:  Confirmed  Probable  Suspect

#### Patient Information:

Name: \_\_\_\_\_ Date of birth: \_\_/\_\_/\_\_ Sex: \_\_\_\_\_  
 Parent's name (if child is <18): \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Hispanic:  Yes  No  Unknown  
 Race:  White  Black  Asian/Pacific Islander  Native American  Other  Unknown  
 Pregnant:  Yes  No Underlying Immunodeficiency:  Yes  No If yes, specify: \_\_\_\_\_  
 Worksite/school/daycare center: \_\_\_\_\_ Address: \_\_\_\_\_  
 Occupation/grade: \_\_\_\_\_ Employer: \_\_\_\_\_

#### Source of Report

Lab  Infection Preventionist  Physician  Other \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_/\_\_/\_\_  
 Primary M.D. \_\_\_\_\_ Phone: \_\_\_\_\_

#### Present Illness

Onset date: \_\_/\_\_/\_\_ Attending/consulting physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospitalized  Yes  No Hospital name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Admission date: \_\_/\_\_/\_\_ Discharge date: \_\_/\_\_/\_\_  
 Admitted to ICU  Yes  No  Unknown  
 Ventilator  Yes  No  Unknown  
 Type:  Foodborne  Infant  Wound  Other: \_\_\_\_\_  
 Outcome of case: Recovered  Yes  No Died:  Yes  No If yes, date of death: \_\_/\_\_/\_\_

#### Symptoms

Abdominal pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Slurred speech	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensation of thick tongue	<input type="checkbox"/> Y <input type="checkbox"/> N
Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N	Dry mouth	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N
Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in voice	<input type="checkbox"/> Y <input type="checkbox"/> N	Double vision	<input type="checkbox"/> Y <input type="checkbox"/> N
Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Blurred vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N
Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N	Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N

Other symptoms: \_\_\_\_\_

#### Clinical Data

Vital signs Temp: \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ HR \_\_\_\_/min RR \_\_\_\_/min  
 Altered mental status:  Yes  No  Unknown  
 Ptosis (drooping eyelid)  Yes  No  Unknown  Bilateral  
 Pupils  Dilated  Constricted  Fixed  Reactive  
 Facial paralysis  Yes  No  Unknown  Bilateral  
 Impaired gag reflex  Yes  No  Unknown  
 Pre-existing wound  Yes  No  Unknown  
 Weakness/paralysis  
 Upper distal  Yes  No  Unknown  Bilateral  Comment \_\_\_\_\_  
 Upper proximal  Yes  No  Unknown  Bilateral  Comment \_\_\_\_\_  
 Lower distal  Yes  No  Unknown  Bilateral  Comment \_\_\_\_\_  
 Lower proximal  Yes  No  Unknown  Bilateral  Comment \_\_\_\_\_  
 Progression of weakness:  Ascending  Descending  Unknown

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**Notes on Antitoxin**

Physician Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Pharmacist Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 CDC Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Antitoxin Released  Yes  No Antitoxin administered:  Yes  No If yes: date: \_\_/\_\_/\_\_ Time: \_\_\_\_\_  
 Details of antitoxin shipping/delivery: \_\_\_\_\_ -

**Laboratory Data**

CSF Date: \_\_/\_\_/\_\_ RBC \_\_\_\_\_ WBC \_\_\_\_\_ Protein \_\_\_\_\_ Glucose \_\_\_\_\_  Not done  
 Serum for toxin Collection date: \_\_/\_\_/\_\_  Positive  Negative  Not done  
 Stool for toxin Collection date: \_\_/\_\_/\_\_  Positive  Negative  Not done  
 Stool culture Collection date: \_\_/\_\_/\_\_  Positive  Negative  Not done  
 Food \_\_\_\_\_ Collection date: \_\_/\_\_/\_\_  Positive  Negative  Not done  
 Other \_\_\_\_\_ Collection date: \_\_/\_\_/\_\_  Positive  Negative  Not done  
 Toxin type  A  B  E  Other \_\_\_\_\_  
 Other relevant testing: \_\_\_\_\_

**Foodborne: Possible Sources of Infection During Exposure Period (within 7 days of illness onset)**

Home canned food  Yes  No  
 Commercially canned food  Yes  No  
 Sausage/other preserved meats  Yes  No  
 Preserved fish  Yes  No  
 Items stored in oil  Yes  No  
 Baked potato stored in foil  Yes  No

Provide details about potential sources (brand names, size, lot number, expiration date, where purchased, when consumed)

**Infant: Possible Sources of Infection During Exposure Period (within 30 days of illness onset)**

Was the infant exposed to soil, dust, or dirt  Yes  No  Unknown If yes where: \_\_\_\_\_  
 Was infant ever breast fed  Yes  No  Unknown If yes, for how many weeks \_\_\_\_\_  
 Was infant ever formula fed  Yes  No  Unknown If yes, for how many weeks \_\_\_\_\_  
 Did infant eat or taste any of the following:

Food/liquid	Never	Once/Few Times	Many Times	Daily	Principal Brand
Cow's milk					
Fruit juice					
Syrup					
Honey					
Sugar					
Tea					
Cooked fruits					
Raw fruits					
Cooked vegetables					
Raw vegetables					
Home canned foods					
Baby food (from a jar)					

### Botulism Case Report Form

#### Additional Information

Similar illness in household member or close contact  Yes  No  Unknown

If yes, complete below:

Name	Relationship	Phone Number	Onset Date

#### Wound: Sources of Infection (within 2 weeks of illness onset)

Details of wound infection: \_\_\_\_\_

Additional Remarks: \_\_\_\_\_

### Case Definition

#### Botulism, Foodborne

**Clinical description:** Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

#### Laboratory criteria for diagnosis:

Detection of botulinum toxin in serum, stool, or patient's food, or  
Isolation of *Clostridium botulinum* from stool

#### Case classification

**Probable:** a clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours)

**Confirmed:** a clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory-confirmed botulism

#### Botulism, Infant

**Clinical description:** An illness of infants, characterized by constipation, poor feeding, and "failure to thrive" that may be followed by progressive weakness, impaired respiration, and death

#### Laboratory criteria for diagnosis:

Detection of botulinum toxin in stool or serum, or  
Isolation of *Clostridium botulinum* from stool

#### Case classification

**Confirmed:** a clinically compatible case that is laboratory-confirmed, occurring in a child aged less than 1 year

#### Botulism, Wound

**Clinical description:** An illness resulting from toxin produced by *Clostridium botulinum* that has infected a wound.

Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

#### Laboratory criteria for diagnosis

Detection of botulinum toxin in serum, or  
Isolation of *Clostridium botulinum* from wound

#### Case classification

**Confirmed:** a clinically compatible case that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms

#### Botulism, Other

#### Clinical description

See Botulism, Foodborne.

#### Laboratory criteria for diagnosis

Detection of botulinum toxin in clinical specimen, or  
Isolation of *Clostridium botulinum* from clinical specimen

#### Case classification

**Confirmed:** a clinically compatible case that is laboratory confirmed in a patient aged greater than or equal to 1 year who has no history of ingestion of suspect food and has no wounds