

**New Jersey Department of Health and Senior Services
GASTROINTESTINAL / FOODBORNE ILLNESS CASE REPORT WORKSHEET**

Disease [incubation period]: <input type="checkbox"/> Campylobacteriosis [1-10 days] <input type="checkbox"/> Shigellosis [0-4 days] <input type="checkbox"/> STEC (shiga toxin-producing E. coli) [1-10 days] <input type="checkbox"/> Salmonellosis [0-5 days] <input type="checkbox"/> Yersiniosis [3-7 days]	CDRSS #	Local #	E#
	Completed By		Date Completed / /
	Agency		

I. CASE IDENTIFICATION

Name		Treating M.D.	
Address		Address	
City	Zip	City	Zip
Home Telephone No.	Work Telephone No.	Treating M.D. Telephone No.	

II. DEMOGRAPHICS

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Race	Ethnicity
Occupation			
	Yes	No	If Yes, Name and Location of Facility
Foodhandler	<input type="checkbox"/>	<input type="checkbox"/>	_____
Healthcare Provider	<input type="checkbox"/>	<input type="checkbox"/>	_____
Daycare Worker/Attendee	<input type="checkbox"/>	<input type="checkbox"/>	_____
Note: Exclusion recommendations are provided in NJDHSS disease-specific chapters (http://www.nj.gov/health/cd/cd_def.shtml).			

III. CLINICAL INFORMATION

Symptomatic <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Onset Date / Time / / /	First Symptom	Resolution Date / Time / / /
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Temperature _____ ° F <input type="checkbox"/> Not Measured		
Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Bloody Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other Symptoms			
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Hospital		
Date of Admission / /	Date of Discharge / /	ED Visit Only – Date / /	
Antibiotic Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No			
Outcome – Died: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of Death / /	Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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CDRSS No. _____

Use incubation period of disease to determine Exposure Period, counting back from illness onset date.

Exposure period: ____ / ____ / ____ To: ____ / ____ / ____

IV. POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

SUSPECT FOODS-Consumption of:

- Y N**
- Undercooked ground beef products
- Raw or lightly cooked eggs or foods made with raw eggs
- Raw/unpasteurized milk, dairy products or juices

If Yes, provide details in "Notes" section.

OTHER EXPOSURE SOURCES:

- Y N**
- Contact with turtles, snakes or other reptiles
- Contact with dogs, cats or other pets
- Contact with cows, chickens or other farm animals or livestock
- Swimming/recreational water exposure

If Yes, provide details in "Notes" section.

Y N

- Travel

Where: _____

Dates:

From: ____ / ____ / ____

To: ____ / ____ / ____

List food establishments (restaurants, fast-food, cafeteria, deli, etc.) frequented during incubation period. Include date, location and items eaten:

List any gatherings (parties, weddings, conventions, etc.) attended during incubation period:

List markets where groceries are purchased (supermarkets, local markets, butcher, live poultry markets, etc.):

Does the case know anyone else with a similar illness, including those he/she lives with?

Yes

No

If Yes, fill out the table below for each ill household member and contact:

IV. ILL HOUSEHOLD MEMBERS / OTHER ILL CONTACTS

Name	Age	Relation to Case	Symptoms	Onset Date	Phone Number

NOTES:

ACTIONS TAKEN

- Patient could not be interviewed

(Reason: _____)

- Entered into CDRSS

- Refer for restaurant inspection

- Daycare inspection/education

- Work/daycare restriction

(Dates: ____ / ____ / ____ to: ____ / ____ / ____)

- Follow-up of ill contacts