Typhoid and Paratyphoid Fever
Patient Demographics

Please complete this information for all cases of typhoid or paratyphoid fever in addition to CDC's Typhoid and Paratyphoid Fever Surveillance Report. Please fax both forms to DSHS Central Office, Attn: Foodborne Illness Team, at 512-458-7616.

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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