BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Typhoid/Paratyphoid Fever*
Case Report Form

Confidential when completed

PERSON REPORTING	
Health Authority:	☐ FHA ☐ IHA ☐ VIHA ☐ NHA ☐ VCH
Name:	*Last* *First*
Phone:	( ) - ext.
Email:	

Date Report Received at HU (YYYY/MM/DD): _____

Contact attempts (date and time)	*Interview?*
1.	☐
2.	☐
3.	☐
4.	☐

Interviewer: ☐ *Not located*

A. CLIENT INFORMATION

Name: *Last* *First* *Middle*			Alternate Name(s):
PHN:	Date of Birth: *YYYY / MM / DD*	Sex: ☐ Male ☐ Female	
Home Address: *Unit #* *Street #* *Street Name*		City:	
Postal code:	Province:	Phone number (home/office/cell) ( ) - ext.	
Email:	Physician Name *Last* *First*	Physician Phone Number:	
Interview conducted with:			

B. ABORIGINAL INFORMATION

Do you wish to self-identify as an Aboriginal Person?		☐ Asked, not provided	☐ No
		☐ Not asked	☐ Yes
Aboriginal Identity:	☐ Asked, but unknown	☐ Asked, not provided	☐ First Nations
☐ First Nations and Inuit	☐ First Nations and Métis	☐ First Nations, Inuit and Métis	☐ Inuit
☐ Inuit and Métis	☐ Métis	☐ Not asked	
First Nations Status:	☐ Asked, but unknown	☐ Asked, not provided	☐ Non-Status Indian
	☐ Not Asked	☐ Status Indian	

C. CLINICAL INFORMATION

Date of onset of symptoms: _____ *YYYY / MM / DD* Onset time: _____ AM / PM ☐ Unknown

Signs and Symptoms Earliest symptom: _____

Other Symptoms: ☐ Abdominal discomfort ☐ Diarrhea ☐ Bloody diarrhea ☐ Fever ☐ Nausea ☐ Vomiting ☐ Other: _____

Hospitalization

Admitted to hospital: ☐ Yes ☐ No ☐ Unknown Hospital name: _____

Admission date: _____ *YYYY / MM / DD* Discharge date: _____ *YYYY / MM / DD*

Immunization Status				
Oral typhoid immunization within 5 years:	☐ Yes	☐ No	☐ Unknown
IM typhoid immunization within 2 years:	☐ Yes	☐ No	☐ Unknown

* For cases of *S*. Paratyphi B Java, use standard Salmonellosis form.

C. CLINICAL INFORMATION *continued*

Outcome

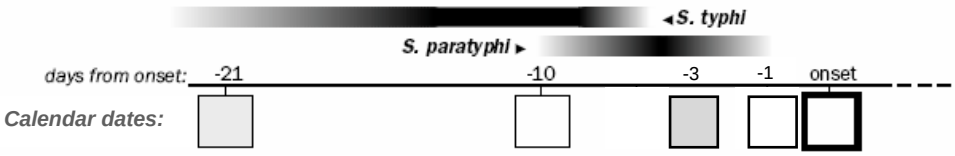
Death: ☐ Yes ☐ No ☐ Unknown *If yes*, death date: _____ *YYYY / MM / DD*

D. LABORATORY INFORMATION

Specimen Type	Reporting Lab	Collection Date	Result
		YYYY / MM / DD	Serotype: ☐ Typhi ☐ Paratyphi

E. RISK FACTORS AND EXPOSURE INFORMATION

Enter onset date in heavy box. Count backwards to figure probable exposure periods. Use grey boxes for *S. typhi* infections.



Communicable until elimination of excretion–usually one to several weeks. A minority become carriers for months or years.

Travel ^

Travel during exposure period: ☐ Yes ☐ No ☐ Unknown *If Yes:* ☐ within BC ☐ outside BC but within Canada ☐ outside Canada

Was travel confirmed as the most likely source of infection? ☐ Yes

NOTE: For *S.* Typhi and *S.* Paratyphi travel to an endemic area during *any* part of the exposure period or travel outside HA of residence during the *entire* exposure period is considered confirmed travel-related.

Dates: DEPARTURE	**Dates: RETURN**	**Locations (e.g., city, country, resort)**	**Additional details**	**Foods brought back**
YYYY / MM / DD	*YYYY / MM / DD*			

Local Exposures Prior to Case Onset

Contact with international visitor or person recently abroad? ☐ Yes ☐ No ☐ Unknown

Contact with any symptomatic person? ☐ Yes ☐ No ☐ Unknown

If contact with international visitor, person recently abroad, or any symptomatic person:

Relationship to case	Was he/she ill?	Date(s) of contact *YYYY / MM / DD*	Details
	☐ Yes ☐ No ☐ U		
	☐ Yes ☐ No ☐ U		

Any imported foods consumed? ☐ Yes ☐ No ☐ Unknown *If yes*, details: _____

For locally-acquired cases:

Exposure	Exposed	Date(s) *YYYY/MM/DD*	Details – foods eaten
Any social gatherings attended?	☐ Yes ☐ No ☐ Unknown		
Any restaurants visited?	☐ Yes ☐ No ☐ Unknown		

^ If case is not travel-related, please notify local MHO and BCCDC.

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F. CONTACTS

people in household:

Name	Date ill *YYYY/MM/DD*	Nature of contact*	Occupation/Details	Contact phone	Sample requested?	^Excluded?

**Household, sexual, close contacts*
^ Please complete a Contact Exclusion Form for each contact excluded.

G. OCCUPATION AND EXCLUSION

Occupation:

(Prompt for working in food service industry and specify)

Sensitive Setting (check if applicable):

- ☐ Work/volunteer or attend day care
- ☐ Work/volunteer in a health care setting
- ☐ Work/volunteer as a food handler
- ☐ Other (e.g. pool): _____

Facility name:

Excluded ☐Y ☐N Effective date *(YYYY/MM/DD)*:

Details:

Symptom end date *(YYYY/MM/DD)*:

Exclusion lifted *(YYYY/MM/DD)*: MHO:

H. CASE EXCLUSION WORKSHEET*

Antibiotic Use: ☐ Y ☐ N ☐ U Specify: _____

Length of treatment: _____ days

Date of Discontinuation *(YYYY/MM/DD)*: _____

Sample No.	Date *(YYYY/MM/DD)*	Result	Notes
1		☐ Pos ☐ Neg	
2		☐ Pos ☐ Neg	
3		☐ Pos ☐ Neg	
4		☐ Pos ☐ Neg	
5		☐ Pos ☐ Neg	
6		☐ Pos ☐ Neg	

* Refer to CD Control Guidelines on Exclusion of Enteric Cases and their Contacts from High Risk Settings

I. INTERVENTIONS

Type	Implemented	Details	Type	Implemented	Details
Referred for Inspection	☐		Health File Sent	☐	
Hygiene Education	☐		Case excluded	☐	As above
Referred to another HA	☐		Contact excluded	☐	
Other:	☐				

J. Additional Details Related to Case Investigation

Date	Comment	Initials