Local ID Number: _____

State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

BOTULISM
CASE REPORT

Check one: ☐ Foodborne ☐ Wound ☐ Other (specify):_____

THIS FORM SHOULD NOT BE USED FOR INFANT BOTULISM

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	
			☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	*Apartment / Unit Number*

City / Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone / Pager*	*Work / School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work / School Location	*Work / School Contact*

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 11)	*Other Describe/Specify*

Occupation (see list on page 11)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 10)

The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

☐ American Indian or Alaska Native

☐ Asian *(check all that apply, see list on page 10)*
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African-American

☐ Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 10)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Fijian
- ☐ Tongan
- ☐ Guamanian
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

First three letters of patient's last name: | | | |

CLINICAL INFORMATION

Physician 1	*Last Name*	*First Name*	
	Specialty ☐ Emergency medicine ☐ Internist / Hospitalist ☐ Intensivist ☐ Infectious disease ☐ Neurologist ☐ Other (specify): _____		*Telephone Number*
Physician 2	*Last Name*	*First Name*	
	Specialty ☐ Emergency medicine ☐ Internist / Hospitalist ☐ Intensivist ☐ Infectious disease ☐ Neurologist ☐ Other (specify): _____		*Telephone Number*

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown	*Onset Date (mm/dd/yyyy)*	*Onset Time (hh:mm)*	*Specify AM/PM*
Date of First Neurologic Symptoms (mm/dd/yyyy)		*Date First Sought Medical Care (mm/dd/yyyy)*	

Symptoms	Yes	No	Unk	Symptoms	Yes	No	Unk
Diplopia (double vision) / blurred vision				Shortness of breath / trouble breathing			
Dysphagia (trouble swallowing)				Nausea			
Slurred speech				Vomiting			
Change in sound of voice				Abdominal pain			
Hoarseness				Diarrhea			
Dry mouth				Constipation			
Thick tongue				Dizziness			
Fatigue				Paresthesia			
Subjective weakness				*Other signs / symptoms (specify)*			

PHYSICAL EXAM FINDINGS

Observation	Yes	No	Unk	If Yes, Specify as Noted
Alert and oriented				
Extraocular palsy (inability to move eye muscles)				*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Ptosis (drooping of upper eyelid)				*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Pupil abnormality				*Abnormality* ☐ Dilated ☐ Constricted ☐ Non-reactive; *Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Facial paralysis				*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Palatal weakness (weakness of soft palate muscles)				*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Impaired gag reflex				
Sensory deficit(s)				*Specify*

(continued on page 3)

PHYSICAL EXAM FINDINGS (continued)

Observation	Yes	No	Unk	If Yes, Specify as Noted	
Muscle weakness and / or paralysis				*Progression of weakness / paralysis* ☐ Ascending, ending with cranial nerves ☐ Descending, beginning with cranial nerves ☐ Other (specify): _____ ☐ Unable to determine	*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Ataxia (poor coordination / balance)					
Abnormal deep tendon reflexes				*Describe*	
Other signs / symptoms (specify)					

CLINICAL TESTS

Type of Test	Yes	No	Unk	If Yes, Specify as Noted		
Lumbar puncture (CSF analysis)				*WBC count (highest)*	*RBC count*	*Opening pressure*
				Protein (highest)	*Glucose*	*Date (mm/dd/yyyy)*
EMG (If copy of EMG test report is available, please attach copy.)				*Result* ☐ Suggestive of / consistent with botulism ☐ Not consistent with botulism ☐ Unknown		
				Was EMG done with rapid stimulation? ☐ Yes ☐ No ☐ Unknown	*If Yes, what Hertz?*	*Date (mm/dd/yyyy)*
CT scan				*Describe results*		*Date (mm/dd/yyyy)*
MRI scan				*Describe results*		*Date (mm/dd/yyyy)*
Autoantibody tests (Guillain-Barré syndrome, Myasthenia Gravis)				*List tests ordered and results if known*		*Date (mm/dd/yyyy)*

PAST MEDICAL HISTORY

Prior botulism diagnosis? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify prior diagnosis date (mm/dd/yyyy)*
Prior neurological impairment? ☐ Yes ☐ No ☐ Unknown	*If Yes, describe impairment*
Allergy to equine products? ☐ Yes ☐ No ☐ Unknown	*If Yes, describe*
Immunocompromised? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify condition*
Gastrointestinal anomaly (e.g., Meckel's diverticulum)? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify condition*
Prior gastrointestinal surgery? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify condition and date of surgery (mm/dd/yyyy)*
Antibiotic use in the 60 days before symptom onset? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify medication name(s) and prescription date(s) (mm/dd/yyyy)*
Acid suppressing medication (e.g., proton pump inhibitor) use in the 60 days before symptom onset? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify medication name(s) and prescription date(s) (mm/dd/yyyy)*
Other (specify)	

First three letters of patient's last name: | | | |

DID PATIENT RECEIVE ANY MEDICATIONS / INJECTIONS THAT COULD CAUSE MUSCULAR PARALYSIS WITHIN 30 DAYS BEFORE ILLNESS ONSET?

Medication / Injection	Yes	No	Unk	If Yes, Specify as Noted
Therapeutic or cosmetic botulinum toxin injection				*Type of botulinum toxin* ☐ Botox (toxin-type A) ☐ Unknown ☐ Myobloc (toxin-type B) — *Date of last injection (mm/dd/yyyy)* *Location(s) on body where botulinum toxin was injected* *Name of facility / location where botulinum toxin was administered (e.g., hospital, clinic, medical spa, private residence, etc.)*
Aminoglycoside (gentamicin, tobramycin)				
Anticholinergic				
Other (specify)				

HOSPITALIZATION

Did patient visit the emergency room for illness?
☐ Yes ☐ No ☐ Unknown

Was patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If Yes, how many total hospital nights? ☐ *Still hospitalized as of* _____ *(mm/dd/yyyy)*

If there were any ER visits or hospital stays related to this illness, specify details in the Hospitalization – Details section below.

HOSPITALIZATION – DETAILS

Hospital Name 1	*Street Address*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*
Hospital Name 2	*Street Address*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*

TREATMENT / MANAGEMENT

Was antitoxin released / authorized? ☐ Yes ☐ No ☐ Unknown	*Date of Antitoxin Release (mm/dd/yyyy)*		*Time of Antitoxin Release (HH:MM AM/PM)*
	Officer Releasing Antitoxin - Last Name, First Name		
	Name of Hospital / Pharmacy that Received Antitoxin		*Pharmacy Phone Number*
Received botulinum antitoxin? ☐ Yes ☐ No ☐ Unknown	*Number of Doses Used*	*Antitoxin Type - First Dose* ☐ Heptavalent ☐ Unknown ☐ Other (specify): _____	*Date Administered (mm/dd/yyyy)*
		Antitoxin Type - Second Dose ☐ Heptavalent ☐ Unknown ☐ Other (specify): _____	*Date Administered (mm/dd/yyyy)*
	Adverse reaction to antitoxin? ☐ Yes ☐ No ☐ Unknown	*If Yes, what type of reaction?* ☐ Anaphylaxis ☐ Infusion reaction ☐ Other (specify): _____ ☐ Serum sickness ☐ Unknown	
Admitted to ICU? ☐ Yes ☐ No ☐ Unknown	*Admit Date (mm/dd/yyyy)*		
Intubated and placed on ventilator? ☐ Yes ☐ No ☐ Unknown	*Intubation Date (mm/dd/yyyy)*		*Extubation Date (mm/dd/yyyy)*

First three letters of patient's last name: | | | |

OUTCOME

Outcome?	If Survived,	Date of Death (mm/dd/yyyy)
☐ Survived ☐ Died ☐ Unknown	Survived as of _____(mm/dd/yyyy)	

ADDITIONAL COMMENTS

LABORATORY INFORMATION

CLINICAL SPECIMENS - DIRECT TOXIN TESTING

Specimen Type 1
☐ Gastric aspirate
☐ Serum (pre-toxin)
☐ Stool

Type of Test
☐ Mouse bioassay ☐ Mass spectrometry ☐ Other (specify): _____

Result
☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test canceled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unknown

Type of Toxin Detected
☐ Type A ☐ Type B ☐ Type E ☐ Type F ☐ Other (specify): _____ ☐ Untypeable ☐ Unknown

Collection Date (mm/dd/yyyy)	Collection Time (24 hour)	Laboratory Name	Telephone Number

Specimen Type 2
☐ Gastric aspirate
☐ Serum (pre-toxin)
☐ Stool

Type of Test
☐ Mouse bioassay ☐ Mass spectrometry ☐ Other (specify): _____

Result
☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test canceled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unknown

Type of Toxin Detected
☐ Type A ☐ Type B ☐ Type E ☐ Type F ☐ Other (specify): _____ ☐ Untypeable ☐ Unknown

Collection Date (mm/dd/yyyy)	Collection Time (24 hour)	Laboratory Name	Telephone Number

CLINICAL SPECIMENS - CULTURE TESTING

Specimen Type 1
☐ Gastric aspirate
☐ Stool
☐ Wound or abscess (specify site): _____
☐ Other (specify): _____

Result
☐ No neurotoxigenic *Clostridium* isolated ☐ *Clostridium butyricum* isolated ☐ Test canceled
☐ *Clostridium botulinum* isolated ☐ Other clostridial species ☐ Unknown
☐ *Clostridium baratii* isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism
☐ Type A ☐ Type B ☐ Type E ☐ Type F ☐ Other (specify): _____ ☐ None ☐ Untypeable ☐ Unknown

Collection Date (mm/dd/yyyy)	Collection Time (24 hour)	Laboratory Name	Telephone Number

Specimen Type 2
☐ Gastric aspirate
☐ Stool
☐ Wound or abscess (specify site): _____
☐ Other (specify): _____

Result
☐ No neurotoxigenic *Clostridium* isolated ☐ *Clostridium butyricum* isolated ☐ Test canceled
☐ *Clostridium botulinum* isolated ☐ Other clostridial species ☐ Unknown
☐ *Clostridium baratii* isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism
☐ Type A ☐ Type B ☐ Type E ☐ Type F ☐ Other (specify): _____ ☐ None ☐ Untypeable ☐ Unknown

Collection Date (mm/dd/yyyy)	Collection Time (24 hour)	Laboratory Name	Telephone Number

First three letters of patient's last name: | | | |

FOOD SPECIMENS

Type of Food Item 1 (specify)	*Food Identification #*	*Did the patient eat this item in the week before illness onset?* ☐ Yes ☐ No ☐ Unknown	*Did anyone else eat this item in the week before patient's illness onset?* ☐ Yes ☐ No ☐ Unknown

Direct Toxin Testing Result
☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test canceled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unknown

Type of Toxin Detected
☐ Type A ☐ Type B ☐ Type E ☐ Type F ☐ Other (specify): _____ ☐ Untypeable ☐ Unknown

Culture Testing Result
☐ No neurotoxigenic *Clostridium* isolated ☐ *Clostridium butyricum* isolated ☐ Test canceled
☐ *Clostridium botulinum* isolated ☐ Other clostridial species ☐ Unknown
☐ *Clostridium baratii* isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism
☐ Type A ☐ Type B ☐ Type E ☐ Type F ☐ Other (specify): _____ ☐ None ☐ Untypeable ☐ Unknown

Collection Date (mm/dd/yyyy)	*Collection Time (24 hour)*	*Laboratory Name*	*Telephone Number*

Type of Food Item 2 (specify)	*Food Identification #*	*Did the patient eat this item in the week before illness onset?* ☐ Yes ☐ No ☐ Unknown	*Did anyone else eat this item in the week before patient's illness onset?* ☐ Yes ☐ No ☐ Unknown

Direct Toxin Testing Result
☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test canceled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unknown

Type of Toxin Detected
☐ Type A ☐ Type B ☐ Type E ☐ Type F ☐ Other (specify): _____ ☐ Untypeable ☐ Unknown

Culture Testing Result
☐ No neurotoxigenic *Clostridium* isolated ☐ *Clostridium butyricum* isolated ☐ Test canceled
☐ *Clostridium botulinum* isolated ☐ Other clostridial species ☐ Unknown
☐ *Clostridium baratii* isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism
☐ Type A ☐ Type B ☐ Type E ☐ Type F ☐ Other (specify): _____ ☐ None ☐ Untypeable ☐ Unknown

Collection Date (mm/dd/yyyy)	*Collection Time (24 hour)*	*Laboratory Name*	*Telephone Number*

ADDITIONAL INFORMATION

If post-antitoxin test was performed and was positive, describe circumstances.	*Additional antitoxin given?* ☐ Yes ☐ No ☐ Unknown

EPIDEMIOLOGIC INFORMATION

EXPOSURES / RISK FACTORS - WOUND AND DRUG USE

Provide information regarding the patient's wound and drug use below.

Wound / Drug Use	Yes	No	Unk	If Yes, Specify as Noted
Wound or abscess				*Date of injury (mm/dd/yyyy)* / *Location(s)* *Description* *How wound occurred* / *Did / does wound appear infected?* ☐ Yes ☐ No ☐ Unknown
Injects heroin				*Injects black tar heroin?* ☐ Yes ☐ No ☐ Unknown *Injection method* ☐ Intravenous ☐ Subcutaneous (skin-pop) ☐ Unknown ☐ Intramuscular ☐ Other:_____
Injects other drugs				*Drugs injected* ☐ Cocaine ☐ Fentanyl ☐ Methamphetamine ☐ Unknown ☐ Other: _____ *Injection method* ☐ Intravenous ☐ Subcutaneous (skin-pop) ☐ Unknown ☐ Intramuscular ☐ Other:_____
Sniffs / snorts drugs				*Drugs sniffed / snorted* ☐ Cocaine ☐ Fentanyl ☐ Heroin ☐ Methamphetamine ☐ Unknown ☐ Other: _____
Other drug use				*Describe type of use and drugs*

EXPOSURES / RISK FACTORS - POTENTIAL HIGH-RISK PRODUCTS

(If foodborne is suspected, contact CDPH Infectious Diseases Branch for hypothesis generating questionnaire, 510-620-3434)

ASK ABOUT HIGH RISK FOODS EVEN IF WOUND BOTULISM IS SUSPECTED (SUCH AS HOME CANNED OR SUSPICIOUS COMMERCIAL OR RESTAURANT FOODS)

Provide information regarding potential high-risk products consumed one week prior to illness onset.

Food Product	Yes	No	Unk	If Yes, Describe
Home canned, jarred, or preserved food products				*Describe*
Fermented food products				*Describe*
Dried or smoked fish products				*Describe*
Marinated food products				*Describe*
Suspicious commercial products (i.e., bulging lids or cans, recalled products, "off-odor" food items)				*Describe*

First three letters of patient's last name: | | | |

EXPOSURES / RISK FACTORS - SPECIFIC FOOD ITEMS

Provide information regarding any suspected food item consumed one week prior to illness onset.

Suspect Food Item 1	*Food Item*	*Date Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)*
	Type of Food ☐ Homemade ☐ Restaurant associated ☐ Commercial product ☐ Unk	*If commercial product, specify* Brand:_____ Lot:_____	
	How was food stored? ☐ Unrefrigerated ☐ Refrigerated ☐ Frozen ☐ Unknown ☐ Other:_____		
	How was food preserved? ☐ Canned ☐ Dried ☐ Fermented ☐ Salted ☐ Pickled ☐ No preservation method ☐ Unknown ☐ Other:_____		
	How was food item served? ☐ Unheated ☐ Only warmed ☐ Microwaved ☐ Heated ☐ Boiled ☐ Fried ☐ Unknown ☐ Other:_____		
	Number of Persons who Shared the Food Item	*Number of Persons Ill*	
	Samples of food item available? ☐ Yes ☐ No ☐ Unknown	*Samples submitted for botulism testing?* ☐ Yes ☐ No ☐ Unknown	*Foods of same batch / lot recovered or recalled?* ☐ Yes ☐ No ☐ Unknown
Suspect Food Item 2	*Food Item*	*Date Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)*
	Type of Food ☐ Homemade ☐ Restaurant associated ☐ Commercial product ☐ Unk	*If commercial product, specify* Brand:_____ Lot:_____	
	How was food stored? ☐ Unrefrigerated ☐ Refrigerated ☐ Frozen ☐ Unknown ☐ Other:_____		
	How was food preserved? ☐ Canned ☐ Dried ☐ Fermented ☐ Salted ☐ Pickled ☐ No preservation method ☐ Unknown ☐ Other:_____		
	How was food item served? ☐ Unheated ☐ Only warmed ☐ Microwaved ☐ Heated ☐ Boiled ☐ Fried ☐ Unknown ☐ Other:_____		
	Number of Persons who Shared the Food Item	*Number of Persons Ill*	
	Samples of food item available? ☐ Yes ☐ No ☐ Unknown	*Samples submitted for botulism testing?* ☐ Yes ☐ No ☐ Unknown	*Foods of same batch / lot recovered or recalled?* ☐ Yes ☐ No ☐ Unknown

EXPOSURES / RISK FACTORS - OTHER POTENTIAL EXPOSURES OF INTEREST

Exposure 1	*Describe*
Exposure 2	*Describe*

CONTACTS / OTHER ILL PERSONS

Any contacts with similar illness? ☐ Yes ☐ No ☐ Unk	*If Yes, specify details below.*

ILL CONTACTS - DETAILS

Name 1	*Age*	*Gender*	*Telephone Number*		*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address				*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City		*State*	*Zip Code*	*Date First Reported to Public Health (mm/dd/yyyy)*	
Name 2	*Age*	*Gender*	*Telephone Number*		*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address				*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City		*State*	*Zip Code*	*Date First Reported to Public Health (mm/dd/yyyy)*	

First three letters of patient's last name: | | | |

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date Form Completed (mm/dd/yyyy)

Date First Reported to Public Health (mm/dd/yyyy)	First Reported by ☐ Clinician ☐ Laboratory ☐ Other (specify): _____

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐ Yes ☐ No ☐ Unknown	Contact Name / Case Number

DISEASE CASE CLASSIFICATION

Case Classification (see case definition on below)

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case

OUTBREAK

Part of known outbreak? ☐ Yes ☐ No ☐ Unknown	If Yes, extent of outbreak: ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other:_____

Vehicle of Outbreak

STATE USE ONLY

State Case Classification

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Need additional information

CASE DEFINITION

BOTULISM, FOODBORNE (2011)

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

(continued on page 10)

CASE DEFINITION (continued)

BOTULISM, WOUND (2011)

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

Probable: a clinically compatible case 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, or a history of injection drug use within the 2 weeks before onset of symptoms

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

BOTULISM, OTHER (2011)

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 ingestionof suspect food and has no wounds

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

First three letters of patient's last name: | | | |

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - waiter or waitress
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - registered nurse
- Medical - other/unknown
- Military - officer
- Military - recruit or trainee
- Protective service - police officer
- Protective service - other
- Professional, technical, or related profession
- Retired
- Sex worker
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high (secondary) school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high (secondary) school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Other
- Refused
- Unknown