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

Local ID Number _____

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)

☐Preliminary ☐Final

LISTERIOSIS
CASE REPORT

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
☐Male ☐Female ☐Other: _____

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

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

Occupation Setting (see list on page 7)	*Other Describe/Specify*

Occupation (see list on page 7)	*Other Describe/Specify*

Primary Language
☐English
☐Spanish
☐Other:_____

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

*Race**
(check all that apply, race descriptions on page 7)
☐African-American/Black
☐American Indian or Alaska Native
☐Asian *(check all that apply)*
- ☐Asian Indian ☐Japanese
- ☐Cambodian ☐Korean
- ☐Chinese ☐Laotian
- ☐Filipino ☐Thai
- ☐Hmong ☐Vietnamese
- ☐Other:_____

☐Pacific Islander *(check all that apply)*
- ☐Native Hawaiian ☐Samoan
- ☐Guamanian
- ☐Other:_____

☐White
☐Other:_____
☐Unk

*Comment: self-identity or self-reporting
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.

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

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

SIGNS AND SYMPTOMS

Symptomatic? ☐Yes ☐No ☐Unk	Onset Date (mm/dd/yyyy)	Date First Sought Medical Care (mm/dd/yyyy)	Duration of Acute Symptoms (days)

Note: For Signs and Symptoms listed below, please review medical records. This is necessary for proper case classification. If the patient was hospitalized, please provide copy of discharge summary.

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Meningitis	☐	☐	☐	
Bacteremia / sepsis	☐	☐	☐	
Febrile gastroenteritis	☐	☐	☐	*If Yes, highest temperature (specify °F/°C)*
Amnionitis	☐	☐	☐	
Miscarriage / stillbirth	☐	☐	☐	
Pneumonia (neonate)	☐	☐	☐	
Granulomatosis infantisepticum (neonate)	☐	☐	☐	

Other signs / symptoms (specify)

PAST MEDICAL HISTORY

Was the patient pregnant at onset? ☐Yes ☐No ☐Unk	*If Yes, weeks gestation*
Does the patient take any medications regularly? ☐Yes ☐No ☐Unk	*If Yes, specify medication(s)*
Does the patient have any medical conditions? (i.e., renal disease, diabetes, immune compromising conditions) ☐Yes ☐No ☐Unk	*If Yes, specify medical condition(s)*

HOSPITALIZATION

Did patient visit emergency room for illness? ☐Yes ☐No ☐Unk	*Was patient hospitalized?* ☐Yes ☐No ☐Unk	*If Yes, how many total hospital nights?*

If there were any ER or hospital stays related to this illness, specify details 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*

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

OUTCOME

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

If patient was pregnant, outcome of fetus?
☐Stillborn ☐Born alive but died within seven days ☐Alive, with complications ☐Alive and well

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type ☐Blood* ☐CSF* ☐Placenta ☐Stool Other:_____	* If pregnancy-associated, specify if Blood or CSF specimen is from mother or neonate ☐Mother ☐Neonate

Collection Date (mm/dd/yyyy)	Results	Laboratory Name	Telephone Number

Was result confirmed by local public health lab? ☐Yes ☐No ☐Unk	Result (including subtype)		Local Lab ID Number
Was isolate sent to state lab for serotyping confirmation? ☐Yes ☐No ☐Unk	Result (including serotype)		State Lab ID Number
Was PFGE requested? ☐Yes ☐No ☐Unk	Pattern 1 #	Pattern 2 #	CDC Cluster ID # (if known)

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 28 DAYS PRIOR TO ILLNESS ONSET

EXPOSURES / RISK FACTORS

If NEONATE / INFANT: Was listeriosis confirmed in mother? ☐Yes ☐No ☐Unk	If Yes, explain
If NEONATE: Did birth mother have febrile illness during this pregnancy? ☐Yes ☐No ☐Unk	If Yes, explain

DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?

Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Cold cuts sliced at a deli, (e.g., turkey breast, ham, pastrami)				Type(s)		Where purchased
Pre-packaged cold cuts				Type(s)	Brand(s)	Where purchased
Hot dogs				Type(s)	Brand(s)	
				Eaten right out of the package? ☐Yes ☐No ☐Unk	Where purchased	
Refrigerated pâté or meat spreads, not canned				Type(s)	Brand(s)	Where purchased
Refrigerated, smoked, or cured seafood (e.g., salmon, whitefish, trout), not canned				Type(s)	Brand(s)	Where purchased
Raw (unpasteurized) milk				Type(s)	Brand(s)	Where purchased
Raw milk products				Type(s)	Brand(s)	Where purchased
Mexican-style fresh cheese (queso fresco) or cheese from a street vendor				Unpasteurized? ☐Yes ☐No ☐Unk	Type(s)	
				Brand(s)	Location(s) Where Cheese Obtained	

(continued on page 4)

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

Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Soft cheese (e.g., Brie, feta, Camembert, goat, blue)	☐	☐	☐	*Type(s)*	*Brand(s)*	*Where purchased*
Ready-to-eat deli style salads (e.g., potato salad, pasta salad, tuna salad)	☐	☐	☐	*Type(s)*	*Brand(s)*	*Where purchased*
Pre-prepared dips (e.g., hummus)	☐	☐	☐	*Type(s)*	*Brand(s)*	*Where purchased*
Other food exposures of interest	☐	☐	☐	*Specify food item(s)*		

FOOD HISTORY - GROCERIES

WHERE DID PATIENT SHOP FOR GROCERIES? (INCLUDE FARMER'S MARKETS, DELIS, SWAP MEETS, ETC.)

Store / Location 1	*Address / Cross-streets*	
	City	*State*
Store / Location 2	*Address / Cross-streets*	
	City	*State*
Store / Location 3	*Address / Cross-streets*	
	City	*State*

FOOD HISTORY - OUTSIDE HOME

Did the patient consume food or drink prepared outside of the home during the incubation period? ☐Yes ☐No ☐Unk	*If Yes, specify name of place (e.g., restaurant, concession stand, friend's house, etc.), location, date, and items consumed below.*

FOOD HISTORY - OUTSIDE HOME - DETAILS

Name of Place 1	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	
Name of Place 2	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	
Name of Place 3	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	
Name of Place 4	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	

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

TRAVEL HISTORY

*Did patient travel **outside county of residence** during the incubation period?* ☐Yes ☐No ☐Unk	*If Yes, specify all locations and dates below.*

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started *(mm/dd/yyyy)*	Date Travel Ended *(mm/dd/yyyy)*

ILL CONTACTS

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

ILL CONTACTS - DETAILS

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

NOTES / REMARKS

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

REPORTING AGENCY

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

First Reported By
☐Clinician ☐Laboratory ☐Other (specify):_____

EPIDEMIOLOGICAL LINKAGE

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

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐Confirmed ☐Probable ☐Suspect

*Neonatal or Non-Neonatal** ☐Neonatal ☐Non-Neonatal	**Note that infected pregnant women and/or their infected offspring are to be designated as "Neonatal" cases.*

Nosocomial or Community Acquired ☐Nosocoial ☐Community acquired	*Specify if Foodborne* ☐Foodborne

OUTBREAK

Part of known outbreak? ☐Yes ☐No ☐Unk	*If Yes, extent of outbreak* ☐One CA jurisdiction ☐Multiple CA jurisdictions ☐Multistate ☐International ☐Unk ☐Other (specify):_____

Mode of Transmission ☐Point source ☐Person-to-person ☐Unk ☐Other:_____	*Vehicle of Outbreak*	*Pattern 1 ID number*	*Pattern 2 ID number*

STATE USE ONLY

State Case Classification
☐Confirmed ☐Not a case ☐Need additional information

CASE DEFINITION

LISTERIOSIS (2010)

CLINICAL DESCRIPTION

In adults, invasive disease caused by *Listeria monocytogenes* manifests most commonly as meningitis or bacteremia; infection during pregnancy may result in fetal loss through miscarriage or stillbirth, or neonatal meningitis or bacteremia. Other manifestations can also be observed.

LABORATORY CRITERIA FOR DIAGNOSIS

A. Isolation of *L. monocytogenes* from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid)
B. In the setting of miscarriage or stillbirth, isolation of *L. monocytogenes* from placental or fetal tissue

CASE CLASSIFICATION

- **Confirmed**: A clinically compatible case that is laboratory-confirmed

COMMENT

The usefulness of other laboratory methods such as fluorescent antibody testing or polymerase chain reaction to diagnose invasive listeriosis has not been established.

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.

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

- Adult film actor/actress
- 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 - server
- 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 - nurse
- Medical - other/unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent/guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Volunteer
- Other
- Refused
- Unknown