ENCLOSURE 4: UNSPECIFIED NEUROLOGIC ILLNESS OUTBREAK

Case investigation form

ID NUMBER:________

INTERVIEWER:____________________ AGENCY:_________________________

DATE OF INTERVIEW:____/____/____

PERSON INTERVIEWED: ?Patient ?Other

If other, Name of person ___________________________________

Telephone contact ______- ______- _________

Describe relationship _______________________________

DEMOGRAPHIC INFORMATION

LAST NAME: __________________________ FIRST NAME: __________________________

SEX: ❐ Male ❐ Female DATE OF BIRTH: ____/____/____ AGE____

RACE: ❐ White ❐ Black ❐ Asian ❐ Other, specify __________ ❐Unknown

ETHNICITY: ❐ Hispanic ❐ Non-Hispanic ❐ Unknown

HOME TELEPHONE: ( ) _______-________

WORK/OTHER TELEPHONE: ( ) _______-________

HOME ADDRESS STREET: ____________________________________

CITY:_______________________________ STATE:______________ZIP:______________

EMPLOYED: ❐ Yes ❐ No ❐ Unknown

OCCUPATION:____

WORKPLACE/SCHOOL NAME:____

WORK/SCHOOL ADDRESS: STREET: ________________________ CITY: ________________

STATE:_____________ZIP:_____________

HOW MANY PEOPLE RESIDE IN THE SAME HOUSEHOLD? __________

LIST NAME(S), AGE(S), AND RELATIONSHIPS (use additional pages if necessary):

Name					
Age					
Relationship					

CLINICAL INFORMATION (as documented in admission history of medical record or from case/proxy interview)

CHIEF COMPLAINT: ______________________________

DATE OF ILLNESS ONSET: ___/___/___

Briefly summarize History of Present Illness:

____

____

____

SIGNS AND SYMPTOMS

Fever	❐ Yes	❐ No	❐ Unknown
If yes, Maximum temperature ______ ❐ °F			
Antipyretics taken	❐Yes	❐No	❐Unknown
Headache	❐Yes	❐No	❐Unknown
Stiff neck	❐Yes	❐No	❐Unknown
Photophobia	❐Yes	❐No	❐Unknown
Fatigue	❐Yes	❐No	❐Unknown
Altered mental status	❐Yes	❐No	❐Unknown
Unconscious/unresponsive	❐Yes	❐No	❐Unknown
Seizures	❐Yes	❐No	❐Unknown
Sensory changes	❐Yes	❐No	❐Unknown
Muscle weakness	❐Yes	❐No	❐Unknown
If yes, specify:	❐Upper Extremities	❐Lower Extremities	❐Both
	❐Unilateral	❐Bilateral	
Pattern of progression: Ascending__	Descending__	Unknown__	
Blurred or double vision	❐Yes	❐No	❐Unknown
Difficulty swallowing	❐Yes	❐No	❐Unknown
Difficulty speaking	❐Yes	❐No	❐Unknown
Dry mouth	❐Yes	❐No	❐Unknown
Excess salivation	❐Yes	❐No	❐Unknown
Sore throat	❐Yes	❐No	❐Unknown
Muscle pains	❐Yes	❐No	❐Unknown
Nausea	❐Yes	❐No	❐Unknown
Diarrhea	❐Yes	❐No	❐Unknown
Vomiting	❐Yes	❐No	❐Unknown
Shortness of breath	❐Yes	❐No	❐Unknown
Cough	❐Yes	❐No	❐Unknown
Rash	❐Yes	❐No	❐Unknown

If yes, describe:______________________________

Other abnormality:______________________________

PAST MEDICAL HISTORY:

Hypertension	❒Yes	❒No	❒Unknown
Diabetes	❒Yes	❒No	❒Unknown
Cardiac disease	❒Yes	❒No	❒Unknown
Seizures	❒Yes	❒No	❒Unknown
Other neurologic condition	❒Yes	❒No	❒Unknown

If yes, describe:____

Malignancy	❒Yes	❒No	❒Unknown

If yes, specify type: ____

Currently on treatment:	❒Yes	❒No	❒Unknown
HIV infection	❒Yes	❒No	❒Unknown
Currently pregnant	❒Yes	❒No	❒Unknown

Other immunocompromising condition (e.g., renal failure, cirrhosis, chronic steroid use)

❒Yes ❒No ❒Unknown

If yes, specify disease or drug therapy:________________________________

Other underlying condition(s): ____

Prescription medications: ____

SOCIAL HISTORY:

Current alcohol abuse:	❒Yes	❒No	❒Unknown
Past alcohol abuse:	❒Yes	❒No	❒Unknown
Current injection drug use	?Yes	?No	?Unknown
Past injection drug use	?Yes	?No	?Unknown
Current smoker	?Yes	?No	?Unknown
Former smoker	?Yes	?No	?Unknown
Other illicit drug use	?Yes	?No	?Unknown

If yes, specify:____

HOSPITAL INFORMATION:

HOSPITALIZED: ❒ Yes ❒ No

NAME OF HOSPITAL: ____

DATE OF ADMISSION: ____/____/____ DATE OF DISCHARGE ____/____/____

ATTENDING PHYSICIAN:

LAST NAME:____________________________ FIRST NAME:____________________________

Office Telephone: (   )____- ______Pager: (   ) ____-______ Fax: (   ) ____-____

MEDICAL RECORD ABSTRACTION :

MEDICAL RECORD NUMBER: ____________________________

HOSPITAL NAME: ____________________________________

WARD/ROOM NUMBER: ______________________

ADMISSION DIAGNOSIS(ES): 1) ______________________

2) ______________________

3) ______________________

PHYSICAL EXAM:

Admission Vital Signs:

Temp:____ (Oral ?/ Rectal ? °F ?/ °C ?) Heart Rate:___ Resp. Rate:___ B/P:___/___

Neurologic examination:

Meningismus (neck stiffness): ?Present ?Absent ?Not Noted

Mental Status: ?Normal ?Abnormal ?Not Noted

If abnormal, level of consciousness:

? Lethargic
? Unconscious
? Other______________________

Agitation: ?Present ?Absent ?Not Noted

Cranial nerve function: ?Normal ?Abnormal ?Not Noted

If abnormal, specify:______________________

Motor Exam: ?Normal ?Abnormal ?Not Noted

If abnormal, describe: (on a scale of 0/5-5/5, less than 5/5 is weak)

Left Arm	?Normal	?Weak	?Not Noted
Right Arm	?Normal	?Weak	?Not Noted
Left Leg	?Normal	?Weak	?Not Noted
Right Leg	?Normal	?Weak	?Not Noted

Reflexes: ?Normal ?Abnormal ?Not Noted

If abnormal, describe (on a scale of 0-5, 0=Absent; 1=decreased; 2= normal; 3, 4, 5=increased):

Left Arm	?Absent	?Decreased	?Normal	?Increased
Right Arm	?Absent	?Decreased	?Normal	?Increased
Left Leg	?Absent	?Decreased	?Normal	?Increased
Right Leg	?Absent	?Decreased	?Normal	?Increased

Sensory exam: ?Normal ?Abnormal ?Not Noted

Respiratory status: ? Normal ?Abnormal ?Not Noted

If abnormal, describe:______________________

Skin: ? Normal ?Abnormal ?Not Noted

If rash present, describe type and location:______________________

DIAGNOSTIC STUDIES:

Test	Results of tests done on Admission (__/__/__)	Abnormal test result at any time (specify date mm/dd/yy)
Hemoglobin (Hb)		(___/___/___)
Hematocrit (HCT)		(___/___/___)
Platelet (plt)		(___/___/___)
Total white blood cell (WBC)		(___/___/___)
WBC differential:		(___/___/___)
% granulocytes (PMNs)		(___/___/___)
% bands		(___/___/___)
% lymphocytes		(___/___/___)
Blood cultures	? positive (specify____________________) ? negative ? pending ? not done	? positive (specify____________________) ? negative ? pending ? not done (___/___/___)

<table>
<tr><th>Test</th><th>Results of tests done on Admission (___/___/___)</th><th>Abnormal test result at any time (specify date mm/dd/yy)</th></tr>
<tr><td>Botulinum toxin testing--serum</td><td>? positive
(specify______________________)
? negative
? pending
? not done</td><td>? positive
(specify______________________)
? negative
? pending
? not done
(____/____/____)</td></tr>
<tr><td>Botulinum toxin testing--stool</td><td>? positive
(specify______________________)
? negative
? pending
? not done</td><td>? positive
(specify______________________)
? negative
? pending
? not done
(____/____/____)</td></tr>
<tr><td>Lumbar puncture—cerebrospinal fluid (CSF) analysis:
Gram stain (check all that apply)</td><td>? no organisms
? gram positive cocci
? gram negative cocci
? gram positive rods
? gram negative coccobacilli
? gram negative rods
? acid-fast bacilli
? fungal forms
? other ________________</td><td>? no organisms
? gram positive cocci
? gram negative cocci
? gram positive rods
? gram negative coccobacilli
? gram negative rods
? acid-fast bacilli
? fungal forms
? other ________________
(____/____/____)</td></tr>
<tr><td>Lumbar puncture—CSF analysis:
Bacterial culture</td><td>? positive
(specify______________________)
? negative
? pending
? not done</td><td>? positive
(specify______________________)
? negative
? pending
? not done
(____/____/____)</td></tr>
</table>

Test	Results of tests done on Admission (__/__/__)	Abnormal test result at any time (specify date mm/dd/yy)
Lumbar puncture—CSF analysis: Viral culture	? positive (specify____________________) ? negative ? pending ? not done	? positive (specify____________________) ? negative ? pending ? not done (____/____/____)
Lumbar puncture—CSF analysis: Other culture	? positive (specify____________________) ? negative ? pending ? not done	? positive (specify____________________) ? negative ? pending ? not done (____/____/____)
Lumbar puncture—CSF analysis: Other test (e.g., herpes PCR) Please describe		(____/____/____)
Chest radiograph	? normal ? unilateral, lobar/consolidation ? bilateral, lobar/consolidation ? interstitial infiltrates ? widened mediastinum ? pleural effusion ? other __________________	? normal ? unilateral, lobar/consolidation ? bilateral, lobar/consolidation ? interstitial infiltrates ? widened mediastinum ? pleural effusion ? other __________________ (____/____/____)
CT Scan of brain	? normal ? abnormal (describe:__________________ ______________________) ? not done	? normal ? abnormal (describe:__________________ ______________________) ? not done (____/____/____)

Test	Results of tests done on Admission (___/___/___)	Abnormal test result at any time (specify date mm/dd/yy)
MRI Scan of brain	? normal ? abnormal (describe:________________ ________________) ? not done	? normal ? abnormal (describe:________________ ________________) ? not done (___/___/___)
Tensilon test	? normal ? abnormal (describe:________________ ________________ ___) ? not done	? normal ? abnormal (describe:________________ ________________ ___) ? not done (___/___/___)
Electromyelogram (EMG)	? normal ? abnormal (describe:________________ ________________) ? not done	? normal ? abnormal (describe:________________ ________________) ? not done (___/___/___)
Other pertinent study results (e.g., toxin assays)		(___/___/___)

NEUROLOGY CONSULTED: ?Yes ?No ?Unknown

Date of Exam:__/__/__

Name of neurologist: Last Name ________________ First Name ________________

Telephone or beeper number ( ) _____ - _______

INFECTIOUS DISEASE CONSULT: ?Yes ?No ?Unknown

Date:___/___/___

Name of physician: Last Name ___________________ First Name _______________

Telephone or beeper number ( ) _____ - _____

H0SPITAL COURSE:

INITIAL TREATMENT:

a. antibiotics? ?Yes ?No ?Unknown

If yes, check all that apply:

? Ampicillin
? Cefepime (Maxipime)
? Cefotaxime (Claforan)
? Ceftazidime (Fortaz, Tazicef, Tazidime)
? Ceftizoxime (Cefizox)
? Ceftriaxone (Rocephin)
? Chloramphenicol
? Gentamicin (Garamycin)
? Penicillin G
? Trimethaprim-sulfamethoxazole (Bactrim, Cotrim, TMP/SMX)
? Vancomycin (Vancocin)
? other____________________________

b. antivirals ?Yes ?No ?Unknown

If yes, check all that apply:

? Acyclovir (Zovirax)
? other ____

c. botulinum anti-toxin ?Yes ?No ?Unknown

Did patient require intensive care? ?Yes ?No ?Unknown

If patient was admitted to Intensive Care Unit:

a. Length of stay in ICU, in days:_________

b . Was patient on mechanical ventilation? ?Yes ?No ?Unknown

WORKING OR DISCHARGE DIAGNOSIS(ES) :

1) ____________________

2) ____________________

3) ____________________

OUTCOME:

?Recovered/discharged

?Died

?Still in hospital: a) improving ? b) worsening ?

? Comment____________________

ADDITIONAL COMMENTS: ____________________

Risk Exposure Questions

The following questions pertain to the 2 week period prior to the onset of your illness/symptoms:

Occupation (provide information for all jobs/ volunteer duties)

1. Please briefly describe your job/ volunteer duties:________________________________

2. Does your job involve contact with the public?
   Yes No If "Yes", specify____

3. Does anyone else at your workplace have similar symptoms?
   Yes No Unk
   If "Yes", name and approximate date on onset (if known)_________________

Knowledge of Other Ill Persons

4. Do you know of other people with similar symptoms? Y / N / Unk

(If Yes, please complete the following questions)

Name of ill person	Age	M/F	Address	Phone number(s)	Date of onset	Relation to you	Did they seek medical care? Where?	Were they diagnosed by a physician? Describe.

Travel*

*Travel is defined as staying overnight (or longer) at somewhere other than the usual residence

8. Have you traveled anywhere in the last two weeks? Y / N / Unk

   Dates of Travel: ____/____/____ to ____/____/____
   Method of Transportation for Travel: ______________________
   Where Did You Stay? __________________________________
   Purpose of Travel? ____________________________________
   Did You Do Any Sightseeing on your trip? Yes ☐ No ☐
   If yes, specify: _______________________________________

Did Anyone Travel With You? Yes ☐ No ☐

If yes, specify: ______________________________

Are they ill with similar symptoms? Yes ☐ No ☐ Unk ☐

Information for Additional Trips during the past two weeks:

____

____

Public Functions/Venues (during 2 weeks prior to symptom onset)

Category	Yes/No/ Unknown (Y/N/U)	Description of Activity	Location of Activity	Date of Activity	Time of Activity (start, end)	Others ill? (Y/N/U)
9. Sporting Event						
10. Performing Arts (ie Concert, Theater, Opera)						
11. Movie Theater						
12. Religious Gatherings						
13. Picnics						
14. Political Events (including Marches and Rallies)						
15. Meetings or Conferences (work or personal)						
16. Family Planning Clinics						
17. Government Office Building						
18. Airports						
19. Shopping Malls						
20. Gym/Workout Facilities						
21. Casinos						
22. Beaches						
23. Parks						
24. Parties (including Raves, Prom, etc)						
25. Bars/Clubs						
26. Tourist Attractions (ie Sea World, Zoo, Disneyland)						
27. Museums						
28. Street Fairs, Swap Meets, Flea Markets						
29. Carnivals/Circus						
30. Campgrounds						

Transportation

Have you used the following types of transportation in the 2 weeks prior to onset?

31. Bus Yes ☐ No ☐ Unk ☐
    Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
    Bus Number: ____________ Origin: ____________
    Any connections? Yes ☐ No ☐ (Specify: Location ____________ Bus# ____________)
    Company Providing Transportation: ____________ Destination: ____________

32. Train/Metro Yes ☐ No ☐ Unk ☐
    Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
    Route Number: ____________ Origin: ____________
    Any connections? Yes ☐ No ☐ (Specify: Location ____________ Route # ____________)
    Company Providing Transportation: ____________ Destination: ____________

33. Airplane Yes ☐ No ☐ Unk ☐
    Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
    Flight Number: ____________ Origin: ____________
    Any connections? Yes ☐ No ☐ (Specify: Location ____________ Flight # ____________)
    Company Providing Transportation: ____________ Destination: ____________

34. Boat/Ferry Yes ☐ No ☐ Unk ☐
    Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
    Ferry Number: ____________ Origin: ____________
    Any connections? Yes ☐ No ☐ (Specify: Location ____________ Ferry # ____________)
    Company Providing Transportation: ____________ Destination: ____________

35. Van Pool/Shuttle Yes ☐ No ☐ Unk ☐
    Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
    Route Number: ____________ Origin: ____________
    Any connections? Yes ☐ No ☐ (Specify: Location ____________ Route # ____________)
    Company Providing Transporation: ____________ Destination: ____________

Food & Beverage

36. During the 2 weeks before your illness, did you eat at any of the following ***food establishments or private gatherings with food or beverages***? (If "yes", circle establishment(s); describe below)

Restaurant, fast-food or deli	Y / N / Unk	Grocery store or salad-bar	Y / N / Unk
Cafeteria at school, hospital, other	Y / N / Unk	Plane, boat, train, other	Y / N / Unk

Concert, movie, other entertainment	Y / N / Unk	Gas station or 24-hr store	Y / N / Unk
Sporting event or snack bar	Y / N / Unk	Street-vended food	Y / N / Unk
Outdoor farmers market or swap meet	Y / N / Unk	Beach, park or outdoor event	Y / N / Unk
Dinner party, barbecue or potluck	Y / N / Unk	Other food establishment	Y / N / Unk
Birthday party or other celebration	Y / N / Unk	Other private gathering	Y / N / Unk

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: ________________ Location: ____
Food/drink consumed: ____
Others also ill?: Y / N / Unk (explain):____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: ________________ Location: ____
Food/drink consumed: ____
Others also ill?: Y / N / Unk (explain): ____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: ________________ Location: ____
Food/drink consumed: ____
Others also ill?: Y / N / Unk (explain): ____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: ________________ Location: ____
Food/drink consumed: ____
Others also ill?: Y / N / Unk (explain): ____

37. During the 2 weeks before your illness, did you consume any free ***food samples*** from........?

Grocery store	Y / N / Unk
Race/competition	Y / N / Unk
Public gathering?	Y / N / Unk
Private gathering?	Y / N / Unk

If "YES" for any in question #34, provide date, time, location and list of food items consumed:
Date/Time: ________________ Location (Name and Address): ________________________
Food/drink consumed: ____
Others also ill?: Y / N / Unk (explain): ____

If "YES" for any in question #34, provide date, time, location and list of food items consumed:
Date/Time: ________________ Location (Name and Address):________________________
Food/drink consumed: ____
Others also ill?: Y / N / Unk (explain): ____

38. During the 2 weeks before your illness, did you consume any of the following ***products***?

Vitamins	Y / N / Unk	Specify (Include Brand Name):_______________
Herbal remedies	Y / N / Unk	Specify (Include Brand Name):_______________
Diet Aids	Y / N / Unk	Specify (Include Brand Name):_______________
Nutritional Supplements	Y / N / Unk	Specify (Include Brand Name):_______________
Other Ingested non-food	Y / N / Unk	Specify (Include Brand Name):_______________

39. During the 2 weeks before your illness, did you consume any unpasteurized products (ie milk, cheese, fruit juices)? Y/N/Unk If yes, specify name of item:_______
Date/Time: _______________ Location (Name and Address):_________________________
Others also ill?: Y / N / Unk (explain): ____

40. During the 2 weeks before your illness, did you purchase food from any internet grocers? Y/N/Unk
If yes, specify date / time of delivery:__________________ Store/Site:__________________
Items purchased:____

41. During the 2 weeks before your illness, did you purchase any mail order food? Y/N/Unk
If yes, specify date/time of delivery:______________ Store purchased from:_____________
Items purchased:____

42. Please check the routine sources for drinking water (check all that apply):
? Community or Municipal ? Well (shared) ? Well (private family)
? Bottled water (Specify Brand:_______________) ? Other (Specify:_______________)

Aerosolized water

43. During the 2 weeks prior to illness, did you consume water from any of the following sources (check all that apply):
? Wells ? Lakes ? Streams ? Springs ? Ponds ? Creeks ? Rivers
? Sewage-contaminated water
? Street-vended beverages (Prepared with water and sold by street vendors)
? Ice prepared w/ unfiltered water (Prepared with water that is not from a municipal water supply or that is not bottled or boiled)
? Unpasteurized milk
? Other (Specify:____)

If "YES" for any in question #43, provide date, time, location and type of water consumed:
Date/Time: ________________ Location (Name and Address):________________________
Type of water consumed: ____
Others also ill?: Y / N / Unk (explain):____

44. During the 2 weeks prior to illness, did you engage in any of the following recreational activities (check all that apply):

? Swimming in public pools (e.g., community, municipal, hotel, motel, club, etc)
? Swimming in kiddie/wading pools
? Swimming in sewage-contaminated water
? Swimming in fresh water, lakes, ponds, creeks, rivers, springs, sea, ocean, bay (please circle)
? Wave pools ? Water parks ? Waterslides ? Surfing
? Rafting ? Boating ? Hot tubs (non-private) ? Whirlpools (non-private)
? Jacuzzis (non-private) ? Other (Specify:__________________________)

If "YES" for any in question #44, provide date, time, location and type of activity:
Date/Time: ________________ Location (Name and Address):_________________________
Type of water consumed: ____
Others also ill?: Y / N / Unk (explain):____

If "YES" for any in question #44, provide date, time, location and type of activity:
Date/Time: ________________ Location (Name and Address):_________________________
Type of water consumed: ____
Others also ill?: Y / N / Unk (explain):____

45. During the 2 weeks prior to illness, were you exposed to aerosolized water from any of the following sources (check all that apply):

? Air conditioning at public places ? Respiratory devices* ? Vaporizers*
? Humidifiers* ? Misters* ? Whirlpool spas* ? Hot tubs*
? Spa baths* ? Creek and ponds ? Decorative fountains*
? Other (please explain) ____
* Non-private (i.e., used at hospitals, spas, salons, etc.)

If "YES" for any in question #45, provide date, time, and location of exposure to aerosolized water:
Date/Time: ________________ Location (Name and Address):_________________________
Explanation of aerosolized water: ____
Others also ill: Y / N / Unk (explain):____

If "YES" for any in question #45, provide date, time, and location of exposure to aerosolized water:
Date/Time: ________________ Location (Name and Address):_________________________
Explanation of aerosolized water: ____
Others also ill: Y / N / Unk (explain):____

Recreation*

**Recreation is defined as non-work related activities*

46. In the past two weeks, did you participate in any outdoor activities? Y / N / Unk
    (If "yes", list all and provide location)

    ____

    ____

47. Do you recall any insect or tick bites during these outdoor activities? Y / N / Unk
    (If "yes", list all and provide location)

    ____

    ____

48. Did you participate in other indoor recreational activities (i.e. clubs, crafts, etc that do not occur in a private home)? Y / N / Unk
    (List all and provide location)

    ____

    ____

Vectors

49. Do you recall any insect or tick bites in the last 2 weeks? Y / N / Unk
    Date(s) of bite(s):____________ Bitten by ☐ Mosquito ☐ Tick ☐ Flea ☐ Fly ☐ Other:
    Where were you when you were bitten? ______________________________

50. Have you had any contact with wild or domestic animals, including pets? Y / N / Unk
    Type of Animal: ______________ Explain nature of contact:______________
    Is / was the animal ill recently: Y / N / Unk Symptoms:________________
    Date / Time of contact:______________ Location of contact:______________

51. To your knowledge, have you been exposed to rodents/rodent droppings in the last 2 weeks?
    Y / N / Unk If yes, explain type of exposure:______________________
    Date/Time of exposure:______________
    Location where exposure occurred: ____________________