Reset Form

DEPARTMENT OF
HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30333

TYPHOID AND PARATYPHOID FEVER SURVEILLANCE REPORT

CDC NO.: ☐☐☐☐☐ STATE LAB ISOLATE ID NO. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved:
OMB No. 0920-0728

Instructions:

– Please complete this form only for new, symptomatic, culture-proven cases of typhoid or paratyphoid fever. –

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: ☐ 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:

☐ Typhi ☐ Paratyphi A ☐ Paratyphi B ☐ 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.
b. Tourism? ..... ☐ Yes ☐ No ☐ Unk.
c. Visiting relatives or friends? ..... ☐ Yes ☐ No ☐ Unk.
d. Immigration to U.S.? ..... ☐ Yes ☐ No ☐ Unk.
e. Other? ..... ☐ 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
Enteric Diseases Epidemiology Branch, Centers for Disease Control and Prevention
Mailstop C-09, Atlanta, Georgia 30333 • Fax: (404) 639-2205

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