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Typhoid Fever Supplemental Form

Kansas Department of Health

Epidemiologic Case History

* indicates required fields

Case Type*
○ *Human Case* ○ *Non Human Case*

Classification*
○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Deleted* ○ *Unknown*

Supplemental Form Status
○ *Not Done* ○ *Form Complete* ○ *Form in Progress* ○ *Form Approved* ○ *Form Sent to CDC*

Report Date*
mm/dd/yyyy

Patient Demographic Information

* indicates required fields

Last Name*	First Name*	Middle Name	Name Type*	Age

Age Unit
○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Date of Birth
mm/dd/yyyy

Race*
(Check all that apply)
☐ *American Indian or Alaska Native* ☐ *Asian* ☐ *Black or African American*
☐ *Native Hawaiian or Other Pacific Islander* ☐ *White* ☐ *Unknown*

Ethnicity*
○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown*

Sex*
○ *Failure to Report* ○ *Female* ○ *Male* ○ *Other* ○ *Transexual* ○ *Unknown*

Street Address

City	County	State	Zip

Evening Phone
###-###-####

Daytime Phone
###-###-####

Occupation

Person Providing Report

Name of Reporting Facility*

Typhoid Fever Surveillance Report

CDC Case No.

Does the patient work as a foodhandler
○ *Yes* ○ *No* ○ *Unknown*

Citizenship
○ *U.S.* ○ *Other:*_____ ○ *Unknown*

Clinical Data

Was the patient ill with typhoid fever?
(fever, abdominal pain, headache, etc.)
○ *Yes* ○ *No* ○ *Unknown*

If Yes, give date of onset of symptoms:
mm/dd/yyyy

Was patient hospitalized because of this illness?
○ *Yes* ○ *No* ○ *Unknown*

If Yes, how many days was the patient hospitalized?

Outcome of case
○ *Recovered* ○ *Died* ○ *Unknown*

Laboratory Data

Date Salmonella typhii first isolated
mm/dd/yyyy

Site(s) of isolation
(Check all that apply)
☐ *Blood* ☐ *Stool* ☐ *Gall bladder* ☐ *Other(specify):*_____

Was antibiotic sensitivity testing performed on this (these) isolate(s) at the laboratory
(Please contact the clinical laboratory for this information)
○ *Yes* ○ *No* ○ *Unknown*

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

Did this case occur as part of an outbreak?
(two or more cases of typhoid fever associated by time and place)
○ *Yes* ○ *No* ○ *Unknown*

Did the patient receive typhoid vaccination (primary series or booster) within five years before onset of illness
○ *Yes* ○ *No* ○ *Unknown*

If Yes, indicate type of vaccine received:

Standard killed typhoid shot (Wyeth-Ayerst)
○ *Yes* ○ *No* ○ *Unknown*

Year Received

Oral Ty21a or Vivotif (Bema) four pill series
○ *Yes* ○ *No* ○ *Unknown*

Year Received

ViCPS or Typhim Vi shot (Pasteur Merleux)
○ *Yes* ○ *No* ○ *Unknown*

Year Received

Did the patient travel or live outside the United States during the 30 days before the illness began
○ *Yes* ○ *No* ○ *Unknown*

If Yes, please list in order the countries visited during the 30 days before the illness began: (other than the United States)

No.	Location
1.	
2.	
3.	
4.	

Date of most recent return or entry to the United States
mm/dd/yyyy

Was the purpose of the international travel:

Business?
○ *Yes* ○ *No* ○ *Unknown*

Tourism?
○ *Yes* ○ *No* ○ *Unknown*

Visiting relatives or friends?
○ *Yes* ○ *No* ○ *Unknown*

Immigration to U.S.?
○ *Yes* ○ *No* ○ *Unknown*

Other?
○ *Yes* ○ *No* ○ *Unknown*

(If other, specify):

Epidemiologic Data cont.

Was the case traced to a typhoid carrier?	If Yes, was the carrier previously known to the health department?
○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*

Thank You Very Much for Taking the Time to Complete This Form

While your response is voluntary your cooperation is necessary for the understanding and control of this disease.

Please send a copy to your State Epidemiology Office and the Foodborne and Diarrheal Branch, Centers for Disease Control and Prevention, Mailstop A-38, Atlanta, Georgia 30333. * Fax: (404) 639-2205

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