

## CAMPYLOBACTERIOSIS CASE INVESTIGATION FORM

Use this form to interview confirmed and probable cases of infection with *Campylobacter*  
Questions marked with \* are required in FoodNet counties (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson) and must be entered into CEDRS

Patient Name: \_\_\_\_\_ CEDRS # \_\_\_\_\_ Interview date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Agency Name: \_\_\_\_\_ Form Completed by: \_\_\_\_\_  
Person interviewed: Case Other (circle: Parent Spouse Household member Friend )

### Demographics and Contact Information

\*Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ (Circle: Yrs., Mos., Days) \*Sex: F M

\*Race (Circle all that apply):  
American Indian/Alaska Native Asian Black Unknown  
Pacific Islander/Hawaiian Native White Other

\*Ethnicity (Circle one): Hispanic Non Hispanic Unknown

Language spoken: \_\_\_\_\_ Parent/legal guardian: \_\_\_\_\_

Residence: \_\_\_\_\_ Phone Numbers:  
Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
City: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
County: \_\_\_\_\_ Pager: (\_\_\_\_) \_\_\_\_\_  
Zip Code: \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_

### Laboratory information \*\*\*\*please confirm lab information with patient, even if already in CEDRS

Culture confirmed: Yes No Species: *C. jejuni* *C. coli* *C. fetus* Other Not known  
Lab or hospital name: \_\_\_\_\_

\*Date specimen(s) collected: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Specimen source: Stool Urine  
Blood Other: \_\_\_\_\_

Physician Name: \_\_\_\_\_ MD Phone: (\_\_\_\_) \_\_\_\_\_  
Clinic Name: \_\_\_\_\_ City/State: \_\_\_\_\_

### Clinical Description (Yes=Y, No=N, Unknown=U)

Did the patient have symptoms?: Y N U If yes, \*onset date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_ AM / PM

Did the patient have:  
Diarrhea Y N U Fever (max temp\_\_\_\_) Y N U Headache Y N U  
Date diarrhea onset \_\_\_\_/\_\_\_\_/\_\_\_\_ Vomiting Y N U Body aches Y N U  
Bloody diarrhea Y N U Abd. cramps Y N U Other\_\_\_\_ Y N U

How many days did the illness last? \_\_\_\_\_ days  
Did case receive antibiotics for this illness? Y N U Antibiotic name: \_\_\_\_\_

\*Outcome: Survived Died Unk (FoodNet counties: record pt outcome on 7th day after specimen collect date)  
If died, date of death: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Was patient hospitalized? Yes No Unk (ER visits only not considered "hospitalized")  
If hospitalized: \*Hospital Name: \_\_\_\_\_  
\*Date of Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Date of Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_  
\*Transferred to another hospital? Yes No Unk \*Transfer hosp name: \_\_\_\_\_

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**Christian Drosten**



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