Botulism Alert Summary

The Botulism Alert Summary form should be completed on all reports of **non-infant botulism**. The Guide to Investigation of Infant Botulism form (CDC52.73) is to be completed for all infant botulism cases. On the initial report as much information as possible should be collected. Additional follow-up may be needed if lab tests are submitted or other clinical or epidemiological information is needed. A copy of Electromyography (EMG) and a copy of the discharge summary should accompany this report.

Patient's Name_____ Age_____ Sex _____ DOB ___/___/___
Address _____Home Phone: (___) _____ Cell phone: (___) _____
Occupation or School location: _____

Is the patient deceased: ___Yes___No___Unknown If yes, date of death: ___/___/___
Cause of Death: _____ Hospitalization: ___Yes ___No ___Unknown. If yes, date hospitalized: ___/___/___ Admitting diagnosis: _____
Hospital_____ Phone: (_____) _____
Address _____

Attending physician_____ Phone: (_____) _____

Consultants (Neurologist if involved):
Name _____ Phone: (_____) _____
Name_____ Phone: (_____) _____

Earliest Date of Report to Local Health Department: ___/___/___
Date of first report to: State Health Department (SHD): ___/___/___ CDC___/___/___
Reason for SHD or CDC contact? Mark all that apply with "X" ☐Lab testing ☐Antitoxin ☐Consultation ☐Reporting ☐Other (Please specify):_____

Preliminary History

Acute illness in the past month (If yes describe) _____

Underlying medical problems (If yes describe) _____

Prior gastric surgery or abnormal GI tract (If yes describe) _____

Tentative diagnosis: _____ What diagnosis have been ruled out: _____

_____ Current status of patient: _____

Date first saw health care provider: ___/___/___ Date botulism diagnosis considered: ___/___/___

Does patient know of any similarly ill persons? ☐Yes ☐No ☐Unknown. If yes, provide name and contact information: _____

_____

_____

Date of presumptive exposure, if know: ___/___/___

Suspected link to outbreak? ☐Yes ☐No. If yes, Specify: _____

Differential Diagnosis:

Stroke (CVA): ☐No ☐Unknown ☐Yes If yes, what test was done: _____ Results: _____

Guillain-Barré syndrome ☐No ☐Unknown ☐Yes If yes, what test was done: _____
Results: _____

Myasthenia gravis: ☐No ☐Unknown ☐Yes If yes, what test was done: _____ Results: _____

Tick paralysis: ☐No ☐Unknown ☐Yes If yes, what test was done: _____ Results: _____

Lambert-Eaton syndrome: ☐No ☐Unknown ☐Yes If yes, what test was done: _____
Results: _____

Toxic exposures ☐No ☐Unknown ☐Yes If yes, what kind of exposure: _____
Results: _____

Poliomyelitis ☐No ☐Unknown ☐Yes If yes, what test was done: _____ Results: _____

Epidemiologic Exposures - Mark all that apply with "X".

	Yes	No	Don't Know		Yes	No	Don't Know
Home canned/ jarred foods	☐	☐	☐	Vacuum packed foods	☐	☐	☐
Dried/preserved/ Salted/ traditionally prepared meats	☐	☐	☐	Preserved/smoked/ salted/traditionally prepared fish	☐	☐	☐
Garlic/herbs/chilies /sun dried tomatoes stored in oil/or any infused oil	☐	☐	☐	**Non-refrigerated** perishable food stored in an airtight container	☐	☐	☐
Marinated foods	☐	☐	☐	Fermented foods	☐	☐	☐
Any improperly cooked or reheated soup/stew	☐	☐	☐	Improperly cooked or reheated baked potatoes wrapped and stored in foil	☐	☐	☐
Suspicious commercial foods	☐	☐	☐	Any homeopathic products/medicinal herbs or plants	☐	☐	☐
Abdominal Surgery	☐	☐	☐	Travel non-routine	☐	☐	☐

If the answer to any of the above questions is yes (for the 10 days prior to illness onset) provide the product name, dates purchased, dates consumed, Lot #s, travel dates, and travel locations: _____

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For Wound Cases Only – (During the 2 weeks before onset)

	Yes	No	Don't Know		Yes	No	Don't Know
Contaminated wound or abscess	☐	☐	☐	Non-injection street drug use	☐	☐	☐
Injection street drug use	☐	☐	☐	Trauma or crush injury	☐	☐	☐

If yes, describe: _____

Date wound sustained: ___/___/___How was wound treated? _____

_____

_____

_____

_____

Symptoms Indicate if symptoms are present the date of the case review with an "X".

Symptom Onset Date: ___/___/___ Case Review Date: ___/___/___

	Yes	No	Don't Know		Yes	No	Don't Know
Abdominal Pain	☐	☐	☐	Dyspnea	☐	☐	☐
Nausea	☐	☐	☐	Fatigue	☐	☐	☐
Vomiting	☐	☐	☐	Dry Mouth	☐	☐	☐
Diarrhea	☐	☐	☐	Sore throat	☐	☐	☐
Blurred Vision	☐	☐	☐	Urinary Retention	☐	☐	☐
Diplopia	☐	☐	☐	Constipation	☐	☐	☐
Photophobia	☐	☐	☐	Dizziness	☐	☐	☐
Dysphagia	☐	☐	☐	Convulsions	☐	☐	☐
Dysphonia	☐	☐	☐	Paresthesia	☐	☐	☐
Muscle Weakness	☐	☐	☐	If yes, where:	_____		
Upper distal	☐	☐	☐	Other:	_____		
Upper proximal	☐	☐	☐		_____		
Lower distal	☐	☐	☐				
Lower proximal	☐	☐	☐				

Where did the muscle weakness start? _____

Signs Indicate if signs are present the date of the case review with an "X".

First medical exam date: ___/___/___

	Yes	No	Don't Know		Yes	No	Don't Know
Ptosis	☐	☐	☐	Abnormal Sensory	☐	☐	☐
Extraocular Palsy	☐	☐	☐	Specify:	_____		
Pupils				Ataxia	☐	☐	☐
Dilated	☐	☐	☐	Symmetrical?	☐	☐	☐
Constricted	☐	☐	☐				
Mid-position	☐	☐	☐	Nystagmus	☐	☐	☐
Reactive	☐	☐	☐				
Equal	☐	☐	☐	**Deep Tendon Reflex**			
Decreased				Normal	☐	☐	☐
Corneals	☐	☐	☐	Hypoactive	☐	☐	☐
Facial Paralysis	☐	☐	☐	Hyperactive	☐	☐	☐
Symmetric	☐	☐	☐	Symmetric	☐	☐	☐
Decreased Gag	☐	☐	☐				
Decreased ability to protrude tongue	☐	☐	☐	Abnl Mental State	☐	☐	☐
Weakness or paralysis of extremity (ies)				Fever	☐	☐	☐
a. Upper	☐	☐	☐	Tracheostomy	☐	☐	☐
b. Lower	☐	☐	☐	Respiratory			
c. Symmetric	☐	☐	☐	Impairment	☐	☐	☐

Toes (Babinski's reflex)	1) Down	2) Up	3) Unknown
	☐	☐	☐

Laboratory Studies

Spinal tap: ☐Yes ☐No

Date	RBC	WBC	Cells	Protein	Glucose	Other
___/___/__	_____	_____	_____	_____	_____	_____
___/___/__	_____	_____	_____	_____	_____	_____

	Date	Positive	Negative	Not Done
Tensilon Test	___/___/__	☐	☐	☐

Comments: _____

_____

EMG:

Date	Area tested	Muscle group weak	Frequency (hertz)	Amplitude (↑↓ nl)	Facilitation (yes or no)
___/___/___	_____	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____	_____

Vital Capacity Date ____/____/____ _____cc
Date ____/____/____ _____cc
Date ____/____/____ _____cc

Was Antitoxin ordered? ____Yes _____No _____Unknown
Antitoxin given? ____Yes ____No _____ Type _____ Route _____
Amount (# vials) _____ Date: ___/___/___
Amount _____
Sensitivity testing done prior to administration? ____Yes ____No ____Unknown
Result_____

Hypersensitivity reaction? _____
Anaphylaxis? _____
Serum sickness? _____
_____

Other treatment given? _____

Morbidity

	Yes	No	Date
NG Tube Feedings	☐	☐	___/___/___
Respirator	☐	☐	___/___/____
Tracheostomy	☐	☐	___/___/___

Outcome

Recovered? ☐ Died? ☐ Cause of Death: _____
Number of days in hospital: _____
Number of days in intensive care: _____
Date discharged from hospital: ___/___/___
Discharged to: ☐ Home
☐ Nursing home
☐ Rehab facility
☐ Other: _____

Botulism laboratory tests

Tested at: ☐CDC Lab ☐State Lab ☐Other, Specify: _____

Lab name/phone: _____ Collection date: ___/___/___

Laboratory tests performed:	Y	N	U	If yes, complete questions below:
Toxin assay	☐	☐	☐	Specimen source: ☐stool ☐other: _____ Lab result: ☐positive ☐negative ☐presumptive positive ☐inconclusive ☐pending If positive, toxin type: ☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐not done
Culture	☐	☐	☐	Specimen source: ☐stool ☐other: _____ Lab result: ☐positive ☐negative ☐presumptive positive ☐inconclusive ☐pending If positive, toxin type: ☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐not done

Food items (List items tested and result as "positive" or "negative")

Food Item	Brand Name	Lot Number	Date Purchased	Result
_____	_____	_____	___/___/__	_____
_____	_____	_____	___/___/__	_____
_____	_____	_____	___/___/__	_____
_____	_____	_____	___/___/__	_____
_____	_____	_____	___/___/__	_____
_____	_____	_____	___/___/__	_____

What food(s) were implicated?

Food Item	Date ingested
_____ _____	___/___/__
_____ _____	___/___/__
_____ _____	___/___/__

Number of cases in outbreak _____

FINAL DIAGNOSIS (circle applicable diagnosis / classification)

- BObotulism: **Foodborne** **Wound** **Other**
  Classification: **Confirmed** **Probable**

- GUILLAIN-BARRÉ SYNDROME
- LAMBERT-EATON SYNDROME
- MYASTHENIA GRAVIS
- POLIOMYELITIS
- STROKE
- TICK PARALYSIS
- TOXIC EXPOSURE
- OTHER: _____

EMG result and discharge summary requested? ☐Yes ☐No

Problems with contacting SHD or CDC (If yes describe)? _____
_____

Comments (use additional pages as needed): _____
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Investigator's Name: _____ Agency: _____ Phone: _____