North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

FOODBORNE POISONING: MUSHROOM

Confidential Communicable Disease Report—Part 2

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐ Y ☐ N ☐ U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy): ____/____/____
Drowsy ☐ Y ☐ N ☐ U
Sweats (diaphoresis) ☐ Y ☐ N ☐ U
Thirst ☐ Y ☐ N ☐ U
Extreme thirst ☐ Y ☐ N ☐ U
Dehydration ☐ Y ☐ N ☐ U
Signs of dehydration (choose all that apply):
☐ Decreased skin turgor
☐ Dry mucous membranes
☐ Non-palpable pulse
☐ Sunken eyes
☐ Decreased urine output
Light-headedness (pre-syncope) ☐ Y ☐ N ☐ U
Dizziness ☐ Y ☐ N ☐ U
Altered mental status ☐ Y ☐ N ☐ U
Patient displayed (select all that apply):
☐ Delirium ☐ Depression ☐ Hallucinations
☐ Disorientation ☐ Excitability ☐ Illusions
☐ Coma ☐ Drowsiness
Memory loss ☐ Y ☐ N ☐ U
Memory loss was: ☐ Short term ☐ Long term
Periods of drowsiness followed by hyperactivity ☐ Y ☐ N ☐ U
Incoherent speech ☐ Y ☐ N ☐ U
Headache ☐ Y ☐ N ☐ U
Seizures/convulsions ☐ Y ☐ N ☐ U
Please specify
☐ New onset
☐ Exacerbation of underlying seizure disorder
☐ Other_____
☐ Unknown
Ataxia ☐ Y ☐ N ☐ U
Mouth tingling/burning ☐ Y ☐ N ☐ U
Numbness of lips or tongue ☐ Y ☐ N ☐ U
Facial flushing ☐ Y ☐ N ☐ U
Pain or paresthesia of the face and/or lower extremities ☐ Y ☐ N ☐ U
Hot/cold temperature sensory reversals ☐ Y ☐ N ☐ U
Acute onset of peripheral neuropathy ☐ Y ☐ N ☐ U
Muscle paralysis ☐ Y ☐ N ☐ U
Skin rash ☐ Y ☐ N ☐ U
Skin itching (pruritis) ☐ Y ☐ N ☐ U
Aching teeth ☐ Y ☐ N ☐ U
Shortness of breath/difficulty breathing/ respiratory distress ☐ Y ☐ N ☐ U
Respiratory arrest ☐ Y ☐ N ☐ U
Palpitations ☐ Y ☐ N ☐ U
Cardiac arrhythmias or cardiac arrest ☐ Y ☐ N ☐ U
Hypotension ☐ Y ☐ N ☐ U
Lowest recorded blood pressure_____
Nausea ☐ Y ☐ N ☐ U
Vomiting ☐ Y ☐ N ☐ U
Abdominal pain or cramps ☐ Y ☐ N ☐ U
Diarrhea ☐ Y ☐ N ☐ U
Describe (select all that apply)
☐ Bloody
☐ Non-bloody
☐ Watery
☐ Other
Maximum number of stools in a 24-hour period:_____
Excessive urination ☐ Y ☐ N ☐ U
Organ failure ☐ Y ☐ N ☐ U
If yes, specify: _____

REASON FOR TESTING

Why was the patient tested for this condition?
☐ Symptomatic of disease
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Exposed to organism causing this disease (asymptomatic)
☐ Household contact to a person reported with this disease
☐ Other, specify:_____
☐ Unknown

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? ☐ Y ☐ N
If yes, specify: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____

_____

Survived? ☐Y ☐N ☐U
Died? ☐Y ☐N ☐U
Died from this illness? ☐Y ☐N ☐U

Date of death (mm/dd/yyyy):_____/_____/_____

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of North Carolina
- ☐ Resident of another state or US territory
- ☐ None of the above

Did patient have a travel history during the 24 hours prior to onset of symptoms? ☐Y ☐N ☐U

Travel dates: From:_____until _____

To city: _____

To country:_____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐Y ☐N ☐U

Name: _____

Additional travel/residency information:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐Y ☐N ☐U

Patient a child care worker or volunteer in child care? ☐Y ☐N ☐U

Patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U

Is patient a student? ☐Y ☐N ☐U

Type of school:

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐Y ☐N ☐U

Give details:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 24 hours prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐Y ☐N ☐U

Name of facility:_____

Dates of contact: _____

During the 24 hours prior to onset of symptoms, did the patient attend social gatherings or crowded settings? ☐Y ☐N ☐U

If yes, specify:_____

In what setting was the patient most likely exposed?

- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify) _____
- ☐ Unknown

FOOD RISK AND EXPOSURE

Where does the patient/patient's family typically buy groceries?

Store name:_____

Store city: _____

Shopping center name/address:

_____

During the 24 hours prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? ☐Y ☐N ☐U

Specify source: _____

Eat any food items that came from a store or vendor where they do not typically shop for groceries? ☐Y ☐N ☐U

Specify source(s): _____

Eat mushrooms or food containing mushrooms harvested from the wild? ☐Y ☐N ☐U

Describe the mushrooms and location where they were collected:

Are any of the wild harvested mushrooms still available for testing? ☐Y ☐N ☐U

Eat raw salads or vegetables other than sprouts? ☐Y ☐N ☐U

Specify raw salad or vegetable:
- ☐ Bagged salad greens without toppings, type: _____
- ☐ Salad with toppings, specify: _____
- ☐ Lettuce, type: _____
- ☐ Spinach
- ☐ Tomatoes, type: _____
- ☐ Cucumbers
- ☐ Mushrooms, type: _____
- ☐ Onions, type: _____
- ☐ Potatoes, type:_____
- ☐ Other, specify: _____

Eat at a group meal? ☐Y ☐N ☐U

Specify:
- ☐ Place of Worship
- ☐ School:
- ☐ Social function
- ☐ Other, Specify:_____

Eat food from a restaurant? ☐Y ☐N ☐U

Name:_____

Location:_____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U

If yes, specify:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐Y ☐N ☐U

Were interviews conducted with others? ☐Y ☐N ☐U

Who was interviewed?

☐ Friend
- Date of Interview: _____
- Location of Interview: _____
- Interpreter Used:_____

☐ Co-Worker
- Date of Interview: _____
- Location of Interview: _____
- Interpreter Used:_____

☐ Relative
- Date of Interview: _____
- Location of Interview: _____
- Interpreter Used:_____

☐ Other
- Date of Interview: _____
- Location of Interview: _____
- Interpreter Used:_____

Were health care providers consulted? ☐Y ☐N ☐U

Who was consulted?

☐ Physician ☐ Infectious disease physician
☐ PA/FNP ☐ Other

Medical records reviewed? ☐Y ☐N ☐U

Sources:

☐ Hospital ☐ Clinic/Health Care provider
☐ Other_____

Please specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
- City _____
- County_____

☐ Outside NC, but within US
- City _____
- State _____
- County_____

☐ Outside US
- City _____
- Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ☐Y ☐N

Notes regarding setting of exposure: