

SECTION 1: DEMOGRAPHIC DATA

Surname:	
Other names:	
Street Address:	
Suburb/Town:	Postcode:
Telephone:	Home: _____ Work: _____ Mobile: _____
Date of Birth: / / or Age:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Country of Birth:	Of Aboriginal or Torres Strait Islander origin?
Language(s) spoken at home:	No <input type="checkbox"/>
	Aboriginal <input type="checkbox"/>
	Torres Strait Islander <input type="checkbox"/>
	Both Aboriginal and Torres Strait Islander <input type="checkbox"/>
	Unknown <input type="checkbox"/>
Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation:	
Name / Address of Employer or School or Child Care Attended:	
Telephone:	Contact Person:
Date Last Attended: / /	High Risk group?* No <input type="checkbox"/> Yes <input type="checkbox"/> Details: _____

* High risk cases are food handlers, carers of patients, carers of children, carers of the elderly, children below primary school age, and those unable to maintain personal hygiene and their carers

SECTION 2: TREATING DOCTOR / HOSPITAL FACILITY

Name of treating doctor: _____	
Address: _____	
Telephone: _____	Fax: _____
ED presentation : <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital name: _____
Date of ED presentation: / /	
Admission to hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital name: _____
Date of admission: / /	Date of discharge: / /

Risk Factor	Applies	Details
Household / Close contact of person known to have travelled overseas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship: Country visited: Dates:.....
Household / Close contact of person known to have typhoid infection or similar illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship: Case name: Database ID No. (if confirmed): Details:
Household / Close contact of person known to have paratyphoid infection or similar illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship: Case name: Database ID No. (if confirmed): Details:
Had previous typhoid/paratyphoid infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Approx. date: ___/___/___
Household / Close contact known to have had previous typhoid/paratyphoid infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship: Approx. date: ___/___/___
Drank untreated water?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify type: Date : ___/___/___ Location:
Participated in swimming / water sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Activity: Date : ___/___/___ Type of water (e.g. pool, river, etc.): Address:
Ate oysters / mussels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ___/___/___ Type / Brand:..... Where purchased:.....
Ate other shellfish?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ___/___/___ Type / Brand:..... Where purchased:.....

Risk Factor	Applies	Details
Ate imported foodstuffs? (if in Australia during incubation period)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ____/____/____ Type / Brand:..... Where purchased:.....
Exposure to raw/untreated sewage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ____/____/____ Exposure/activity:.....

SECTION 5: LOCAL FOOD EXPOSURES

If the case was in Australia for their incubation period, did they visit / attend any of the following? If no, skip to Section 6.

Incubation period

/ /

to

/ /

(Onset date minus 60 days for typhoid)
(Onset date minus 10 days for paratyphoid)

(Onset date minus 3 days for typhoid)
(Onset date minus 1 day for paratyphoid)

	Name and address of premises	What was eaten?
Cafes or restaurants <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know		
Takeaway / fast food outlets <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know		
Parties or functions with family or friends <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know		
Festivals or commercial public gatherings (e.g. fetes, club social events, markets, etc.) <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know		
Continental deli or specialty grocer (e.g. Asian supermarket) <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know		
Farms or growers (farm gate sales or consumption of unprocessed products) <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know		

SECTION 6: FOLLOW UP AND EXCLUSIONS FOR CASE

Exclude all cases from work, school, childcare and swimming pools until 48 hours after a course of antibiotics has been completed and symptoms have resolved.

‡ Exclusion until clearance required for high risk cases (food handlers, carers of patients, carers of children, carers of the elderly, children below primary school age, and those unable to maintain personal hygiene and their carers)

§ Clearance is defined as: 2 consecutive negative stool cultures. These must be taken under the following conditions – (a) **specimens collected ≥48 hours after cessation of antibiotic therapy**, (b) **individual specimens taken ≥48 hrs apart**.

Tick box that describes case:

- Food handler
- Carer of patients, children, elderly, or individuals unable to maintain their own hygiene
- Child below primary school age
- Person unable to maintain own hygiene

OR None of these

If one of the above high risk groups is selected, please provide the following information:

Name / address of related premises / institution:		Date last attended: ___/___/___
Movements of case at work / institution / premises:		
Date: ___/___/___	Day:	Hours: Location:
Date: ___/___/___	Day:	Hours: Location:
Date: ___/___/___	Day:	Hours: Location:
Date: ___/___/___	Day:	Hours: Location:
Exclusion required‡?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>It is required that if the case is in a high risk setting / occupation, they be excluded from attendance / work until cleared. § If possible, they may return to work to undertake other duties (not handling food or caring for people) once they have been free of symptoms for 48 hours and provided they are continent and can undertake adequate hygiene practices.</i>
Exclusion discussed with case / guardian / next-of-kin.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Letter sent to contacts at premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date sent: ___/___/___
Environmental Health inspection required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact date: ___/___/___ Contact name: Action required: Feedback received: <input type="checkbox"/> no <input type="checkbox"/> yes,
Clearance stools taken§	<input type="checkbox"/> Yes <input type="checkbox"/> No	#1: ___/___/___ <input type="checkbox"/> Detected <input type="checkbox"/> Not Detected #2: ___/___/___ <input type="checkbox"/> Detected <input type="checkbox"/> Not Detected

Clearance urine taken

(urine samples required in addition to stool samples if case originally had:

•A positive urine culture Yes No

•Concurrent schistosomiasis

•A history of kidney stones.)

#1: ___ / ___ / ___ Detected Not Detected

#2: ___ / ___ / ___ Detected Not Detected

Typhoid and paratyphoid fever

Case Questionnaire

SECTION 7: FOLLOW UP (AND EXCLUSIONS) FOR HOUSEHOLD / TRAVEL COMPANIONS OF CASE

§ If contact has compatible symptoms, they need to be tested to exclude typhoid / paratyphoid.
 † Exclusion and screening required for high risk contacts ‡ Clearance is defined as: 2 consecutive negative stool cultures. These specimens **must be taken individually and ≥24hours apart.**

Name and contact details	Relationship to case	Symptoms?	High risk status / exclusion†	Screening required‡	Results
Name: _____ _____ Address: _____ _____ Phone: _____ _____	<input type="checkbox"/> Household contact <input type="checkbox"/> Travel companion <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Yes§ <input type="checkbox"/> No	High risk? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes" specify below & record detail in notes <input type="checkbox"/> Food handler <input type="checkbox"/> Carer of patients, children, elderly, or individuals unable to maintain their own hygiene <input type="checkbox"/> Child below primary school age <input type="checkbox"/> Person unable to maintain own hygiene	<input type="checkbox"/> Yes† <input type="checkbox"/> No If 'Yes" indicate <input type="checkbox"/> via GP (provide name and contact details) _____ _____ <input type="checkbox"/> via Pathology service (provide details)	Stool 1. / / _____ Stool 2. / / _____ _____

Notes:

Name and contact details	Relationship to case	Symptoms?	High risk status / exclusion†	Screening required‡	Results
Name: _____ _____ Address: _____ _____ Phone: _____ _____	<input type="checkbox"/> Household contact <input type="checkbox"/> Travel companion <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Yes§ <input type="checkbox"/> No	High risk? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes" specify below & record detail in notes <input type="checkbox"/> Food handler <input type="checkbox"/> Carer of patients, children, elderly, or individuals unable to maintain their own hygiene <input type="checkbox"/> Child below primary school age <input type="checkbox"/> Person unable to maintain own hygiene	<input type="checkbox"/> Yes† <input type="checkbox"/> No If 'Yes" indicate <input type="checkbox"/> via GP (provide name and contact details) _____ _____ <input type="checkbox"/> via Pathology service (provide details)	Stool 1. / / _____ Stool 2. / / _____ _____

Notes:

Name and contact details	Relationship to case	Symptoms?	High risk status / exclusion [‡]	Screening required [‡]	Results
Name: _____ _____ Address: _____ _____ Phone: _____	<input type="checkbox"/> Household contact <input type="checkbox"/> Travel companion <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Yes [§] <input type="checkbox"/> No	High risk? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes" specify below & record detail in notes <input type="checkbox"/> Food handler <input type="checkbox"/> Carer of patients, children, elderly, or individuals unable to maintain their own hygiene <input type="checkbox"/> Child below primary school age <input type="checkbox"/> Person unable to maintain own hygiene	<input type="checkbox"/> Yes [‡] <input type="checkbox"/> No If 'Yes" indicate <input type="checkbox"/> via GP (provide name and contact details) _____ _____ <input type="checkbox"/> via Pathology service (provide details)	Stool 1. / / _____ Stool 2 . / / _____ _____

Notes:

Name and contact details	Relationship to case	Symptoms?	High risk status / exclusion [‡]	Screening required [‡]	Results
Name: _____ _____ Address: _____ _____ Phone: _____	<input type="checkbox"/> Household contact <input type="checkbox"/> Travel companion <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Yes [§] <input type="checkbox"/> No	High risk? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes" specify below & record detail in notes <input type="checkbox"/> Food handler <input type="checkbox"/> Carer of patients, children, elderly, or individuals unable to maintain their own hygiene <input type="checkbox"/> Child below primary school age <input type="checkbox"/> Person unable to maintain own hygiene	<input type="checkbox"/> Yes [‡] <input type="checkbox"/> No If 'Yes" indicate <input type="checkbox"/> via GP (provide name and contact details) _____ _____ <input type="checkbox"/> via Pathology service (provide details)	Stool 1. / / _____ Stool 2 . / / _____ _____

Notes:

