State of California—Health and Human Services Agency

Local ID Number:

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

BOTULISM
CASE REPORT

Check one: Foodborne Wound Other (specify):

THIS FORM SHOULD NOT BE USED FOR INFANT BOTULISM

Reset Form

PATIENT INFORMATION

Last Name | *First Name* | *Middle Name* | *Suffix*

Social Security Number (9 digits) | *DOB (mm/dd/yyyy)* | *Age* (Years / Months / Days)

Address Number & Street – Residence | *Apartment / Unit Number*

City / Town | *State* | *Zip Code*

Census Tract | *County of Residence* | *Country of Residence*

Country of Birth | *If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone | *Cellular Phone / Pager* | *Work / School Telephone*

E-mail Address | *Other Electronic Contact Information*

Work / School Location | *Work / School Contact*

Gender
- Female
- Male
- Trans female / transwoman
- Trans male/ transman
- Genderqueer or non-binary
- Identity not listed
- Unknown
- Declined to answer

Pregnant? Yes No Unknown

If Yes, Est. Delivery Date (mm/dd/yyyy)

Medical Record Number | *Patient's Parent/Guardian Name*

Occupation Setting (see list on page 11) | *Other Describe/Specify*

Occupation (see list on page 11) | *Other Describe/Specify*

Primary Language
- English
- Spanish
- Other:

Ethnicity (check one)
- Hispanic/Latino
- Non-Hispanic/Non-Latino
- Unknown

Race(s)
(check all that apply, race descriptions on page 10)

The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

- American Indian or Alaska Native
- Asian *(check all that apply, see list on page 10)*
  - Asian Indian
  - Bangladeshi
  - Cambodian
  - Chinese
  - Filipino
  - Hmong
  - Indonesian
  - Japanese
  - Korean
  - Laotian
  - Malaysian
  - Pakistani
  - Sri Lankan
  - Taiwanese
  - Thai
  - Vietnamese
  - Other:
- Black or African-American
- Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 10)*
  - Native Hawaiian
  - Fijian
  - Guamanian
  - Samoan
  - Tongan
  - Other:
- White
- Other:
- Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
- Female
- Male
- Unknown
- Declined to answer

Sexual Orientation
- Heterosexual or straight
- Gay, lesbian, or same-gender loving
- Bisexual
- Questioning, unsure, or patient doesn't know
- Orientation not listed
- Declined to answer
- Unknown

First three letters of patient's last name:

CLINICAL INFORMATION

Physician 1	*Last Name*	*First Name*		
	Specialty ☐ Infectious diseases ☐ Neurologist ☐ Other (specify):		*Telephone Number*	*Fax Number*
Physician 2	*Last Name*	*First Name*		
	Specialty ☐ Infectious diseases ☐ Neurologist ☐ Other (specify):		*Telephone Number*	*Fax Number*

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown	*Onset Date (mm/dd/yyyy)*	*Onset Time (hh:mm)*	*Specify AM/PM*
Date of First Neurologic Symptoms (mm/dd/yyyy)		*Date First Sought Medical Care (mm/dd/yyyy)*	

Signs and Symptoms	Yes	No	Unk	Signs and Symptoms	Yes	No	Unk
Nausea				Change in sound of voice			
Vomiting				Hoarseness			
Abdominal pain				Dry mouth			
Diarrhea				Dysphagia (trouble swallowing)			
Constipation				Shortness of breath / trouble breathing			
Diplopia (double vision) / blurred vision				Subjective weakness			
Dizziness				Fatigue			
Slurred speech				Paresthesia			
Thick tongue				*Other signs / symptoms (specify)*			

PHYSICAL EXAM FINDINGS

Observation	Yes	No	Unk	If Yes, Specify as Noted
Alert and oriented				
Extraocular palsy				*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Ptosis				*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Pupil abnormality				*Abnormality* ☐ Dilated ☐ Constricted ☐ Non-reactive — *Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Facial paralysis				*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Palatal weakness				*Is it bilateral?* ☐ Yes ☐ No ☐ Unknown
Impaired gag reflex				
Sensory deficit(s)				*Specify*

(continued on page 3)

First three letters of patient's last name:

PHYSICAL EXAM FINDINGS (continued)

Observation	Yes	No	Unk	If Yes, Specify as Noted	
Muscle weakness and / or paralysis				*Progression of weakness / paralysis* Ascending, ending with cranial nerves Descending, beginning with cranial nerves Other (specify):	*Is it bilateral?* Yes No Unknown
Ataxia					
Abnormal deep tendon reflexes				*Describe*	

Other signs / symptoms (specify)

MUSCLE STRENGTH EXAM

Proximal Upper Extremity *Right:* / 5 *Left:* / 5	*Distal Upper Extremity* *Right:* / 5 *Left:* / 5	Scale: 0 = no evidence of contractility 1 = slight contractility, no movement 2 = full range of motion, gravity eliminated 3 = full range of motion with gravity 4 = full range of motion against gravity, some resistance 5 = full range of motion against gravity, full resistance 9 9 = unknown
Proximal Lower Extremity *Right:* / 5 *Left:* / 5	*Distal Lower Extremity* *Right:* / 5 *Left:* / 5	

CLINICAL TESTS

Type of Test	Yes	No	Unk	If Yes, Specify as Noted		
Lumbar puncture (CSF analysis)				*WBC count (highest)*	*RBC count*	*Opening pressure*
				Protein (highest)	*Glucose*	*Date (mm/dd/yyyy)*
EMG (If copy of EMG test report is available, please attach copy.)				*Result* Suggestive of / consistent with botulism Not consistent with botulism Unknown		
				Was EMG done with rapid stimulation? Yes No Unknown	*If Yes, what Hertz?*	*Date (mm/dd/yyyy)*
Edrophonium (Tensilon)				*Describe results*		*Date (mm/dd/yyyy)*
CT or MRI scan				*Describe results*		*Date (mm/dd/yyyy)*

PAST MEDICAL HISTORY

Prior botulism diagnosis? Yes No Unknown	*If Yes, specify prior diagnosis date (mm/dd/yyyy)*
Prior neurological impairment? Yes No Unknown	*If Yes, describe impairment*
Allergy to equine products? Yes No Unknown	*If Yes, describe*
Immunocompromised? Yes No Unknown	*If Yes, specify condition*

Other (specify)

DID PATIENT USE ANY DRUGS THAT COULD CAUSE MUSCULAR PARALYSIS WITHIN 30 DAYS BEFORE ILLNESS ONSET?

Myobloc (toxin-type B)?	*Botox (toxin-type A)?*	*Aminoglycoside (gentamicin, tobramycin)?*	*Anticholinergic?*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown

Other (specify)

First three letters of patient's last name:

HOSPITALIZATION

Did patient visit emergency room for illness?	Was patient hospitalized?	If Yes, how many total hospital nights?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	

If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION – DETAILS

Hospital Name 1	Street Address				Admit Date (mm/dd/yyyy)	
	City				Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number		Medical Record Number	Discharge Diagnosis
Hospital Name 2	Street Address				Admit Date (mm/dd/yyyy)	
	City				Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number		Medical Record Number	Discharge Diagnosis

TREATMENT / MANAGEMENT

Was antitoxin released / authorized? ☐ Yes ☐ No ☐ Unknown	Date of Antitoxin Release (mm/dd/yyyy)	Time of Antitoxin Release (HH:MM AM/PM)	
	Officer Releasing Antitoxin - Last Name, First Name		
	Name of Hospital / Pharmacy that Received Antitoxin	Pharmacy Phone Number	
Received botulinum antitoxin? ☐ Yes ☐ No ☐ Unknown	Number of Doses Used	Antitoxin Type - First Dose ☐ Cangene heptavalent ☐ Unknown ☐ Other (specify):	Date Administered (mm/dd/yyyy)
		Antitoxin Type - Second Dose ☐ Cangene heptavalent ☐ Unknown ☐ Other (specify):	Date Administered (mm/dd/yyyy)
Admitted to ICU? ☐ Yes ☐ No ☐ Unknown	Admit Date (mm/dd/yyyy)		
Intubated and placed on ventilator? ☐ Yes ☐ No ☐ Unknown	Intubation Date (mm/dd/yyyy)		

OUTCOME

Outcome?	If Survived,	Date of Death (mm/dd/yyyy)
☐ Survived ☐ Died ☐ Unknown	Survived as of _____ (mm/dd/yyyy)	

ADDITIONAL COMMENTS

First three letters of patient's last name:

FOOD SPECIMENS (continued)

Type of Food Item 2 (specify)	Food Identification #	Did the patient eat this item in the week before illness onset?	Did anyone else eat this item in the week before patient's illness onset?
		☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Direct Toxin Testing Results

☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test cancelled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unknown

Type of Toxin Detected

☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ Untypeable ☐ Unk

Culture Testing Results

☐ No *Clostridium* organism isolated ☐ *Clostridium butyricum* organism isolated ☐ Test cancelled
☐ *Clostridium botulinum* organism isolated ☐ Other clostridial species ☐ Unknown
☐ *Clostridium baratii* organism isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism

☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ None ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number

ADDITIONAL INFORMATION

If post-antitoxin test was performed and was positive, describe circumstances.	Additional antitoxin given?
	☐ Yes ☐ No ☐ Unknown

EPIDEMIOLOGIC INFORMATION

EXPOSURES / RISK FACTORS - WOUND AND DRUG USE

Provide information regarding the patient's wound and drug use below.

Wound / Drug Use	Yes	No	Unk	If Yes, Specify as Noted
Wound or abscess				*Date of injury (mm/dd/yyyy)* / *Location(s)* *Description* *How wound occurred* / *Did / does wound appear infected?* ☐ Yes ☐ No ☐ Unknown
Injects black tar heroin (chiba)				*Date last used (mm/dd/yyyy)* / *Injection method* ☐ Intravenous ☐ Subcutaneous (skin-pop) ☐ Unknown ☐ Intramuscular ☐ Other:
Injects other drugs				*Drugs injected* ☐ Heroin ☐ Cocaine ☐ Methamphetamine ☐ Unknown ☐ Other: *Injection method* ☐ Intravenous ☐ Subcutaneous (skin-pop) ☐ Unknown ☐ Intramuscular ☐ Other:
Sniffs / snorts drugs				*Drugs sniffed / snorted* ☐ Heroin ☐ Cocaine ☐ Methamphetamine ☐ Unknown ☐ Other:
Other drug use				*Describe type of use and drugs*

EXPOSURES / RISK FACTORS - One month prior to illness onset

Other Risk Factors, one month	Yes	No	Unk		If Yes, Describe and Specify as Noted
Sustained any wounds or injuries (e.g. fractures, falls, etc.)				*Date of injury (mm/dd/yyyy)*	
Tattoo/Piercing, surgrical or dental procedure				*Date of procedure(mm/dd/yyyy)*	
Pharmacological botulism toxin (such as Botox, Mybloc) for therapeutic or cosmetic reasons?				*Date of receipt (mm/dd/yyyy)* / *Number of units:* *Describe:*	

First three letters of patient's last name:

LABORATORY INFORMATION

CLINICAL SPECIMENS - DIRECT TOXIN TESTING

Specimen Type 1

☐ Gastric aspirate
☐ Serum (pre-toxin)
☐ Serum (post-toxin)
☐ Stool

Result

☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test cancelled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unknown

Type of Toxin Detected

☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

Specimen Type 2

☐ Gastric aspirate
☐ Serum (pre-toxin)
☐ Serum (post-toxin)
☐ Stool

Result

☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test cancelled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unknown

Type of Toxin Detected

☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

CLINICAL SPECIMENS - CULTURE TESTING

Specimen Type 1

☐ Gastric aspirate
☐ Stool
☐ Wound or abscess (specify site): _____
☐ Other (specify): _____

Result

☐ No *Clostridium* organism isolated ☐ *Clostridium butyricum* organism isolated ☐ Test cancelled
☐ *Clostridium botulinum* organism isolated ☐ Other clostridial species ☐ Unknown
☐ *Clostridium baratii* organism isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism

☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ None ☐ Untypeable ☐ Unknown

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

Specimen Type 2

☐ Gastric aspirate
☐ Stool
☐ Wound or abscess (specify site): _____
☐ Other (specify): _____

Result

☐ No *Clostridium* organism isolated ☐ *Clostridium butyricum* organism isolated ☐ Test cancelled
☐ *Clostridium botulinum* organism isolated ☐ Other clostridial species ☐ Unknown
☐ *Clostridium baratii* organism isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism

☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ None ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

FOOD SPECIMENS

Type of Food Item 1 (specify)

Food Identification #	*Did the patient eat this item in the week before illness onset?*	*Did anyone else eat this item in the week before patient's illness onset?*
	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Direct Toxin Testing Results

☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test cancelled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unknown

Type of Toxin Detected

☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ Untypeable ☐ Unk

Culture Testing Results

☐ No *Clostridium* organism isolated ☐ *Clostridium butyricum* organism isolated ☐ Test cancelled
☐ *Clostridium botulinum* organism isolated ☐ Other clostridial species ☐ Unknown
☐ *Clostridium baratii* organism isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism

☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ None ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

First three letters of patient's last name:

EXPOSURES / RISK FACTORS - POTENTIAL HIGH RISK PRODUCTS

ASK ABOUT HIGH RISK FOODS EVEN IF WOUND BOTULISM IS SUSPECTED
(SUCH AS HOME CANNED OR SUSPICIOUS COMMERCIAL OR RESTAURANT FOODS)

Provide information regarding potential high-risk products consumed one week prior to illness onset.

Food Product	Yes	No	Unk	If Yes, Describe
Home canned, jarred, or preserved food products				*Describe*
Fermented food products				*Describe*
Dried or smoked fish products				*Describe*
Marinated food products				*Describe*
Suspicious commercial products (i.e., bulging lids or cans, recalled products, "off-odor" food items)				*Describe*

EXPOSURES / RISK FACTORS - SPECIFIC FOOD ITEMS

Provide information regarding any suspected food item consumed one week prior to illness onset.

Suspect Food Item 1

Food Item | *Date Eaten (mm/dd/yyyy)* | *Time Eaten (HH:MM AM/PM)*

Type of Food
☐ Homemade ☐ Restaurant associated ☐ Commercial product ☐ Unk

If commercial product, specify
Brand: Lot:

How was food stored?
☐ Unrefrigerated ☐ Refrigerated ☐ Frozen ☐ Unknown ☐ Other:

How was food preserved?
☐ Canned ☐ Dried ☐ Fermented ☐ Salted ☐ Pickled ☐ No preservation method ☐ Unknown ☐ Other:

How was food item served?
☐ Unheated ☐ Only warmed ☐ Microwaved ☐ Heated ☐ Boiled ☐ Fried ☐ Unknown ☐ Other:

Number of Persons who Shared the Food Item | *Number of Persons Ill*

Samples of food item available? ☐ Yes ☐ No ☐ Unknown

Samples submitted for botulism testing? ☐ Yes ☐ No ☐ Unknown

Foods of same batch / lot recovered or recalled? ☐ Yes ☐ No ☐ Unknown

Suspect Food Item 2

Food Item | *Date Eaten (mm/dd/yyyy)* | *Time Eaten (HH:MM AM/PM)*

Type of Food
☐ Homemade ☐ Restaurant associated ☐ Commercial product ☐ Unk

If commercial product, specify
Brand: Lot:

How was food stored?
☐ Unrefrigerated ☐ Refrigerated ☐ Frozen ☐ Unknown ☐ Other:

How was food preserved?
☐ Canned ☐ Dried ☐ Fermented ☐ Salted ☐ Pickled ☐ No preservation method ☐ Unknown ☐ Other:

How was food item served?
☐ Unheated ☐ Only warmed ☐ Microwaved ☐ Heated ☐ Boiled ☐ Fried ☐ Unknown ☐ Other:

Number of Persons who Shared the Food Item | *Number of Persons Ill*

Samples of food item available? ☐ Yes ☐ No ☐ Unknown

Samples submitted for botulism testing? ☐ Yes ☐ No ☐ Unknown

Foods of same batch / lot recovered or recalled? ☐ Yes ☐ No ☐ Unknown

EXPOSURES / RISK FACTORS - OTHER POTENTIAL EXPOSURES OF INTEREST

Exposure 1	*Describe*
Exposure 2	*Describe*

First three letters of patient's last name:

TRAVEL HISTORY (INCUBATION PERIOD IS 7 DAYS PRIOR TO ILLNESS ONSET)

*Did patient travel **outside county of residence** during the **incubation period**?*
☐ Yes ☐ No ☐ Unknown

If Yes, specify all locations and dates below.

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.)	Date Travel Started *(mm/dd/yyyy)*	Date Travel Ended *(mm/dd/yyyy)*
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					

CONTACTS / OTHER ILL PERSONS

Any contacts with similar illness?
☐ Yes ☐ No ☐ Unk

If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Date First Reported to Public Health (mm/dd/yyyy)*	
Name 2	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Date First Reported to Public Health (mm/dd/yyyy)*	

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*
Date First Reported to Public Health (mm/dd/yyyy)		*First Reported by* ☐ Clinician ☐ Laboratory ☐ Other (specify):	

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐ Yes ☐ No ☐ Unknown	*Contact Name / Case Number*

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐ Confirmed ☐ Probable ☐ Suspect

First three letters of patient's last name:

OUTBREAK

Part of known outbreak?	*If Yes, extent of outbreak:*
☐ Yes ☐ No ☐ Unknown	☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other:

Vehicle of Outbreak	*Pattern 1 ID number*	*Pattern 2 ID number*

STATE USE ONLY

State Case Classification
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Need additional information

CASE DEFINITION

BOTULISM, FOODBORNE (2011)

CLINICAL DESCRIPTION
Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

LABORATORY CRITERIA FOR DIAGNOSIS
- Detection of botulinum toxin in serum, stool, or patient's food, or
- Isolation of *Clostridium botulinum* from stool

CASE CLASSIFICATION
Probable: a clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours)
Confirmed: a clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory confirmed botulism

BOTULISM, WOUND (2011)

CLINICAL DESCRIPTION
An illness resulting from toxin produced by *Clostridium botulinum* that has infected a wound. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

LABORATORY CRITERIA FOR DIAGNOSIS
- Detection of botulinum toxin in serum, or
- Isolation of *Clostridium botulinum* from wound

CASE CLASSIFICATION
Probable: a clinically compatible case in a patient who has no suspected exposure to contaminated food and who has a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms
Confirmed: a clinically compatible case that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has either a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms

BOTULISM, OTHER (2011)

CLINICAL DESCRIPTION
See Botulism, Foodborne.

LABORATORY CRITERIA FOR DIAGNOSIS
- Detection of botulinum toxin in clinical specimen, or
- Isolation of *Clostridium botulinum* from clinical specimen

CASE CLASSIFICATION
Confirmed: a clinically compatible case that is laboratory confirmed in a patient aged greater than or equal to 1 year who has no history of ingestionof suspect food and has no wounds

First three letters of patient's last name:

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

First three letters of patient's last name:

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - waiter or waitress
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - registered nurse
- Medical - other/unknown
- Military - officer
- Military - recruit or trainee
- Protective service - police officer
- Protective service - other
- Professional, technical, or related profession
- Retired
- Sex worker
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high (secondary) school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high (secondary) school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Other
- Refused
- Unknown