

MEDICAL CHART ABSTRCTION FORM

Fungal Bloodstream Infections Related to Oncology Practice A – Chart Abstraction Form

CDCID: _____

Clinic Chart #: _____

1. Past Medical History

Underlying diseases (check all that apply):

Cancer, type: _____

Diabetes mellitus Alcohol dependence/heavy alcohol use

Immunosuppressive condition i.e. HIV/AIDS

Other disease (list below) Info not available

If other, list: _____

2. Clinic Visits

Visit 1	Visit Date: ___/___/___ (MM/DD/YYYY)
	Does the patient have any of the following access types? <input type="checkbox"/> Port-a-cath <input type="checkbox"/> PICC line <input type="checkbox"/> Central line <input type="checkbox"/> Hickman catheter <input type="checkbox"/> Implantable port <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Peripheral IV
	Did the patient receive any of the following (check all that apply): <input type="checkbox"/> Heparin <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Ondansetron <input type="checkbox"/> Aloxi <input type="checkbox"/> Chemo1: _____ <input type="checkbox"/> Chemo2: _____ <input type="checkbox"/> Chemo3: _____ <input type="checkbox"/> Flush1 <input type="checkbox"/> Flush2 <input type="checkbox"/> None <input type="checkbox"/> Other: _____
Visit 2	Visit Date: ___/___/___ (MM/DD/YYYY)
	Does the patient have any of the following access types? <input type="checkbox"/> Port-a-cath <input type="checkbox"/> PICC line <input type="checkbox"/> Central line <input type="checkbox"/> Hickman catheter <input type="checkbox"/> Implantable port <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Peripheral IV
	Did the patient receive any of the following (check all that apply): <input type="checkbox"/> Heparin <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Ondansetron <input type="checkbox"/> Aloxi <input type="checkbox"/> Chemo1: _____ <input type="checkbox"/> Chemo2: _____ <input type="checkbox"/> Chemo3: _____ <input type="checkbox"/> Flush1 <input type="checkbox"/> Flush2 <input type="checkbox"/> None <input type="checkbox"/> Other: _____
Visit 3	Visit Date: ___/___/___ (MM/DD/YYYY)
	Does the patient have any of the following access types? <input type="checkbox"/> Port-a-cath <input type="checkbox"/> PICC line <input type="checkbox"/> Central line <input type="checkbox"/> Hickman catheter <input type="checkbox"/> Implantable port <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Peripheral IV
	Did the patient receive any of the following (check all that apply): <input type="checkbox"/> Heparin <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Ondansetron <input type="checkbox"/> Aloxi <input type="checkbox"/> Chemo1: _____ <input type="checkbox"/> Chemo2: _____ <input type="checkbox"/> Chemo3: _____ <input type="checkbox"/> Flush1 <input type="checkbox"/> Flush2 <input type="checkbox"/> None <input type="checkbox"/> Other: _____

Visit 4	Visit Date: ___/___/___ (MM/DD/YYYY)
	Does the patient have any of the following access types? <input type="checkbox"/> Port-a-cath <input type="checkbox"/> PICC line <input type="checkbox"/> Central line <input type="checkbox"/> Hickman catheter <input type="checkbox"/> Implantable port <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Peripheral IV
	Did the patient receive any of the following (check all that apply): <input type="checkbox"/> Heparin <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Ondansetron <input type="checkbox"/> Aloxi <input type="checkbox"/> Chemo1: _____ <input type="checkbox"/> Chemo2: _____ <input type="checkbox"/> Chemo3: _____ <input type="checkbox"/> Flush1 <input type="checkbox"/> Flush2 <input type="checkbox"/> None <input type="checkbox"/> Other: _____
Visit 5	Visit Date: ___/___/___ (MM/DD/YYYY)
	Does the patient have any of the following access types? <input type="checkbox"/> Port-a-cath <input type="checkbox"/> PICC line <input type="checkbox"/> Central line <input type="checkbox"/> Hickman catheter <input type="checkbox"/> Implantable port <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Peripheral IV
	Did the patient receive any of the following (check all that apply): <input type="checkbox"/> Heparin <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Ondansetron <input type="checkbox"/> Aloxi <input type="checkbox"/> Chemo1: _____ <input type="checkbox"/> Chemo2: _____ <input type="checkbox"/> Chemo3: _____ <input type="checkbox"/> Flush1 <input type="checkbox"/> Flush2 <input type="checkbox"/> None <input type="checkbox"/> Other: _____
Visit 6	Visit Date: ___/___/___ (MM/DD/YYYY)
	Does the patient have any of the following access types? <input type="checkbox"/> Port-a-cath <input type="checkbox"/> PICC line <input type="checkbox"/> Central line <input type="checkbox"/> Hickman catheter <input type="checkbox"/> Implantable port <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Peripheral IV
	Did the patient receive any of the following (check all that apply): <input type="checkbox"/> Heparin <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Ondansetron <input type="checkbox"/> Aloxi <input type="checkbox"/> Chemo1: _____ <input type="checkbox"/> Chemo2: _____ <input type="checkbox"/> Chemo3: _____ <input type="checkbox"/> Flush1 <input type="checkbox"/> Flush2 <input type="checkbox"/> None <input type="checkbox"/> Other: _____
Visit 7	Visit Date: ___/___/___ (MM/DD/YYYY)
	Does the patient have any of the following access types? <input type="checkbox"/> Port-a-cath <input type="checkbox"/> PICC line <input type="checkbox"/> Central line <input type="checkbox"/> Hickman catheter <input type="checkbox"/> Implantable port <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Peripheral IV
	Did the patient receive any of the following (check all that apply): <input type="checkbox"/> Heparin <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Ondansetron <input type="checkbox"/> Aloxi <input type="checkbox"/> Chemo1: _____ <input type="checkbox"/> Chemo2: _____ <input type="checkbox"/> Chemo3: _____ <input type="checkbox"/> Flush1 <input type="checkbox"/> Flush2 <input type="checkbox"/> None <input type="checkbox"/> Other: _____
Visit 8	Visit Date: ___/___/___ (MM/DD/YYYY)
	Does the patient have any of the following access types?

<input type="checkbox"/> Port-a-cath <input type="checkbox"/> PICC line <input type="checkbox"/> Central line <input type="checkbox"/> Hickman catheter <input type="checkbox"/> Implantable port <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Peripheral IV
Did the patient receive any of the following (check all that apply): <input type="checkbox"/> Heparin <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Ondansetron <input type="checkbox"/> Aloxi <input type="checkbox"/> Chemo1: _____ <input type="checkbox"/> Chemo2: _____ <input type="checkbox"/> Chemo3: _____ <input type="checkbox"/> Flush1 <input type="checkbox"/> Flush2 <input type="checkbox"/> None <input type="checkbox"/> Other: _____

3. Microbiology

Culture	Date/Time	Specimen Site	Culture type	Result
1	____/____/____ ____:____	<input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Peripheral <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Aer/Anaer <input type="checkbox"/> Fungal	<input type="checkbox"/> No growth final <input type="checkbox"/> Positive Organism 1 _____ Organism 2 _____ Organism 3 _____
Culture	Date/Time	Specimen Site	Culture type	Result
2	____/____/____ ____:____	<input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Peripheral <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Aer/Anaer <input type="checkbox"/> Fungal	<input type="checkbox"/> No growth final <input type="checkbox"/> Positive Organism 1 _____ Organism 2 _____ Organism 3 _____
Culture	Date/Time	Specimen Site	Culture type	Result
3	____/____/____ ____:____	<input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Peripheral <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Aer/Anaer <input type="checkbox"/> Fungal	<input type="checkbox"/> No growth final <input type="checkbox"/> Positive Organism 1 _____ Organism 2 _____ Organism 3 _____
Culture	Date/Time	Specimen Site	Culture type	Result
4	____/____/____ ____:____	<input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Peripheral <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Aer/Anaer <input type="checkbox"/> Fungal	<input type="checkbox"/> No growth final <input type="checkbox"/> Positive Organism 1 _____ Organism 2 _____ Organism 3 _____
Culture	Date/Time	Specimen Site	Culture type	Result
5	____/____/____ ____:____	<input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Peripheral <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Aer/Anaer <input type="checkbox"/> Fungal	<input type="checkbox"/> No growth final <input type="checkbox"/> Positive Organism 1 _____ Organism 2 _____ Organism 3 _____
Culture	Date/Time	Specimen Site	Culture type	Result

Public reporting burden of this collection of information is estimated to average 0 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

6	____/____/____ ____:____	<input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Peripheral <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Aer/Anaer <input type="checkbox"/> Fungal	<input type="checkbox"/> No growth final <input type="checkbox"/> Positive Organism 1 _____ Organism 2 _____ Organism 3 _____
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4. Symptoms at time of culture

Did patient have any of the following symptoms at the time of culture?

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
If yes, Temp: _____ °F				
Malaise (feeling poorly)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Arthralgias	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Lethargy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Night Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Muscle ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
If Yes, describe: _____				
Other symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UNK	_____
If Yes, specify: _____				

5. Beta-D-glucan (if applicable)

Date performed	Specimen	Result
____/____/____	<input type="checkbox"/> CSF <input type="checkbox"/> Blood	Level: _____
____/____/____		Level: _____
____/____/____		Level: _____

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____/____/____		Level: _____
____/____/____		Level: _____
____/____/____		Level: _____

6. Hospitalization Information

Admission Date: ____/____/____ (MM/DD/YY) Discharge Date: ____/____/____ (MM/DD/YY)	
Did patient have any of the following symptoms at time of admission?	
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____ If yes, Temp: _____ °F	
Malaise (feeling poorly) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Chills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Arthralgias <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Lethargy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Night Sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Muscle ache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
Rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____	
If Yes, describe: _____	
Other symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK _____ If Yes, specify: _____	
Was port removed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no port) If Yes, date of port removal: ____/____/____ Results of port culture: _____	
If No, reason port was not removed: _____	

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Complete table for all antifungals and antibiotics received, if known: Unknown

Antifungal/Antibiotic	Dose	Start Date	Stop Date

Admitted to:
 MICU General medicine Other _____ Unknown

Outcome:
 Died Survived

If deceased, date of death:
 ____/____/____ (MM/DD/YY) Unknown

If survived, date of discharge:
 ____/____/____ (MM/DD/YY) Unknown

Notes:

Chart Review Completed by: _____

**CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016**

Abstractor initials _____ Date _____ CDC # _____

CASE INFORMATION
Medical facility <input type="checkbox"/> Correctional facility health services unit <input type="checkbox"/> Hospital, name _____ Medical record # _____ Patient Age _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Hispanic or Latino origin: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Race: <input type="checkbox"/> White <input type="checkbox"/> Black/ African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown Height _____ in / cm Weight _____ lb / kg BMI _____ Notes:

PAST MEDICAL HISTORY	
Health condition	Notes
Notes:	

PAST SURGICAL HISTORY		
Procedure	Date	Notes
Notes:		

**CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016**

Abstractor initials _____ Date _____ CDC # _____

MEDICATIONS IN PAST 6 MONTHS (Prior to hospitalization)				
Name	Frequency	Duration	Dose	Notes
Notes:				

BEHAVIORAL HEALTH RISK FACTORS				
Behavior	Yes	No	Prior	Notes (Type, frequency, etc.)
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recreational drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Injection drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Notes:				

EXPOSURE HISTORY
Reported consuming hooch or pruno: <input type="checkbox"/> Yes <input type="checkbox"/> No When _____
Amount _____ Color of hooch/pruno _____
Notes:

**CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016**

Abstractor initials _____ Date _____ CDC # _____

HOSPITAL ADMISSION

Presentation: Date _____ Time _____ Admitted: Yes No

Vital signs upon presentation:

Temperature _____ °C / °F Blood pressure _____ / _____ mmHg

Heart Rate _____ beats/ min Respiration Rate _____ breaths/min

Presenting symptoms _____

Onset Date _____ Time _____

Notes:

SYMPTOMS (ER and admission note, plus neuro consult)

Symptom	Yes	No	Unknown	Date / time first reported
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness, or change in sound of voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Slurred Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thick tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Double vision / diplopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Notes:

**CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016**

Abstractor initials _____ Date _____ CDC # _____

PHYSICAL EXAM FINDINGS (ER and admission note, plus neuro consult)				
Exam Finding	Yes	No	Unknown	Date / time first reported
Alert and Oriented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Extraocular Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it bilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it symmetric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ptosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it bilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it symmetric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pupils dilated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it bilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pupils constricted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it bilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pupils non-reactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it bilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Facial paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it bilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, is it symmetric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Palatal weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impaired gag reflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sensory deficits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Notes:				

Musculoskeletal Exam						
Upper Extremity	Proximal	R: /5	L: /5	Distal	R: /5	L: /5
Lower Extremity	Proximal	R: /5	L: /5	Distal	R: /5	L: /5
Deep Tendon Reflexes						
Upper Extremity	Bi/triceps	R: /4	L: /4	Brachial	R: /4	L: /4
Lower Extremity	Patellar	R: /4	L: /4	Ankle	R: /4	L: /4
Is muscle weakness / paralysis present, describe progression	<input type="checkbox"/> Ascending <input type="checkbox"/> Descending					
Notes:						

**CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016**

Abstractor initials _____ Date _____ CDC # _____

CLINICAL TESTS (ER and admission note, plus neuro consult)				
Test	Yes	No	Unknown	
Lumber puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date:
If yes	WBC:		RBC:	Glucose: Protein:
EMG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date:
With rapid, repetitive stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hertz:
Suggestive of botulism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endophonium (Tensilon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date:
Findings:				
CT scan or MRI scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date:
Findings:				
Toxicology screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urine				
Serum				
Blood Alcohol Conc.				
Alcohol Panel				
Electrolytes on admission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Na (sodium)				
K (potassium)				
Cl (chloride)				
HCO ₃ (bicarbonate)				
BUN				
Creatinine				
Glucose				
Other diagnostic tests or labs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Notes:				

**CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016**

Abstractor initials _____ Date _____ CDC # _____

CLINICAL COURSE

Admitted to the ICU: Yes No If yes, date _____

Intubated: Yes No If yes, date _____

Respiratory muscle strength used to predict need for intubation

Test name	Value on admission	Value on "worst" measurement	Date and time of "worst" measurement
NIF (negative inspiratory flow)			
MIP (maximal inspiratory pressure)			
MEP (maximal expiratory pressure)			
SNIP (sniff nasal inspiratory pressure)			

Tracheostomy: Yes No If yes, date _____

Administered HBAT: Yes No If yes, date _____ Time _____

Adverse effects: Anaphylaxis Infusion Reaction
 Hemodynamic instability Other: _____

Date that neurologic improvement was noted: _____

Outcome: Date _____

Discharged alive Died Transfer _____
 Still hospitalized Other _____

Notes:

Additional notes:

QUESTIONNAIRE FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*, JUNE 2016

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

QUESTIONNAIRE FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*, JUNE 2016

Section 1: INTERVIEWER INFORMATION (Questions 1-5 to be completed by interviewer prior to questionnaire administration)

1. CDC ID: _____ 2. Inmate #: _____

3. Date of Interview: _____ / _____ / _____ (if unknown, enter 99/99/9999)
M M D D Y Y Y Y

4. Interviewer Information Name: _____
 Agency or Organization: _____

5. Location of interview: _____ Teleconference

6. Respondent is: Confirmed case Suspected case Not a case Other (Specify): _____

7. Staff present for interview: State Health Correctional facility CDC Other (Specify): _____

8. Current cell/housing unit: _____

9. Cell/housing unit on June 1st: _____
 Different from current cell/housing unit? Yes No Unknown
 If yes, when did the inmate change cell/housing unit?: _____ / _____ / _____ Notes: _____
M M D D Y Y Y Y

10. Inmate duty assignment (kitchen staff, janitorial, etc.): _____

Section 2: INMATE DEMOGRAPHIC DATA:

1. Age: _____ years

2. Sex: Male Female Unknown

3. How would you describe your race? White Black/ African American American Indian/Alaska Native Asian
 Native Hawaiian/Other Pacific Islander Other (specify): _____ Unknown

4. Do you identify as Hispanic or Latino origin? Yes No Unknown

Section 3: FOOD ALLERGIES, SPECIAL DIETS: I am going to ask you questions about your diet.

Yes	Maybe	No	Don't Know	Did you have:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Any allergies that prevent you from eating a certain food(s)?
				1a. What foods? <input type="checkbox"/> Milk <input type="checkbox"/> Eggs <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree nuts <input type="checkbox"/> Fish Please check all that apply. <input type="checkbox"/> Soy <input type="checkbox"/> Wheat <input type="checkbox"/> Shellfish <input type="checkbox"/> other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Do you follow a special or restricted diet?
				Which? _____

Section 3 Comments. Please fill in any comments/notes from this section in the space provided below:

Section 4: ALTERNATE SOURCES OF FOOD AND DRINK: Now we are going to ask you about food and drink you may have consumed outside of the prison cafeteria.

Yes	Maybe	No	Don't Know	Since Wednesday, June 1 st , have you:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Stored food in your cell?
				1a. What foods? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Consumed food prepared in your cell?
				2a. What foods? _____
				Did you share with other inmates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Yes	Maybe	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Stored food in your housing unit?
				3a. What foods? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Consumed food prepared in your housing unit?
				4a. What foods? _____
				Did you share with other inmates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Received food from outside the prison, such as food brought to you by a friend or family member?
				5a. What foods? _____
				Did you share with other inmates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Bought food from the commissary?
				6a. What foods? _____
				Did you share with other inmates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Received food from another inmate (shared, traded, bought)?
				7a. What foods? _____
				Did you share with other inmates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Section 4 Comments. Please fill in any comments/notes from this section in the space provided below:				

Section 5: HOCH: Now I have a few questions about hooch, brew or pruno. You can skip any question you prefer not to answer.

Yes	Maybe	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever drank hooch since you entered the prison? <input type="checkbox"/> Refusal
				1a. How often do you drink hooch? <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> less than monthly <input type="checkbox"/> when it is available <input type="checkbox"/> don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Do you brew hooch yourself? <input type="checkbox"/> Refusal
				If no, do you know how hooch is made? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Have you drunk hooch since June 1st? <input type="checkbox"/> Refusal
				3a. On which days did you drink and how much each day? FILL IN CALENDAR ON THE NEXT PAGE WITH DRINKING HISTORY
				3b. What type of container(s) did you receive the hooch in? _____ <input type="checkbox"/> Multiple containers (if multiple indicate on calendar)
				3c. What type of container did you keep the hooch in? _____ <input type="checkbox"/> Same container as container received in
				3d. Where did you get the hooch? <input type="checkbox"/> Refusal _____ _____ _____

				<p>3e. Can you describe the color of the hooch that you drank? _____</p> <p>_____</p> <p><input type="checkbox"/> Multiple colors (if multiple indicate on calendar)</p> <p>3f. Do you know when the batch of hooch that you drank was dug up or ready to drink?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>If yes, when? ___ / ___ / _____</p> <p>(if multiple batches, describe in comments)</p> <p>3g. Did you share with other people? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>How many people did you share with? _____</p> <p>Did any of these people go to the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>How many? _____</p> <p>3h. Is the hooch you drank is still available for purchase?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>3i. Can you tell me anything else about this batch of hooch? _____</p> <p>_____</p>
--	--	--	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Before the recent outbreak, did you know hooch could make you sick (more than a hangover)?
--------------------------	--------------------------	--------------------------	--------------------------	-----------------------------------------------------------------------------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Before the recent outbreak, had you heard of the illness botulism before?
--------------------------	--------------------------	--------------------------	--------------------------	------------------------------------------------------------------------------

Section 5 Comments. Please fill in any comments/notes from this section in the space provided below:

(Optional questions:

About how many brewers are there?

About how much do they brew per week (how often do they brew)?

How much hooch could you get right now if you wanted to?

How many stamps would a cup of hooch cost?)

JUNE

Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
						1	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	2	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	3	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	4	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____
5	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	6	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	7	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	8	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	9	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	10	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	11	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____
12	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	13	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	14	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	15	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	16	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	17	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____	18	Drank? Yes No How much? () Sip () Cup () Pint () More than a pint Color: _____ Source: _____ Container: _____

Section 6: CLINICAL INFORMATION: I am now going to ask you about your current illness and symptoms.

1. What day/time did you first feel sick? $\frac{_}{M} \frac{_}{M} / \frac{_}{D} \frac{_}{D} / \frac{_}{Y} \frac{_}{Y} \frac{_}{Y} \frac{_}{Y}$ Time: $_ _ : _ _ \text{ AM / PM}$ Not sick (**Skip to Section 8**)
2. What day/time did you first report your symptoms to correctional staff? $\frac{_}{M} \frac{_}{M} / \frac{_}{D} \frac{_}{D} / \frac{_}{Y} \frac{_}{Y} \frac{_}{Y} \frac{_}{Y}$ Time: $_ _ : _ _ \text{ AM / PM}$
3. What day/time did you first see a doctor? $\frac{_}{M} \frac{_}{M} / \frac{_}{D} \frac{_}{D} / \frac{_}{Y} \frac{_}{Y} \frac{_}{Y} \frac{_}{Y}$ Time: $_ _ : _ _ \text{ AM / PM}$
4. Were you hospitalized? Yes No Don't know
- When? $\frac{_}{M} \frac{_}{M} / \frac{_}{D} \frac{_}{D} / \frac{_}{Y} \frac{_}{Y} \frac{_}{Y} \frac{_}{Y}$ Time: $_ _ : _ _ \text{ AM / PM}$
- Where were you first hospitalized? _____
5. How many days total were you sick? _____ days (enter 999 if unknown) or Still Ill

At any point during your illness, have you had:

Yes	No	Don't Know	Symptom
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness, or change in sound of voice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slurred Speech
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thick tongue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling

Clinical history:

At any point in your life have you been told by a doctor that you have any of the following illnesses:

Yes	No	Don't Know	Comorbidity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other chronic illness?
			Which other(s)? _____

Section 6 Comments.

Section 7: Medications: I will now ask you about medication, tobacco, and other substance use since June 1st. You can skip any question/s you do not want to answer.

Yes	Maybe	No	Don't Know	Since June 1st, have you:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Do you currently smoke cigarettes or other tobacco product(s)? <input type="checkbox"/> Refusal
				How often? <input type="checkbox"/> at least once a day <input type="checkbox"/> at least once a week <input type="checkbox"/> at least once a month <input type="checkbox"/> when it is available <input type="checkbox"/> don't know If daily, how many cigarettes/tobacco per day on average? _____ (Specify: _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Do you currently chew tobacco or dip? <input type="checkbox"/> Refusal
				How often? <input type="checkbox"/> at least once a day <input type="checkbox"/> at least once a week <input type="checkbox"/> at least once a month <input type="checkbox"/> when it is available <input type="checkbox"/> don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Taken any over the counter medication(s)?
				Which? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Taken medication(s) that was prescribed to you by a doctor?
				Which?: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Taken any prescription medication(s) that was NOT prescribed to you by a doctor?
				Which? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you smoked, snorted, or ingested any drug(s) for recreational use? <input type="checkbox"/> Refusal
				Which? <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine/crack <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Hallucinogen (Specify: _____) <input type="checkbox"/> Other (Specify: _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you injected any drug(s) for recreational use? <input type="checkbox"/> Refusal
				Which? <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Other (Specify: _____)

Section 3 Comments. Please fill in any comments/notes from this section in the space provided below:

DETAILED ENTERICS QUESTIONNAIRE

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

INTERVIEW DATE: _____/_____/_____

INTERVIEWER: _____

PATIENT ID: _____

CULTURE POSITIVE DATE: _____

Thank you for all of the information you gave us so far. We are still working hard to try to understand what caused you to become ill with Elizabethkingia infection.

Because you reported consuming some fruit or nuts in previous interviews, we have a few more specific questions about what fruit or nuts you might have had before you became ill in 2015 or 2016, when you might have consumed these foods, and how they were packaged.

1. Did you consume fruit or nuts purchased in bulk from a truck, delivery or mail order service, or receive fruit or nuts from someone you know who uses one of these services in 2015 or 2016, before you became ill?

Yes No Maybe

2. Did you purchase or receive any fruit or nuts, or items that contain fruits or nuts, from any of the following sources in 2015 or 2016, before you became ill? This could include any fruits or nuts that you did not consume.

Via home delivery or mail order? Yes No Maybe

Company/Business name: _____

Street address: _____

City _____ State _____ Date(s) of delivery _____

Pick-up from truck or other pick-up location? Yes No Maybe

Pick-up location/business name: _____

Street address: _____

City _____ State _____ Date(s) of pick-up _____

From a friend, family member, or co-worker? Yes No Maybe

Name of friend/family member: _____

Telephone number: _____ Date(s) _____

From a fundraiser (e.g., school, church, FFA)? Yes No Maybe

Name of organization/ school /club: _____

Street address: _____

City _____ State _____ Date(s) of pick-up _____

From a farmer's market? Yes No Maybe

Market name/location: _____

Street address: _____

City _____ State _____ Date(s) of pick-up _____

From another source (specify)? Yes No Maybe

Location/source: _____

Street address: _____

City _____ State _____ Date(s) of pick-up _____

INTERVIEW DATE: ____/____/____

INTERVIEWER: _____

PATIENT ID: _____

CULTURE POSITIVE DATE: _____

3. Which of the following fruit or nuts, or items that contain fruits or nuts, did you purchase or consume from the above source(s)? (please circle)

Specific fruit/nuts	Source of fruit/nuts based on above information
Blueberries	
Peaches	
Grapefruit	
Honeybells / Minneola tangelos	
Oranges (any type)	
Navel oranges	
Cranberries	
Dried fruit	
Other fruit purchased in bulk from the above source (specify) _____	
Pecans	
Chocolate-covered pecans	
Other nut purchased in bulk from the above source (specify) _____	

4. For the fruits that you reported having in 2015 or 2016 before you became ill (see question 3), please answer each item individually by circling Yes, No, or Maybe and provide as many details as possible.

Produce / Beverages / Nuts					
Item	Y	N	M	Unk	Additional information: variety or brand, purchase location, how prepared, when and where consumed etc.
Fruits					
Blueberries	Y	N	M	Unk	Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____

INTERVIEW DATE: ____/____/____

INTERVIEWER: _____

PATIENT ID: _____

CULTURE POSITIVE DATE: _____

					<p>Date(s) consumed: _____</p> <p>If you froze, made, or received anything with the blueberries, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
<p>Peaches (fresh, frozen, in desserts or jams/preserves)</p>	Y	N	M	Unk	<p>Fresh / frozen / in desserts or jams/preserves (circle)</p> <p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze or made, or received anything with the peaches, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
<p>Grapefruit</p>	Y	N	M	Unk	<p>Fresh / frozen / in desserts or jams/preserves (circle)</p> <p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, made, or received anything with the grapefruit, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p>

INTERVIEW DATE: ____/____/____

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					Are there any left? Y / N / Not sure
Honeybells / Minneola tangelos	Y	N	M	Unk	<p>Fresh / frozen / in desserts or jams/preserves (circle)</p> <p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, made, or received anything with the honeybells, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
Orange(s) (any type)	Y	N	M	Unk	<p>Fresh / frozen / in desserts or jams/preserves (circle)</p> <p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the oranges, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
Navel oranges	Y	N	M	Unk	<p>Fresh / frozen / in desserts or jams/preserves (circle)</p> <p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p>

INTERVIEW DATE: ____/____/____

INTERVIEWER: _____

PATIENT ID: _____

CULTURE POSITIVE DATE: _____

					<p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the navel oranges, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
<p>Cranberries (fresh, frozen, dried, in desserts or sauces)</p>	<p>Y</p>	<p>N</p>	<p>M</p>	<p>Unk</p>	<p>Fresh / frozen / dried / in desserts or jams/preserves (circle)</p> <p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the cranberries, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
<p>Other fresh fruit purchased in bulk</p>	<p>Y</p>	<p>N</p>	<p>M</p>	<p>Unk</p>	<p>Fresh / frozen / in desserts or jams/preserves (circle)</p> <p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the fruit, have you used or eaten them since? Y / N / Not sure</p>

INTERVIEW DATE: ____/____/____

INTERVIEWER: _____

PATIENT ID: _____

CULTURE POSITIVE DATE: _____

					<p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
Dried fruit purchased in bulk	Y	N	M	Unk	<p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the fruit, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
Other fruit purchased in bulk	Y	N	M	Unk	<p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the fruit, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
Nuts					
Pecans (by themselves or in pies, desserts, ice cream, cheese ball)					<p>Not in shell / in-shell (circle)</p> <p>Fresh / frozen / in desserts or jams/preserves (circle)</p> <p>Description/type: _____</p>

INTERVIEW DATE: ____/____/____

INTERVIEWER: _____

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CULTURE POSITIVE DATE: _____

					<p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the pecans, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
Chocolate-covered nuts					<p>Specify nut: _____</p> <p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the nuts, have you used or eaten them since? Y / N / Not sure</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any left? Y / N / Not sure</p>
Other nuts purchased in bulk	Y	N	M	Unk	<p>Description/type: _____</p> <p>Where purchased: _____</p> <p>Date(s) purchased: _____</p> <p>Where received (if not purchased): _____</p> <p>Received from (if not purchased): _____</p> <p>Dates(s) received (if not purchased): _____</p> <p>Date(s) consumed: _____</p> <p>If you froze, received, or made anything with the nuts, have you used or eaten them since? Y / N / Not sure</p>

INTERVIEW DATE: ____/____/____

INTERVIEWER: _____

PATIENT ID: _____

CULTURE POSITIVE DATE: _____

					<hr/> <hr/> <p>Are there any left? Y / N / Not sure</p>
--	--	--	--	--	---------------------------------------------------------

5. How were these fruits or nuts (or items with fruits or nuts) packaged when you purchased or received them?

6. Did you freeze any of the above fruits/nuts purchased or received in 2015 or 2016, before you became ill?

Yes No Maybe

7. Did you dry/dehydrate any of the above fruits/nuts purchased or received in 2015 or 2016, before you became ill?

Yes No Maybe

8. Did you make jams or preserves from any of the above fruits/nuts purchased or received in 2015 or 2016, before you became ill?

Yes No Maybe

9. Did you make anything from else from the above fruits/nuts purchased or received in 2015 or 2016, before you became ill?

Yes No Maybe

10. Did you give or donate any of the above fruits/ nuts to other people or facilities in 2015 or 2016, before you became ill?

Yes No Maybe

11. Did you eat at the following restaurants, or receive any food from the following restaurants located in Milwaukee, during 2015 or 2016, before you became ill?

Honeypie Café

Yes No Maybe

Lulu Café

Yes No Maybe

Palomino Bar

Yes No Maybe

Juniper 61

Yes No Maybe

INTERVIEW DATE: _____/_____/_____

INTERVIEWER: _____

PATIENT ID: _____

CULTURE POSITIVE DATE: _____

Amilinda

Yes No Maybe

12. Did you receive any products from Tree Ripe Citrus during 2015 or 2016, before you became ill?

Yes No Maybe

13. Did you receive any products delivered by Spee-dee Delivery regional shipping company during 2015 or 2016, before you became ill?

Yes No Maybe

ETHNOGRAPHIC INTERVIEW GUIDE

Public reporting burden of this collection of information is estimated to average 120 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Interviewer: _____

Date: _____

Time: _____ AM/PM

Location: _____

Focus Group #: _____

Patient identifier 1: _____	Date of Positive Elizabethkingia Test PI 1: ___/___/____	Patient History PI 1: _____ _____ _____ _____
Patient identifier 2: _____	Date of Positive Elizabethkingia Test PI 2: ___/___/____	Patient History PI 2: _____ _____ _____ _____
Patient identifier 3: _____	Date of Positive Elizabethkingia Test PI 3: ___/___/____	Patient History PI 3: _____ _____ _____ _____
Patient identifier 4: _____	Date of Positive Elizabethkingia Test PI 4: ___/___/____	Patient History PI 4: _____ _____ _____ _____
Patient identifier 5: _____	Date of Positive Elizabethkingia Test PI 5: ___/___/____	Patient History PI 5: _____ _____ _____ _____

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

I. Daily activities

I. Typical daily routine

Our first step will be to have everyone to introduce themselves. Let's go around the room and have you say your name as it appears on your name card. Remember, this can just be a made up name, if you want it to be; we just want a way to be able to identify each of you during the discussion today.

Along with your name, I would like to ask you about some of your daily activities in the 3 months before you got ill [refer to calendar visual for everyone.] Could you tell me VERY briefly what do you all do on a typical day or week? We can just quickly go around the room. [Gauge discussion of below topics based on responses from participants. Limit to about 2 minutes per person]

I. Home environment

1. Could you describe where you live? Tell me about your neighborhood.
 - a. Are you in an urban or rural area?
 - b. Who else lives in your household?

II. Consumption of foods and drinks

Thank you for sharing this information with us. Now we're going to specifically talk about what you ate or drank you did in the 90 days before you became ill.

1. What did you eat and drink on a typical day from during the 3 months before you became ill?
 - a. How is your food typically prepared?
 - i. Do you cook your own food?
 - ii. Do you get your food from the grocery store?
 - iii. Do people bring you food? (either prepared or from a grocery store)
 - a. Probe for: fruit or pecan pies, ice creams with fruit or pecans, jams/jellies, specifically oranges, grapefruit, tangelos, honeybells, blueberries, peaches
 - b. Fruit baskets? (especially around the holidays)
 - iv. Do you eat packaged or frozen foods?
 - v. If your food comes from a market, does it come from...
 - a. A regular grocery store?
 - b. Local store or farmer's market?
 - c. Ethnic markets?
 - vi. Do you get your food from other sources, like:
 - a. Bulk food shops

Interviewer: _____

Date: _____

Time: _____ AM/PM

Location: _____

Focus Group #: _____

- b. Food delivery trucks or systems, e.g., Schwann's, seafood truck, FFA
- c. Specially ordered bulk fruit, typically brought in from out of state that you or someone you know ordered (if yes use fruit supplemental)
- d. Fruit as gift, in gift baskets or seasonally delivered (if yes use fruit supplemental)
- e. Specifically ask about Tree Ripe Citrus Fruit company? (mail order/pick up)
 - i. If picked up food from Tree Ripe Citrus, which location?
 - ii. Pick up from high school; from door-to-door sellers
- f. Do you freeze fruit? If so, how old is this fruit (if you buy in bulk, how long does your supply last in the freezer)? Do you still have the fruit from the time period in question? (**Is it available for testing?)
 - iii. Probe for pecans, oranges, grapefruit, tangelos, honeybells, blueberries, peaches from this or other delivery trucks during 2015

2. Did you go to any restaurants during this time? If so, did you consume any...

a. Dairy?

b. Meats?

c. Seafoods?

(Have participants elaborate)

d. Did you eat at: HoneyPie Café, Lulu Café, Palomino Bar, Juniper 61, Amilinda in Milwaukee?

(these restaurants serve products that contain Tree Ripe Citrus products)

3. Now I'd like to ask specifically about food you may have eaten that would have been produced locally, meaning somewhere in South or Southeastern Wisconsin.

a. Dairy (milk, cheese, yogurt)

Spreadable cheese

Artisanal cheese or from a local cheesemaker

b. Produce (fruits, vegetables)

i. Sources of fruit: fruit delivery trucks, fruit stand on side of road or in parking lots

ii. Do you freeze fruit? If so, how old is this fruit (if you buy in bulk, how long does your supply last in the freezer)? Do you still have the fruit from the time period in question? (**Is it available for testing?)

iii. Mail order any fruit?

iv. Probe for pecans, oranges, grapefruit, tangelos, honeybells, blueberries, peaches from this or other delivery trucks during 2015

c. Meats (hunted, grocery store, fresh vs. processed such as sausages or salami)

From local meat markets or butcher shops

Did you receive or order any holiday or specialty meat/cheese baskets or gifts

d. Seafood

4. Did you drink any...

a. Alcohol? (probe for any new or local alcoholic drinks like beer or wine)

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

- b. Juices? (probe for new or local juices)
 - c. Teas? (e.g., kombucha, herbal)
 - d. Milk? (probe for unpasteurized sources)
5. Did you use any local spice blends?

III. Employment

Thank you for telling us about your experiences so far. We know this is a long discussion so we appreciate your patience. We will now talk a little bit about where you might have worked or volunteered outside your home in the 3 months before you became ill. Even though we are moving on to a different topic, you can feel free to tell us at any point if there is something you might have forgotten to tell us earlier.

1. Did you work or volunteer outside your home during the 3 months before you became ill? How would you describe your work environment (Was it dusty or clean? Was it a warehouse or office building)?
2. What kind of work did you do? Describe what your typical day was like.
 - a. Welding
 - b. Factory work
 - c. Farm/garden
 - d. Office work
3. Did you work in areas that had a lot of:
 - a. Dust?
 - b. Sawdust or other small particles?
 - c. Chemicals around the area?
4. Did you interact with many people around you while working?
 - a. How many people did you typically interact with daily?
 - b. Do you remember if any of these people were typically healthy or at all ill?
5. Were there any birds or other animals nesting in areas where you were working?
6. Were there many insects in the area where you worked?

IV. Leisure activities/hobbies

Now we will talk about how you spend your free time. This can include any hobbies or pastimes you might have. Could we quickly go around the room and talk about how you spent your free time in the 3 months before you became sick? [Limit to 2 minutes per person]

1. Do you like to spend time outdoors? If so, tell me what that looked like during the 3 months before you got sick when you were not traveling. For example, did you do any:
 - a. Hunting

Interviewer: _____

Date: _____

Time: _____ AM/PM

Location: _____

Focus Group #: _____

- i. Location of activity:
 - ii. Frequency of activity:
 - iii. How many other people were involved and how often?:
 - b. Bird watching
 - i. Location of activity:
 - ii. Frequency of activity:
 - iii. How many other people were involved and how often?:
 - c. Hiking
 - i. Location of activity:
 - ii. Frequency of activity:
 - iii. How many other people were involved and how often?:
 - d. Gardening
 - i. Location of activity:
 - ii. Frequency of activity:
 - iii. How many other people were involved and how often?:
 - e. Fishing
 - i. Location of activity:
 - ii. Frequency of activity:
 - iii. How many other people were involved and how often?:
 - f. Any other outdoor activities that you might think of?
2. Now I'd like to discuss time you've spent around animals. First, I am going to ask if any of you had a variety of different exposures. Please say yes or raise your hand if you had the exposure. Then we will talk about some of them in more detail. Did you spend time with or were around any of the following:
 - a. Household pet, even if you didn't touch it (cat, dog, rabbit)
 - b. Farm animals
 - c. Wild Birds (birdbath, birdfeeder, waterfowl watching or hunting)
 - d. Other wild animals (e.g., deer hunting)
 - e. Did you visit any areas with animals, such as farms, petting zoos, gardens or green spaces?
 - f. Mice, rats (such as handling a mousetrap)
 - g. Did you find insects in or around your home or anywhere you might have spent a lot of time during this period? Did you get any insect bites? Did a pet have insect bites, such as from fleas or ticks?
 - h. Any other animal exposures you'd like to share?
3. Did you go to any social gatherings or regular meet-ups with friends or family? This could be on a routine basis (like you go play cards every Saturday night) or gatherings that you might have attended for special occasions.
 - a. What did you do during these gatherings? Where were they?
 - b. What did you eat?

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

- c. What did you drink?
- d. Did you smoke any tobacco or other products?
- e. Do you consume any tobacco or illicit products?
4. Did you keep any plants or flowers around the house, either inside or outside?
 - a. What kind of plants? (Probes: from where, newly acquired?, did patient plant or re-pot them)
 - i. Did you have any seasonal plants? (this can include things like cacti, poinsettias, Christmas tree, Easter lilies...)
 - b. How did you take care of these plants? (e.g., water, re-pot them, give plant food or fertilizer if needed)
 - c. Were there cut flowers in your home?
 - i. Were these plants/flowers from your garden or somewhere else?
 - ii. Were the plants/flowers delivered? (probe for source)
 - d. Were there cut flowers or plants anywhere else you spent time? This could be at work, in a hospital, at a family member's home, etc.

V. Health and wellness activities

Thank you for sharing your experiences with us so far. We know this is a long discussion so we appreciate your patience. I know we have talked a lot in the past about your medical care before you got sick. Now we're going to ask you about some wellness activities and some other activities in the 3 months before you became ill. Even though we are moving on to a different topic, you can feel free to tell us at any point if there is something you might have forgotten to tell us earlier.

1. Did you receive any massages during this time?
2. Did you receive acupuncture?
3. Did you receive any other health-related treatments that you did not get from your physician's office? (like alternative or holistic medicine?)
 - a. Did you go to a pain clinic?
 - b. Did you take anything, or receive any injections, to help with your health that you did not receive at your physician's office?
4. Did you ever visit a sauna or hot tub?
5. Did you take any products or supplements for your health and wellness, such as...
 - a. Probiotics
 - b. Herbal teas
 - c. Other supplements or vitamins
6. Did you do anything for exercise during this time?
 - a. What do you do for exercise? Where do you exercise?
 - b. Did you attend any gyms or exercise classes? What kind of classes did you attend, if any?
 - c. Did you ever visit a swimming pool or water park?

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

7. Did you use a neti-pot?

VI. Any visitation periods/ travel

Let's now talk about any travel you might have had or times when someone (such as a family member or friend) came to visit you during the 3 months before you became ill. For the purpose of our conversation, travel is anywhere outside your home where you stayed for the day, or overnight. This could include routine travel or travel for special occasions.

1. Did you travel during the 3 months before you became ill?
 - a. Where did you go? When?
 - b. For how long did you travel during each of these trips?
2. Did anyone visit you during the 3 months before you became ill?
 - a. Who visited you?
 - b. How long did they visit you? (Were these regular visits?)

For each travel or visitation period, ask the following:

3. What was the purpose of your travel / visitation period (if visited by someone)?
 - a. Visit family
 - b. Vacation
 - c. Work
 - d. Event
4. Who did you see during this travel / visitation period?
 - a. What was the occupation of these people?
 - b. Did anyone have much contact with **[especially probe for people with outdoor occupations and grandchildren]**:
 - i. Dirt or soil?
 - ii. Plants?
 - iii. Insects?
 - iv. Animals?
 - v. Manure?
 - vi. Chemicals?
5. How did you spend your time? (prompts: dining out, shopping, spa, gym, outdoor activities)
 - a. Did you participate in any outdoor activities?
 - i. Hunting
 - ii. Bird watching
 - iii. Hiking
 - iv. Gardening
 - v. Fishing
 - b. Did you spend time with animals? This includes time spent around household pets or farm animals, as well as visiting a petting zoo or aquarium.

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

- i. What animals did you interact with? (e.g., dog, cat, fish in fish tank, exotic animals)
- ii. Tell me more about time spent with this animal.
- c. Did you go to any social gatherings or events with family or friends?
- d. Where did you eat or drink on these trips... (restaurant, family/friend house, brought food from home)
 - i. Did you have any...
 1. Local or home brews of alcohol beverages (e.g., beer, wine)
 2. Homemade beverages, such as sodas or teas
 3. Fermented drinks, like kefir
 4. Local dairy products, like milk, cheese, or yogurt?
 5. Local produce, like fruits or vegetables?
 6. Meats?
 - a. Game meats obtained through hunting
 - b. Meats obtained from butcher or grocery store
 - c. Processed meats, like sausages or meat sticks?
- e. Did you smoke or spend time with people who were smoking tobacco or other products? Smoking includes cigarettes, e-cigarettes, pipes, cigars, and water pipes, often called hookahs.
(if yes - what were they smoking?, where? Who was smoking if it wasn't the patient?)

VII. Miscellaneous

1. Did it snow in the 3 months before you became ill? If so, did you or someone else shovel snow from around where you live? If so, did you or they use any products to treat ice, like gravel, salt, or kitty litter?
2. How did you heat your home?
 - a. Did you have central heat?
 - b. Did you use a wood stove, pellet stove, or fireplace? If so, what did you burn in the fireplace?
3. Did you go anywhere else, either inside or outside (e.g., neighbor or friend's home, outside next to fire pit), with another source of heat?
2. Did you have any home deliveries during the 3 months before you became ill?
 - a. Regular delivery of medicines or other items?
 - b. Special deliveries of gifts or ordered items?
 - c. Did you receive any deliveries of flowers?
 - d. Did you receive deliveries of fruit or nuts from anywhere? (probe for Tree Ripe fruit)
Specifically: pecans, oranges, grapefruit, tangelos, honeybells, blueberries, peaches
 - e. Do you remember which company might have delivered these items (fedex, ups, usps)?
3. Did you take any free samples of items, such as foods, drinks lotions, soaps from any stores or through the mail during the 3 months before you got sick?

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

Thank you again for all of your responses. We so appreciate all of your patience. As you might know, we have talked to a lot of people and spent a lot of time trying to figure out what is causing people to become ill with this infection. We are still looking for clues as to what happened. Could you all briefly tell me what YOU think might have caused you to become sick?

[Limit this to < 5 minute discussion.]

[COLLECT ACTIVITY SHEETS BEFORE EVERYONE LEAVES.]

Undetermined Mode of Transmission: Zika Virus among Utah Community Members, 2016

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Household Member Log

Household ID								
Home Address								
Street address: _____								
City: _____ State: _____ Zip: _____ County: _____								
(Best way to contact them in the future) Phone: _____ or e-mail: _____								
<i>List first and last name for each person who meets definition of a Household Resident and verify that they have been at this address for the last month.</i>								
Can you tell me the names of all the people who stayed in your house for at least two nights per week since mid-June (June 15) until now?								
No.	Name of Resident	Age (*Record in complete months if child <2 years)		Sex	Record of consent for INTERVIEW	Date interview conducted	Record of consent for SPECIMENS	Specimens collected
01			<input type="radio"/> years <input type="radio"/> months	<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> Consent obtained <input type="radio"/> Consent refused <input type="radio"/> Parental consent provided <input type="radio"/> Parental consent refused <input type="radio"/> Person never reached		<input type="radio"/> Consent obtained <input type="radio"/> Consent refused <input type="radio"/> Parental consent provided <input type="radio"/> Parental consent refused <input type="radio"/> Person never reached	<input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> None
02			<input type="radio"/> years <input type="radio"/> months	<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> Consent obtained <input type="radio"/> Consent refused <input type="radio"/> Parental consent provided <input type="radio"/> Parental consent refused <input type="radio"/> Person never reached		<input type="radio"/> Consent obtained <input type="radio"/> Consent refused <input type="radio"/> Parental consent provided <input type="radio"/> Parental consent refused <input type="radio"/> Person never reached	<input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> None
03			<input type="radio"/> years <input type="radio"/> months	<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> Consent obtained <input type="radio"/> Consent refused <input type="radio"/> Parental consent provided <input type="radio"/> Parental consent refused <input type="radio"/> Person never reached		<input type="radio"/> Consent obtained <input type="radio"/> Consent refused <input type="radio"/> Parental consent provided <input type="radio"/> Parental consent refused <input type="radio"/> Person never reached	<input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> None
04			<input type="radio"/> years <input type="radio"/> months	<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> Consent obtained <input type="radio"/> Consent refused <input type="radio"/> Parental consent provided <input type="radio"/> Parental consent refused <input type="radio"/> Person never reached		<input type="radio"/> Consent obtained <input type="radio"/> Consent refused <input type="radio"/> Parental consent provided <input type="radio"/> Parental consent refused <input type="radio"/> Person never reached	<input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> None

Community Evaluation Questionnaire

HH ID: _____

Interviewer Information

Interviewer Name (First, Last): _____

State/Local/Territorial Health Department: _____

Language survey was conducted in: _____

Informant Information Not applicable

If not the specific individual, who is providing information for this form?

HH ID Number: _____

Relationship to resident: _____

Reason individual unable to provide information him/herself:

Child Mentally handicapped Other: _____

Exposures

Now I would like to ask you about your time outdoors or potential exposure to mosquitoes.

Since June 15, 2016, how much time on average have you spent outdoors each day?

less than 1 hour 1-4 hours 5-10 hours more than 10 hours Don't know

How often did you wear mosquito repellent when you were outdoors for 15 minutes or more?

Always Most of the time Sometimes Never Don't know

Since June 15, 2016, did you get any mosquito bites?

Yes No Don't know

For windows and outside doors that you have left open this summer, how many of these have screens?

None 1-2 3-4 5-10 More than 10

None 1-2 3-4 5-10 More than 10

Resident's Travel and Potential Flavivirus exposure

Now I would like to ask you about if you might have been exposed to Zika virus or related viruses before.

Did you travel outside the United States (or to a US territory: Puerto Rico, USVI, Am Samoa) in the last year (since July 2015)? Yes No

If yes: Name of country(s): _____

Dates of travel: Start date: ___/___/___ End date: ___/___/___

Name of country(s): _____

Dates of travel: Start date: ___/___/___ End date: ___/___/___

Name of country(s): _____

Dates of travel: Start date: ___/___/___ End date: ___/___/___

Name of country(s): _____

Dates of travel: Start date: ___/___/___ End date: ___/___/___

Name of country(s): _____

Dates of travel: Start date: ___/___/___ End date: ___/___/___

Name of country(s): _____

Dates of travel: Start date: ___/___/___ End date: ___/___/___

Were you born or lived for several years outside the United States? Yes No

Unknown

If yes, where? _____

Medical Information			
<p>Since June 15, 2016, have you had any of these symptoms? We are talking about symptoms that would have been new for you, not long standing problems?</p>			
Fever	<input type="radio"/> Yes	<input type="radio"/> No	If yes, first date with this ____/____/____ How many days did it last? _____ <i>(Note, here we would count their report of subjective fever. Interviewer, please use calendar aid)</i>
Rash	<input type="radio"/> Yes	<input type="radio"/> No	If yes, first date with this ____/____/____ How many days did it last? _____ <i>(here we are NOT asking about a rash that was just on one arm or one leg, like poison ivy)</i>
Conjunctivitis (redness of the white part of the eyes)	<input type="radio"/> Yes	<input type="radio"/> No	If yes, first date with this ____/____/____ How many days did it last? _____ <i>(here we are NOT asking about red, itchy eyes that you may know you get because of allergies)</i>
Joint Pain	<input type="radio"/> Yes	<input type="radio"/> No	If yes, first date with this ____/____/____ How many days did it last? _____ <i>(here we are NOT asking about pain that was definitely from an injury)</i>
For this illness, did you go to a clinic/hospital to be checked? <input type="radio"/> Yes <input type="radio"/> No If yes, what did the doctor/nurse decide that you had? _____			
<i>((Use this additional space if more than one episode, or additional notes))</i>			
For females age ≥ 12 years and < 45 years: Are you pregnant or think you might be pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Information related to blood specimens and interpretation of results			
If NO blood specimen is consented for. Thank you again for your willingness to provide the information. If we have any additional questions, is it okay to contact you again? <input type="radio"/> Yes <input type="radio"/> No (If yes, verify contact details on household list)			
If blood specimen is consented for, complete specimen collection form, and ask these additional questions: We would like to ask you just a few more questions about your health so we can better understand your blood test results.			
To the best of your knowledge, have you ever received these vaccines (these are vaccines that may be given to persons who travel out of the country)			
Yellow fever vaccine	<input type="radio"/> No	<input type="radio"/> Unsure	<input type="radio"/> Yes, year of last dose _____
Japanese encephalitis vaccine	<input type="radio"/> No	<input type="radio"/> Unsure	<input type="radio"/> Yes, year of last dose _____
Tick-borne encephalitis vaccine	<input type="radio"/> No	<input type="radio"/> Unsure	<input type="radio"/> Yes, year of last dose _____
Has your doctor told you that you have any medical conditions that limit your ability to fight infections? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Are you taking any medications that suppress your immune system? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
In the past 2 months, did you receive a blood transfusion or organ transplant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			

For this last question, we will ask you to read it and point to the answer.

In the last year, have you ever had unprotected sex with someone who had recently returned from a country where Zika has been spreading? (By recently returned, we mean your partner had returned sometime during the 2 months *before* the time you had unprotected sex)

Your Answer Yes

No

Unknown

Thank you very much for your willingness to answer these questions and provide a blood sample.

We will next contact you directly about your results of the blood test. It may take several weeks to get the final results.

Healthcare Personnel Risk Assessment Questionnaire and Serosurvey for Zika Virus Exposure—Utah, 2016

Public reporting burden of this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

ID _____

**Zika Virus Exposure Assessment for
Healthcare Personnel**

Date of interview:

Name of interviewer:

Subject name:

Job Title:

Is contact information correct?

If no, please provide

Address:

Phone:

Where was interview administered (circle one)?

Wellness clinic

Phone

Home

Other (please specify) _____

Has sample been collected?

Yes

No

Not indicated at this time

Case or Control (circle one)

ID _____

Section 1: Demographics, Role-----

1. Gender Male Female

2. Age _____ years

3. Please indicate your job title at this facility

Laboratory staff Environmental services Nurse Radiology tech

Physician/Advanced Care Provider Respiratory therapy Certified nursing assistant/Health care assistant

Other (please specify) _____

4. How long have you been working in your current role (at any facility)? _____ months/years

Section 2: Risks and symptoms-----

Country of origin:

Have you lived outside of the US? Yes No

If yes, what countries have you lived in and when did you live there?

Country	Start date	End date

Travel history (past year)

Region/country	Start date (XX/XX/XXXX)	End date (XX/XX/XXXX)
Mexico		
Cape Verde		
Caribbean (please specify) _____		
Puerto Rico		
Central America (please specify) _____		
Pacific Islands (please specify) _____		
South American (please specify) _____		
Africa (please specify) _____		
Asia (please specify) _____		

Vaccination history

Previous vaccinations: Yellow Fever Last dose: Tick-borne Encephalitis Last dose: Japanese Encephalitis Last dose:

Pregnancy

Are you or your partner currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test (group A)
Are you or your partner trying to become pregnant now?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test (group A)

ID _____

Are you or your partner planning to become pregnant in the next 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test
---------------------------------------------------------------------------	-------------------------------------------------------------------------------------------	--------------

Symptoms (developed since patient interaction)

Fever <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____ <input type="checkbox"/> Subjective <input type="checkbox"/> Measured (Max measured temperature: _____ F/C)	Rash <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____ Type: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Other Pruritic: <input type="checkbox"/> Yes <input type="checkbox"/> No Distribution: _____
Arthralgia <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____	Conjunctivitis <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____

Do they have 2 or more symptoms occurring within one week?

If no	<input type="checkbox"/> Asymptomatic
If yes	<input type="checkbox"/> Symptomatic

If symptomatic, are you currently symptomatic or have been symptomatic in the past 14 days?

<input type="checkbox"/> No	
<input type="checkbox"/> Yes	Call Dr. Rubin for further instructions

If symptomatic, were symptoms more than 14 days ago?

<input type="checkbox"/> No	
<input type="checkbox"/> Yes	If yes, test (group B)

Section 4: PPE training-----

Have you received training on proper selection of PPE for standard precautions? Yes No

Have you received training on how to don:

Gloves? Yes No

Gown? Yes No

Eye protection? Yes No

Have you received training on how to doff (so as not to contaminate):

Gloves? Yes No

Gown? Yes No

Eye protection? Yes No

How often does this training occur? _____

When did you last receive training? _____

Were you required to demonstrate competency? Yes No

Healthcare Personnel Risk Assessment Questionnaire and Serosurvey for Zika Virus Exposure—Utah, 2016

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

ID _____

**Zika Virus Exposure Assessment for
Healthcare Personnel**

Date of interview:

Name of interviewer:

Subject name:

Job Title:

Is contact information correct?

If no, please provide

Address:

Phone:

Where was interview administered (circle one)?

Wellness clinic

Phone

Home

Other (please specify) _____

Has sample been collected?

Yes

No

Not indicated at this time

Case or Control (circle one)

ID _____

Section 1: Demographics, Role-----

1. Gender Male Female

2. Age _____ years

3. Please indicate your job title at this facility

Laboratory staff Environmental services Nurse Radiology tech

Physician/Advanced Care Provider Respiratory therapy Certified nursing assistant/Health care assistant

Other (please specify) _____

4. How long have you been working in your current role (at any facility)? _____ months/years

Section 2: Risks and symptoms-----

Country of origin:

Have you lived outside of the US? Yes No

If yes, what countries have you lived in and when did you live there?

Country	Start date	End date

Travel history (past year)

Region/country	Start date (XX/XX/XXXX)	End date (XX/XX/XXXX)
Mexico		
Cape Verde		
Caribbean (please specify) _____		
Puerto Rico		
Central America (please specify) _____		
Pacific Islands (please specify) _____		
South American (please specify) _____		
Africa (please specify) _____		
Asia (please specify) _____		

Vaccination historyPrevious vaccinations: Yellow Fever Last dose: Tick-borne Encephalitis Last dose: Japanese Encephalitis Last dose:**Pregnancy**

Are you or your partner currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test (group A)
Are you or your partner trying to become pregnant now?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test (group A)

ID _____

Are you or your partner planning to become pregnant in the next 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test
---------------------------------------------------------------------------	-------------------------------------------------------------------------------------------	--------------

Symptoms (developed since patient interaction)

Fever <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____ <input type="checkbox"/> Subjective <input type="checkbox"/> Measured (Max measured temperature: _____ F/C)	Rash <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____ Type: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Other Pruritic: <input type="checkbox"/> Yes <input type="checkbox"/> No Distribution: _____
Arthralgia <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____	Conjunctivitis <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____

Do they have 2 or more symptoms occurring within one week?

If no	<input type="checkbox"/> Asymptomatic
If yes	<input type="checkbox"/> Symptomatic

If symptomatic, are you currently symptomatic or have been symptomatic in the past 14 days?

<input type="checkbox"/> No	
<input type="checkbox"/> Yes	Call Dr. Rubin for further instructions

If symptomatic, were symptoms more than 14 days ago?

<input type="checkbox"/> No	
<input type="checkbox"/> Yes	If yes, test (group B)

Section 3: Patient Interaction-----

Days with any patient interaction?

6/19 6/20 6/22 6/23 6/24 6/25

Site interaction occurred <input type="checkbox"/> ER <input type="checkbox"/> ECU <input type="checkbox"/> Ward <input type="checkbox"/> ICU <input type="checkbox"/> Other _____	
<input type="checkbox"/> Patient care <input type="checkbox"/> Device reprocessing <input type="checkbox"/> Environmental cleaning <input type="checkbox"/> Food service needs <input type="checkbox"/> Other (please specify) _____	
Did you enter patient's room or care area? Yes No	If yes, then low
Did you touch patient? Yes No	If yes, then medium and test (group B)
Did you (circle all that apply): Have any contact with blood or body fluids? Clean up vomit? Clean up stool? Draw blood? Collect urine sample or empty Foley bag? Collect stool sample? Wipe away sweat? Wipe away tears? Suction or manipulate airway? Place Foley? Place or manipulate rectal tube? Reposition the patient? Bathe the patient? Change linens? Perform physical exam? Perform radiology exam or Echo? Device reprocessing? Perform procedure (please specify)? _____	If any circled, then high and test (group B)
Cumulative time in room in hours < 1 hour 1 to 2 hours 59 minutes 3 to 5 hours 59 minutes 6 or more hours	

Did you have any contact with blood or body fluids? Yes No

Body fluid	What were you doing?	Was this protected (PPE)?	What PPE did you typically wear?	Did you have visible soilage of PPE?	Areas of contact (pick all that apply)?
Blood # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected <input type="checkbox"/> Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Respiratory # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected <input type="checkbox"/> Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Stool # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected <input type="checkbox"/> Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____

Body fluid	What were you doing?	Was this protected (PPE)?	What PPE did you typically wear?	Did you have visible soilage of PPE?	Areas of contact (pick all that apply)?
Urine # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Vomit # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Tears # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____

Body fluid	What were you doing?	Was this protected (PPE)?	What PPE did you typically wear?	Did you have visible soilage of PPE?	Areas of contact (pick all that apply)?
Sweat # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Other (Please specify) <hr/> # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Other (Please specify) <hr/> # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____

Were you involved with any procedures (either performing or in room)?		
Intubation	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Central line placement	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Bronchoscopy	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
CPR	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Sputum induction	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Extubation	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Airway suctioning	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Nasogastric tube placement	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Nebulizer treatment	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Dialysis	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Rectal tube placement or manipulation	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Arterial line placement	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Peripheral IV placement	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Noninvasive ventilation	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Lumbar puncture	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____

ID _____

Other (please specify) _____	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
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Did you come into contact with body following death? Yes No

Did you have any other contact with the patient not previously mentioned?

Section 4: PPE training-----

Have you received training on proper selection of PPE for standard precautions? Yes No

Have you received training on how to don:

Gloves? Yes No

Gown? Yes No

Eye protection? Yes No

Have you received training on how to doff (so as not to contaminate):

Gloves? Yes No

Gown? Yes No

Eye protection? Yes No

How often does this training occur? _____

When did you last receive training? _____

Were you required to demonstrate competency? Yes No

Hepatitis A: Supplemental Case Questionnaire

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Section 1: Interviewer information (Questions 1-3 to be completed by interviewer prior to questionnaire administration)

1. Date of Interview: ____ / ____ / ____ (if unknown, enter 99/99/9999)
M M D D Y Y Y Y

2. Interviewer Information:

a. Name: _____

b. Contact phone number: (____) _____ - _____

c. Agency or Organization: _____

3. Respondent was: Self Parent Spouse Other (Specify): _____

MAVEN ID: _____

Section 2: Food Recall

1. In the period 15 to 50 days before you became ill, did you eat at a Sushi Restaurant A location in Hawaii?

(This date must be on or before August 15, 2016. If a later date is provided, ask about dates on or before August 15.)

Yes No Unknown

****If No or Unknown, proceed to QUESTION #7

2. If yes, at which Sushi Restaurant A location or locations did you eat? (ask each location)

- Aina Hana, Honolulu
- Ala Moana Center, Honolulu
- Ewa Town Center, Ewa
- Kaneohe, Kaneohe
- Kapahulu, Honolulu
- Kapolei Commons, Kapolei
- Pearlridge Center, Uptown
- Waialele Center, Waipahu
- Waiiau, Pearl City
- Ward Center, Honolulu
- Kukui Grove Shopping Center, Lihue

Other (write in location) _____

Don't know

Refused

3. What were the date(s) of your most recent visit(s) to Sushi Restaurant A within this period?

4. Did you eat raw or undercooked fish or seafood while at Sushi Restaurant A during this period?

Yes No Unknown

5. If yes, did you eat scallops?

Yes No Unknown

6. Did you eat scallops anywhere besides Sushi Restaurant A in the 15 to 50 days before becoming ill?

Yes No Unknown

*****If No or Unknown, proceed to QUESTION #9*

7. Were the scallops raw or undercooked?

Yes No Unknown

8. Where did the scallops come from? (Please specify restaurant/store name and location)

_____ Unknown

9. Did you eat at a potluck in the 15 to 50 days before becoming ill?

Yes No Unknown

*****If No or Unknown, proceed to End of Survey Instructions.*

10. Did you eat raw or undercooked fish or seafood at the potluck?

Yes No Unknown

*****If No or Unknown, proceed to End of Survey Instructions.*

11. Did you eat scallops at the potluck?

Yes No Unknown

****If No or Unknown, proceed to End of Survey Instructions.

12. Were these scallops raw or undercooked?

Yes No Unknown

13. Where did the potluck scallops come from? (Please specify restaurant/store name and location)

_____ Unknown

Notes from call:

Data Entry By: _____

CASE INTERVIEW FORM

CDC ID:

Date: //2016

Data collector initials: _____

1. Last Name _____ First Name _____

2. **Unit:**

3. **Room:**

4. **DOB:** //

Foodborne disease outbreak questionnaire

Part I. Demographics:

1. Age: _____ Sex _____ (M/F)	2. Race (check all that apply) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> American Indian or Alaska Native</td> <td><input type="checkbox"/> Asian</td> </tr> <tr> <td><input type="checkbox"/> Black or African American</td> <td><input type="checkbox"/> White</td> </tr> <tr> <td><input type="checkbox"/> Native Hawaiian/other Pacific Islander</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Other race</td> <td></td> </tr> </table>	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian/other Pacific Islander	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other race		3. Ethnicity: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Hispanic or Latino</td> </tr> <tr> <td><input type="checkbox"/> Not Hispanic or Latino</td> </tr> <tr> <td><input type="checkbox"/> Unknown</td> </tr> </table>	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Unknown
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian												
<input type="checkbox"/> Black or African American	<input type="checkbox"/> White												
<input type="checkbox"/> Native Hawaiian/other Pacific Islander	<input type="checkbox"/> Unknown												
<input type="checkbox"/> Other race													
<input type="checkbox"/> Hispanic or Latino													
<input type="checkbox"/> Not Hispanic or Latino													
<input type="checkbox"/> Unknown													

4. When were you admitted to this detention center? Date: ____ / ____ / ____ (MM/DD/YY)

5. Do you help in the kitchen? Yes / No

6. Do you help serve the food on the food cart? Yes / No

Part II. Clinical information: We're going to ask you some questions about your symptoms when you got sick.

7. Have you had any symptoms of gastrointestinal illness during the week of July 10th, 2016? Yes / No
8. What day did your symptoms begin: _____ / ____ / ____ / 2016 (example: Tuesday MM/DD)
9. Please circle when you began feeling sick:

1 AM	7 AM	1 PM	7 PM
2	8	2	8
3	9	3	9
4	10	4	10
5	11	5	11
6 AM	12 Noon	6 PM	12 Midnight

10. Did you have any of the following symptoms during the week of July 10th, 2016?:

Symptom	Yes/ No/Unknown	Onset Date	Resolution date	Notes
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/2016	////////////////////	
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/2016	___/___/2016	If yes, what is the largest number of episodes you had in a 24 hour period ? _____
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/2016	___/___/2016	If yes, what is the largest number of episodes you had in a 24 hour period ? _____ Did you provide a stool sample? <input type="checkbox"/> Yes <input type="checkbox"/> No
Bloody Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/2016	////////////////////	If yes, what is the largest number of episodes you had in a 24 hour period ? _____
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/2016	___/___/2016	Highest temperature, if measured _____°C or _____°F
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/2016	////////////////////	
Abdominal pain/cramping	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/2016	////////////////////	
Other:_____		___/___/2016	////////////////////	

11. Did you seek medical care at the medical unit? Yes / No
 - a. When? Date___ / ___ / 2016 Time___:___ AM/ PM
12. Did you receive any medications? Yes / No
13. If yes, specify: _____
14. Were any of your cube/room/bunk mates vomiting or having diarrhea during those days? Yes / No

Part III. Food: Now we are going to ask your some questions about the foods that you ate on July 9 through July 12. We know that it may be difficult to remember what you ate a month ago, but please try to answer these questions as best as you can.

- 15. Did you eat food from the food cart on Saturday, July 9? Yes / No
- 16. Did you eat a special meal on Saturday, July 9? Yes / No
- 17. If yes, specify:_____
- 18. Did you eat food from the food cart on Sunday, July 10? Yes / No
- 19. Did you eat a special meal on Sunday, July 10? Yes / No
- 20. If yes, specify:_____
- 21. Did you eat food from the food cart on Monday, July 11? Yes / No
- 22. Did you eat a special meal on Monday, July 11? Yes / No
- 23. If yes, specify:_____
- 24. Did you eat food from the food cart on Tuesday, July 12? Yes / No
- 25. Did you eat a special meal on Tuesday, July 12? Yes / No
- 26. If yes, specify:_____

27. Please place an X next to any food item the inmate ate on any of these days:

CDC ID:

Saturday, July 9		Sunday, July 10		Monday, July 11		Tuesday, July 12	
Breakfast		Breakfast		Breakfast		Breakfast	
Grits		Oatmeal		Grits		Fruit Drink	
Breakfast Sausage		Scrambled Egg		Biscuit		Oatmeal	
Pancake Square		Oven Brown Potatoes		Sausage		Scrambled Eggs	
Margarine		Biscuit		Gravy		O'Brien potatoes	
Maple Syrup		Margarine		Lyonnais Potatoes		Biscuit	
Dairy Drink		Jelly		Margarine		Margarine	
		Dairy Drink		Dairy Drink		Jelly	
						Dairy Drink	
Lunch		Lunch		Lunch		Lunch	
Cheese Slice		Ham		Turkey Bologna		Cheese Slice	
Turkey Salami		Lettuce/Cabbage Salad		Creamy Cole Slaw		Turkey Salami	
Pasta Salad		Bread		Bread		Marinated Vegetable Salad	
Bread		Mustard		Mustard		Bread	
Mustard		Salad Dressing		Cookie Square		Mustard	
Cookie Square		Cookie square		Fruit Drink		Cookie Square	
Fruit Drink		Fruit Drink				Fruit Drink	
Dinner		Dinner		Dinner		Dinner	
Roast Turkey		Chicken Patty		Italian Meat Sauce		Chili Con Carne	
Poultry Gravy		Rice Pilaf		Spaghetti Noodles		Plain rice	
Mashed Potatoes		Seasoned Carrots		Seasoned Green Beans		Seasoned Cabbage	
Seasoned Mixed Vegetables		Cornbread		Garlic Bread		Cornbread	
Cornbread		Margarine		Dessert Bar		Margarine	
Margarine		Brownie		Sweet tea		Sweet Tea	
Frosted cake		Sweet Tea					
Sweet Tea							

28. Do you purchase food from the canteen? Yes / No

CDC ID:

If yes, please indicate which foods you ate on July 9 through July 12.	
Jalapeno cheese packets	
Honey bun glazed	
Honey bun iced	
Jalapeno pretzel pieces	
Dill pickle	
Hot pickle	
Beef & cheese stick	
Hickory beef stick	
BF summer sausage	
Hot sausage	
Hot BF summer sausage	
Tuna in pouch	
Mayonnaise packet	
BBQ sauce 1.25oz	
Peanut butter pkt	
Ranch dressing 1.5oz	
Grape jelly pkt	
Chex mix	
Trail mix	
Salted peanuts	
Strawberry cheese claw	
Cinnamon roll	
Chocolate cupcakes	
Banana pudding cupcake	
Donut sticks	
Instant grits 12CT	
Oatmeal pkts	
Nutty bar	
Oatmeal cream pie	
Brownie	
Pop-tarts – Strawberry	
Granola bar	
Peanut butter crème	
Duplex crème	
Strawberry crème	
Chocolate crème cookies	
Toastchee	
Jalapeno cheddar cracker	
Grill cheese cracker	
Saltine crackers	
S.F. wafers – vanilla	
S.F wafers – chocolate	
Cheetos	
Krispie treat	
Chocolate moon pie	
Snack crackers	
Banana moon pie	
Chocolate chip cookies	
Salt & vinegar chips 1oz	
Jalapeno cheese puffs 1oz	
BBQ chips	
Plain chips	
BBQ corn chips	

Nacho cheese chips	
Cheddar & sour cream (chips) 1oz	
Buffalo chips	
Voodoo chips	
BBQ pork skins	
Cheez-its	
White cheddar popcorn	
Cheese curls – 10oz	
Spicy hot chips 5.5oz	
Ridged potato chips 5.5oz	
GF 5.5oz BBQ chips	
Salsa verde tortilla chips	
Sour cream & onion chips 5.5oz	
Chicken cup-a-soup	
Shrimp cup-a-soup	
Beef cup-a-soup	
Chili soup	
Beef soup	
Lime chili shrimp soup	
Chicken soup	
Cajun chicken soup	
Oriental soup	
Spam (pouch)	
Mackerel fillet – 3.53oz	
Flour tortilla	
Sardines n hot sauce	
Loaded mashed potatoes	
Chicken breast – 3oz	
Sweet & salty nut mix 2oz	
Iced oatmeal cookies	

Now, I will ask you more questions about what you ate and drank during July 9-12th. Try to remember and answer as best as you can.

- 29. Was any of the food you ate undercooked? Yes / No / Don't Know
- 30. If yes, Specify: _____
- 31. Did you eat any food that was not provided on the food cart or in the canteen? Yes / No
- 32. Specify: _____
- 33. If yes, where was that food obtained?
- 34. Specify: _____
- 35. Did you drink any beverages that were not provided on the food cart or in the canteen? Yes / No
- 36. Specify: _____
- 37. If yes, where was that drink obtained?
- 38. If yes, Specify: _____
- 39. Did you eat any leftover food from the food cart from previous days? Yes / No
- 40. If yes, Specify: _____
- 41. If yes, do you remember when you got that food? ____/____ (MM/DD)
- 42. Did you prepare any food in your room (e.g. "spread")? **Yes / No**
- 43. If yes, specify: _____
- 44. Did you share the food that you prepared in your barracks with anyone else? Yes / No
- 45. If yes, specify: _____
- 46. Do you have any food allergies? **Yes / No**
- 47. If yes, specify: _____
- 48. Are there any foods that you refuse to eat here? **Yes / No**
- 49. If yes, specify: _____
- 50. What time do you typically eat? Breakfast _____AM Lunch _____AM / PM Dinner: _____ PM
Other _____

Part IV. Handwashing Practices

- 51. Do you typically wash your hands? Yes / No
- 52. How many times per day do you usually wash your hands? _____
- 53. Can you tell me when you wash your hands? (*keep prompting for additional responses*)

- 54. Do you have your own soap? Yes / No
- 55. Do you use soap every time you wash your hands? Yes / No

Part V.

Notes: (*Add any comments not specifically asked on questionnaire*)

CASE INTERVIEW FORM

CDC ID:

Date: //

Data collector initials: _____

1. Last Name _____ First Name _____

2. **Unit:**

3. **Room:**

4. **DOB:** //

Foodborne disease outbreak questionnaire

Screening question for controls

Between Saturday, July 9th and Tuesday, July 19th, did you experience any vomiting or diarrhea, which we define as three or more loose stools in a 24 hour period?

YES / NO

If, yes: Thank you for participating. That is the only information that we need to collect.

If no: Thank you. Now we would like to collect some background information.

Part I. Demographics:

1. Age: _____ Sex _____(M/F)	2. Race (check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> Other race <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown	3. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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4. When were you admitted to this detention center? Date: ____ / ____ / ____

5. Do you help in the kitchen? Yes / No

6. Do you help serve the food on the food cart? Yes / No

Part II. Illnesses

14. Were any of your cube/room/bunk mates vomiting or having diarrhea during the week of July 10th? Yes / No

CDC ID _____

Part III. Food: Now we are going to ask you some questions about the foods that you ate on July 9 through July 12. We know that it may be difficult to remember what you ate a month ago, but please try to answer these questions as best as you can.

7. Did you eat food from the food cart on Saturday, July 9? Yes / No
8. Did you eat a special meal on Saturday, July 9? Yes / No
9. If yes, specify:_____
10. Did you eat food from the food cart on Sunday, July 10? Yes / No
11. Did you eat a special meal on Sunday, July 10? Yes / No
12. If yes, specify:_____
13. Did you eat food from the food cart on Monday, July 11? Yes / No
14. Did you eat a special meal on Monday, July 11? Yes / No
15. If yes, specify:_____
16. Did you eat food from the food cart on Tuesday, July 12? Yes / No
17. Did you eat a special meal on Tuesday, July 12? Yes / No
18. If yes, specify:_____

CDC ID _____

19. Please place an X next to any food item the inmate ate on any of these days:

Saturday, July 9		Sunday, July 10		Monday, July 11		Tuesday, July 12	
Breakfast		Breakfast		Breakfast		Breakfast	
Grits		Oatmeal		Grits		Fruit Drink	
Breakfast Sausage		Scrambled Egg		Biscuit		Oatmeal	
Pancake Square		Oven Brown Potatoes		Sausage		Scrambled Eggs	
Margarine		Biscuit		Gravy		O'Brien potatoes	
Maple Syrup		Margarine		Lyonnaise Potatoes		Biscuit	
Dairy Drink		Jelly		Margarine		Margarine	
		Dairy Drink		Dairy Drink		Jelly	
						Dairy Drink	
Lunch		Lunch		Lunch		Lunch	
Cheese Slice		Ham		Turkey Bologna		Cheese Slice	
Turkey Salami		Lettuce/Cabbage Salad		Creamy Cole Slaw		Turkey Salami	
Pasta Salad		Bread		Bread		Marinated Vegetable Salad	
Bread		Mustard		Mustard		Bread	
Mustard		Salad Dressing		Cookie Square		Mustard	
Cookie Square		Cookie square		Fruit Drink		Cookie Square	
Fruit Drink		Fruit Drink				Fruit Drink	
Dinner		Dinner		Dinner		Dinner	
Roast Turkey		Chicken Patty		Italian Meat Sauce		Chili Con Carne	
Poultry Gravy		Rice Pilaf		Spaghetti Noodles		Plain rice	
Mashed Potatoes		Seasoned Carrots		Seasoned Green Beans		Seasoned Cabbage	
Seasoned Mixed Vegetables		Cornbread		Garlic Bread		Cornbread	
Cornbread		Margarine		Dessert Bar		Margarine	
Margarine		Brownie		Sweat tea		Sweet Tea	
Frosted cake		Sweet Tea					
Sweet Tea							

Now, I will ask you more questions about what you ate and drank during July 9-12th. Try to remember and answer as best as you can.

- 20. Was any of the food you ate undercooked? Yes / No / Don't Know
- 21. If yes, Specify: _____
- 22. Did you eat any food that was not provided on the food cart or in the canteen? Yes / No
- 23. Specify: _____
- 24. If yes, where was that food obtained?
- 25. Specify: _____
- 26. Did you drink any beverages that were not provided on the food cart or in the canteen? Yes / No
- 27. Specify: _____
- 28. If yes, where was that drink obtained?
- 29. If yes, Specify: _____
- 30. Did you eat any leftover food from the food cart from previous days? Yes / No
- 31. If yes, Specify: _____
- 32. If yes, do you remember when you got that food? ____/____ (MM/DD)
- 33. Did you prepare any food in your room (e.g. "spread")? **Yes / No**
- 34. If yes, specify: _____
- 35. Did you share the food that you prepared in your barracks with anyone else? Yes / No
- 36. If yes, specify: _____
- 37. Do you have any food allergies? **Yes / No**
- 38. If yes, specify: _____
- 39. Are there any foods that you refuse to eat here? **Yes / No**
- 40. If yes, specify: _____
- 41. What time do you typically eat? Breakfast _____AM Lunch _____AM / PM Dinner: _____ PM
Other _____

Part IV. Handwashing Practices

- 42. Do you typically wash your hands? Yes / No
- 43. How many times per day do you usually wash your hands? _____
- 44. Can you tell me when you wash your hands? (*keep prompting for additional responses*)

- 45. Do you have your own soap? Yes / No
- 46. Do you use soap every time you wash your hands? Yes / No

Part V.

Notes: (*Add any comments not specifically asked on questionnaire*)
