# Infant Botulism Investigation Form

**Texas Department of State Health Services**
**Infectious Disease Control Unit**
**1100 West 49th Street, T801**
**Austin, Texas 78756**
**(512) 458-7676 (512) 458-7616 fax**

## PERSONAL DATA

Patient name: _____ Birth date: _____/_____/_____ Sex: _____
Race: ____ W=White; B=Black/African American; N=American Indian/Alaska Native; P=Native Hawaiian/Pacific Islander; A=Asian; O=Other; U=Unknown
Ethnicity: ____ H=Hispanic or Latino; N=not Hispanic or Latino; U=Unknown
Patient address: _____ Patient phone: (_____)_____
Hospital name: _____ Hospital phone: (_____)_____
Physician name: _____ Physician phone: (_____)_____
Physician address: _____
Mother's occupation: _____ Father's occupation: _____
What was infant's birth weight? ____ (lb) ____ (oz) ____ (gm)
Was infant premature? ☐ Yes ☐ No ☐ Unknown
If yes, gestational age: _____ weeks Type of delivery: ☐ Vaginal ☐ C-Section

## DIETARY HISTORY (BEFORE ONSET OF PRESENT ILLNESS)

PRESENT ILLNESS—INFANT BOTULISM (Defined as onset of constipation or if no constipation when mother says child became ill)

Before onset of present illness:
Was infant ever breast fed? ☐ Yes ☐ No If yes, for how many weeks? _____
Was infant ever formula fed? ☐ Yes ☐ No If yes, formula with iron? ☐ Yes ☐ No
Was infant primarily (more than 50%):
Breast fed? ☐ Yes ☐ No Formula fed? ☐ Yes ☐ No Fed both approximately equally? ☐ Yes ☐ No
Did infant ever eat or taste (before onset of illness):

| Food/Liquid | Never | Once or a few times | Many times | Daily or most days | Principal type or brand (please describe) |
|---|---|---|---|---|---|
| formula | ☐ | ☐ | ☐ | ☐ | |
| cow's milk | ☐ | ☐ | ☐ | ☐ | |
| fruit juices | ☐ | ☐ | ☐ | ☐ | |
| cereal | ☐ | ☐ | ☐ | ☐ | |
| bread | ☐ | ☐ | ☐ | ☐ | |
| syrup/water | ☐ | ☐ | ☐ | ☐ | |
| honey/water | ☐ | ☐ | ☐ | ☐ | |
| sugar/water | ☐ | ☐ | ☐ | ☐ | |
| tea/water | ☐ | ☐ | ☐ | ☐ | |
| fruits, cooked | ☐ | ☐ | ☐ | ☐ | |
| fruits, raw | ☐ | ☐ | ☐ | ☐ | |
| vegetables, cooked | ☐ | ☐ | ☐ | ☐ | |
| vegetables, raw | ☐ | ☐ | ☐ | ☐ | |
| home-canned foods | ☐ | ☐ | ☐ | ☐ | |
| baby foods, jars | ☐ | ☐ | ☐ | ☐ | |
| other, specify: _____ | ☐ | ☐ | ☐ | ☐ | |

Did the infant use a pacifier? ☐ Often ☐ Sometimes ☐ Rarely ☐ No
If Yes, was it ever dipped in: ☐ Syrup ☐ Honey ☐ Other ☐ Nothing

**PHYSICAL FINDINGS**

| SIGNS: (*are typical) | YES | NO | UNK |
|---|---|---|---|
| a) *Loss of facial expression | ☐ | ☐ | ☐ |
| b) *Ptosis | ☐ | ☐ | ☐ |
| c) Extraocular muscle palsies | ☐ | ☐ | ☐ |
| d) Pupils: | | | |
| a. *dilated | ☐ | ☐ | ☐ |
| b. constricted | ☐ | ☐ | ☐ |
| c. *sluggish reactivity | ☐ | ☐ | ☐ |
| e) Trouble swallowing | ☐ | ☐ | ☐ |
| f) *Constipation | ☐ | ☐ | ☐ |
| g) Diarrhea | ☐ | ☐ | ☐ |
| h) *Altered cry | ☐ | ☐ | ☐ |
| i) *Weak sucking | ☐ | ☐ | ☐ |
| j) *Muscle weakness | | | |
| a. poor head control | ☐ | ☐ | ☐ |
| b. upper extremities | ☐ | ☐ | ☐ |
| c. lower extremities | ☐ | ☐ | ☐ |
| d. "floppy" | ☐ | ☐ | ☐ |

| SIGNS: (cont'd) | YES | NO | UNK |
|---|---|---|---|
| k) Knee deep tendon reflex | | | |
| a. absent | ☐ | ☐ | ☐ |
| b. depressed | ☐ | ☐ | ☐ |
| l) *Somnolent | ☐ | ☐ | ☐ |
| m) Irritable | ☐ | ☐ | ☐ |
| n) Fever | ☐ | ☐ | ☐ |
| o) Dehydration | ☐ | ☐ | ☐ |
| p) *Respiratory difficulty | ☐ | ☐ | ☐ |
| q) Respiratory arrest | ☐ | ☐ | ☐ |
| r) Pneumonia | ☐ | ☐ | ☐ |
| s) Other: _____ | ☐ | ☐ | ☐ |

**DIAGNOSTIC TESTS**

Laboratory results:

a) Spinal tap performed? ☐ Yes ☐ No

*(Normal in botulism, myasthenia gravis; protein may be elevated in Guillain-Barré)*

| Date (Normal range) | RBC's (0) | WBC's (<10) | Protein (15-45 mg%) | Glucose (50-70 mg%) | Other |
|---|---|---|---|---|---|
| ____/____/____ | _____ | _____ | _____ | _____ | _____ |
| ____/____/____ | _____ | _____ | _____ | _____ | _____ |

b) Tensilon test *[Negative in botulism and Guillain-Barré, positive in myasthenia gravis. After administration of Tensilon (edrophonium chloride) the patient's eye signs (ptosis & extraocular abnormalities) markedly decrease.]*

Date: _____ Result: ☐ Positive ☐ Negative ☐ Equivocal ☐ Not done

c) EMG results (electromyography): *[(Botulism: action potential diminished after a single supramaximal stimulus, facilitation with repetitive stimuli at 20-50/sec) (Myasthenia gravis: similar to botulism) (In Guillain-Barré: slowed nerve conduction, whereas there is normal conduction in botulism)]*

| Date | Nerve Stimulated | Stimulated Frequency | Not done | Amplitude (Circle One) | Facilitation |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | increase / decrease | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | increase / decrease | ☐ Yes ☐ No |

**CURRENT SYMPTOMS**

Mother first noted infant was ill on _____ at _____ weeks of age.
(mm/dd/yyyy)

First symptom: _____

Second symptom: _____

The initial visit to a physician was on _____ at _____ weeks of age.
(mm/dd/yyyy)

The infant was hospitalized on _____ at _____ weeks of age.
(mm/dd/yyyy)

| Symptoms noted before patient hospitalized: | YES | NO | UNKNOWN |
|---|---|---|---|
| Constipation: _____ (mm/dd/yyyy) | ☐ | ☐ | ☐ |
| Poor feeding | ☐ | ☐ | ☐ |
| Altered cry | ☐ | ☐ | ☐ |
| Irritable | ☐ | ☐ | ☐ |
| Poor head control | ☐ | ☐ | ☐ |
| General weakness | ☐ | ☐ | ☐ |
| Difficulty breathing | ☐ | ☐ | ☐ |
| Fever | ☐ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ | ☐ |

If infant had constipation, how many bowel movements were occurring?

- ☐ Two or more per day
- ☐ One per day
- ☐ One every other day
- ☐ Two to three per week
- ☐ One per week
- ☐ Less than one per week
- ☐ Other

**PHYSICIAN/HOSPITAL DATA**

_____ _____ _____
Physician Name | Physician Address | Physician Phone

_____ _____ _____
Physician Name | Physician Address | Physician Phone

_____ _____ _____/_____/_____ _____/_____/_____
Hospital Name | Medical Record # | Date Admitted | Date Discharged

_____
Hospital Address

_____ _____ _____/_____/_____ _____/_____/_____
Hospital Name | Medical Record # | Date Admitted | Date Discharged

_____
Hospital Address

**TREATMENT**

Respiratory assistance needed? ☐ Yes ☐ No ☐ Unknown If yes, number of days: _____
Oxygen only? ☐ Yes ☐ No Tracheostomy? ☐ Yes ☐ No
Intubation? ☐ Yes ☐ No Ventilator? ☐ Yes ☐ No

Infant feeding: feeding tube? ☐ Yes ☐ No ☐ Unknown If yes, number of days: _____

| Antibiotics given | Route (circle one) | Dose (gms/day) | Duration (days) | Date started (mm/dd) |
|---|---|---|---|---|
| _____ | Oral / Parenteral | _____ | _____ | _____ |
| _____ | Oral / Parenteral | _____ | _____ | _____ |
| _____ | Oral / Parenteral | _____ | _____ | _____ |
| _____ | Oral / Parenteral | _____ | _____ | _____ |

Was antitoxin given? ☐ Yes ☐ No ☐ Unknown If yes, route? ☐ I.V. ☐ I.M. ☐ Both ☐ Unknown
If yes, how many c.c. total (Connaught adult 10cc/vial, Connaught ped. 2cc/vial): _____total cc
Other specific therapeutic medication given: _____

Patient outcome: ☐ Improving ☐ Recovered ☐ Died If patient died: _____/_____/_____
Date of Death

**ENVIRONMENTAL HISTORY**

Was there any construction, excessive dust, or environmental change around the home from birth of infant until onset of present illness (infant botulism)?
☐ Yes ☐ No ☐ Unknown

If yes, describe:
_____

_____

Was parent(s) involved in gardening or yard work from birth of infant until onset of present illness?
☐ Yes ☐ No ☐ Unknown

If yes, describe:
_____

_____

Did infant remain away from home for more than 1 week prior to onset of present illness?
☐ Yes ☐ No ☐ Unknown

If yes, describe:
_____

_____

**SUBMITTER**

Reported by: _____ Phone: (_____)_____ Date Reported: ____/____/____

Investigated by: _____ Investigation Start Date: ____/____/____

Agency: _____ Phone: (_____)_____

Stock Number EF59-11344
Revised date 05/16/2007