Yersiniosis Case Report

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

PATIENT

Name: _____ _____ _____
Last First MI

Address: _____ _____
Street City

_____ _____ _____ (_____)_____
County State Zip Code Phone #

DOB: _____/_____/_____ **Age:** _____ **Sex:** _____ **Occupation:** _____

Race: _____ W=White; B=Black/African American; N=American Indian/Alaska Native; P=Native Hawaiian/Pacific Islander; A=Asian; O=Other; U=Unk

Ethnicity: _____ H=Hispanic or Latino; N=not Hispanic or Latino; U=Unknown

If patient is a child:

Mother's name: _____ **Mother's occupation:** _____

Father's name: _____ **Father's occupation:** _____

SYMPTOMOTOLOGY

Has patient had bloody or severe diarrhea?

(circle) YES NO

If YES, onset date: _____/_____/_____

Duration of symptoms: _____

Check all that apply:

- ☐ Fever (Highest temp _____.___°F)
- ☐ Bloody diarrhea
- ☐ Non-bloody diarrhea
- ☐ Vomiting
- ☐ Poor feeding
- ☐ Abdominal cramps
- ☐ Chills
- ☐ Nausea
- ☐ Headache
- ☐ Irritable

If patient had diarrhea, how many loose stools per day?

☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ 10+

LAB DATA

Name/address of laboratory:

_____

_____

_____

Specimen source:

- ☐ Stool/feces
- ☐ Blood
- ☐ Other

Specify: _____

Collection date: ____/_____/_____

Results: _____

_____

***Y. enterocolitica* isolated? (circle)**

YES NO

LINKAGE

Prior to and immediately after onset, was the patient:

Associated with another case?

YES NO

If YES, identify case:

_____

_____

Associated with an outbreak?

YES NO

TREATMENT

Was the patient ill enough to require a doctor visit? YES NO **Physician visit date:** _____/_____/_____

Was the patient hospitalized? YES NO **Admission date:** _____/_____/_____ **Discharge date:** _____/_____/_____

Was the patient treated with antibiotics? YES NO **Antibiotics start date:** _____/_____/_____

Which antibiotic(s)? _____

Patient outcome: ☐ Survived ☐ Died **Date of death:** _____/_____/_____

EXPOSURE DATA

If patient is an infant or toddler, is the child: ☐ **Breast fed** ☐ **Formula fed** ☐ **Both**

If formula fed, which brand(s) did the child consume in the 10 days before onset: _____

_____

Please indicate whether the patient ate any of the following food items in the 10 days before onset:

☐ **Bacon** ☐ **Cooked sausage** ☐ **Chorizo** ☐ **Chitterlings** ☐ **Lunch meats** ☐ **Pork chops** ☐ **Ham**

☐ **Barbecued pork** ☐ **Hot dogs** ☐ **Tofu** ☐ **Other pork:** _____

What raw or uncooked fruits or vegetables did the patient eat in the 10 days before onset? _____

_____

_____

Did the patient consume unpasteurized milk or dairy products in the 10 days before onset? YES NO

If YES, please identify: _____

Other Potential Risk Factors (Please check all that apply):

☐ **Exposure to untreated water**

☐ **Contact with pet(s). Type(s) of animal(s):** _____

☐ **Contact with other animals. Type(s) of animal(s):** _____

☐ **Contact with animal waste**

☐ **Blood transfusion prior to illness onset. Date of transfusion:** _____/_____/_____

☐ **Travel 10 days prior to illness onset. Date(s) and destination(s):** _____

_____

☐ **Underlying medical conditions or immunocompromised. Explain:** _____

_____

What restaurants or fast food places did the patient eat at in the 10 days before onset?

Restaurant	Date

What grocery store(s) did the patient/patient's parents shop at during the 10 days before onset?

Store	Date

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

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

Agency: _____ **Phone: (_____)**_____