NJDOH INFANT BOTULISM INVESTIGATION WORKSHEET MR #: _____ CDRSS #: _____

Demographics

Patient Last Name	First Name	DOB:	Phone number
		____ / ____ / ____	
Address		**City**	**Municipality**

Ethnicity
- ○ Hispanic
- ○ Non-Hispanic
- ○ Unknown

Race
☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown

Guardian Name	Guardian phone number

Clinical Status

Was the patient hospitalized because of this illness?
○ Yes ○ No ○ Unknown

Hospital: _____

Admitted: _____ / _____ / _____ Discharged: _____ / _____ / _____

Did the patient die because of this illness?
○ Yes ○ No ○ Unknown

If yes, specify date of death: _____ / _____ / _____

Treating physician

Name:
Address:
Phone: Fax:
Email:

Lab contact information

Name of lab:
Point of contact at lab:
Address:
Phone: Fax:
Email:

Select a response for each sign or symptom below and include onset/resolution dates

Sign/Symptom	Response	Onset Date	Resolution Date
Constipation	○ Yes ○ No ○ Unk.		
Decreased suck	○ Yes ○ No ○ Unk.		
Difficulty feeding	○ Yes ○ No ○ Unk.		
Hypotonia	○ Yes ○ No ○ Unk.		
Lethargy	○ Yes ○ No ○ Unk.		
Droopy eyes	○ Yes ○ No ○ Unk.		
Paralysis	○ Yes ○ No ○ Unk.		
Sensory deficit	○ Yes ○ No ○ Unk.		
Weakness	○ Yes ○ No ○ Unk.		
Weak cry	○ Yes ○ No ○ Unk.		

Other signs/symptoms (specify):

Risk Factors			
Did the baby consume honey?	○ Yes	○ No	○ Unk.
Does patient's household member work in construction?	○ Yes	○ No	○ Unk.
Is patient's home near a construction site?	○ Yes	○ No	○ Unk.

Describe any YES responses:

Diagnostic Testing

Provide any information on pertinent diagnostic testing:

Additional Case Notes