## **Typhoid and Paratyphoid Investigation form**

			NICIA	
NCIMS ID			NSW GOVERNMENT	Health
Notification date	1 1		3372141112111	
Treating doctor consent to interview case obtained	Yes □ No □	Date of consent:	/ /	
Case (or proxy) consent to conduct interview obtained	Yes □ No □	Date of consent:	/ /	
Name of person interviewed (if not case)				
Interviewer name				
Database details finalised	Yes □ No □	Date:	/ /	

Typhoid fever (Salmonella Typhi) and Paratyphoid fever (Salmonella Paratyphi A, B, and C excluding Paratyphi B biovar Java)

ATTEMPTS TO CONTACT TREATING DOCTOR AND CASE					
Date	Time	Comments			

SECTION 1: DEMOG	RAPHIC DATA			
Surname:				
Other names:				
Street Address:				
Suburb/Town:		Postcode:		
Talanhana	Home: V	Vork:		
Telephone:	Mobile:			
Date of Birth:	/ / or Ag	_		
		Of Aboriginal or Torres Strait Islander origin?		
Country of Birth:		No		
Language(s) spoken at		Aboriginal		
home:		Torres Strait Islander		
		Both Aboriginal and Torres Strait Islander		
		Unknown		
		Olikilowii		
Interpreter required:	☐ Yes ☐ No			
Occupation:				
Name / Address of Employer or School or Child Care Attended:				
	Telephone:	Contact Person:		
Date Last Attended:	1 1	High Risk group?* No  Yes Details:		
* High risk cases are food handlers, carers of patients, carers of children, carers of the elderly, children below primary school age, and those unable to maintain personal hygiene and their carers				
SECTION 2: TREATI	NG DOCTOR / HOSPITAI	FACILITY		
Name of treating doctor:				
Address:				
Telephone:		_ Fax:		
ED presentation :	☐ Yes ☐ No	Hospital name:		
Date of ED presentation: / /				
Admission to hospital:	☐ Yes ☐ No	Hospital name:		
Date of admission:	1 1	Date of discharge: / /		

# Typhoid and paratyphoid fever

## **Case Questionnaire**

SECTION 3: ILLNES	e (Slimmady)			
	S (SUMMART)			
Onset date of illness:		-	Date(s) of specimen collection:	
Specimen type:	☐ Blood ☐	Faeces 🗌 C	Other	(specify, e.g. urine)
Typhoid immunisation history (if known):				
Treatment (list antibiotic(s and treatment duration:	s)			
Signs & symptoms	Yes / No / Unkr	nown	Signs & symptoms	Yes / No / Unknown
Malaise	☐ Yes ☐ No ☐	Unk	Body aches	☐ Yes ☐ No ☐ Unk
Anorexia	☐ Yes ☐ No ☐	Unk	Diarrhoea	☐ Yes ☐ No ☐ Unk
Fever	☐ Yes ☐ No ☐	Unk	Constipation	☐ Yes ☐ No ☐ Unk
Headache	☐ Yes ☐ No ☐	Unk	Vomiting	☐ Yes ☐ No ☐ Unk
Cough	☐ Yes ☐ No ☐	Unk	Other (specify below): e.g. splenomegaly	☐ Yes ☐ No ☐ Unk
Rash / skin spots	☐ Yes ☐ No ☐	Unk		
Section 4: Risk Factors				
Incubation period				
	1	l	to	1 1
	ninus 60 days for typhoid lus 10 days for paratyph			minus 3 days for typhoid) ninus 1 day for paratyphoid)
Risk Factor	Applies	Details		
Travel – Domestic	☐ Yes ☐ No Places Visited:			
		Departure:		n:// Yes No
Travel – International	☐ Yes ☐ No		ed:	
		-	commodation:	
If Travel to endemic			// Return	
country within 28 days		Illness while	e away	Yes No
prior to symptom onset,				

Risk Factor	Applies	Details
Household / Close contact of person known to have travelled overseas?	☐ Yes ☐ No	Relationship:
Household / Close contact of person known to have typhoid infection or similar illness	<ul><li>☐ Yes ☐ No</li><li>☐ Yes ☐ No</li></ul>	Relationship:
Household / Close contact of person known to have paratyphoid infection or similar illness	<ul><li>☐ Yes ☐ No</li><li>☐ Yes ☐ No</li></ul>	Relationship:  Case name:  Database ID No. (if confirmed):  Details:
Had previous typhoid/paratyphoid infection?	☐ Yes ☐ No	Approx. date://
Household / Close contact known to have had previous typhoid/paratyphoid infection?	☐ Yes ☐ No	Relationship:        //           Approx. date:        //
Drank untreated water?	☐ Yes ☐ No	Specify type:
Participated in swimming / water sports?	☐ Yes ☐ No	Activity:  Date ://  Type of water (e.g. pool, river, etc.):  Address:
Ate oysters / mussels?	☐ Yes ☐ No	Date:        /
Ate other shellfish?	☐ Yes ☐ No	Date:/  Type / Brand:  Where purchased:

Risk Factor	Applies	Details		
Ate imported foodstuffs?  (if in Australia during incubation period)	☐ Yes ☐ No			
Exposure to raw/untreated sewage?	☐ Yes ☐ No	Date:// Exposure/activity:	_	
SECTION 5: LOCAL I If the case was in Australia Section 6.			end any of the following?	If no, skip to
Incubation period				
	I	/ to	1 1	
	nus 60 days for typhoi us 10 days for paratyph		(Onset date minus 3 days for (Onset date minus 1 day for pa	
	Name an	nd address of premises	What was ea	ten?
Cofee an westerments				
Cafes or restaurants  yes no don't kno	w			
Takeaway / fast food outlets	<u> </u>			
yes no don't kno				
Parties or functions with fan or friends	nily			
yes no don't kno	w			
Festivals or commercial pub	olic			
gatherings (e.g. fetes, club social events, markets, etc.)				
yes no don't kno	w			
Continental deli or specialty grocer (e.g. Asian supermarket)				
yes no don't kno	w			
Farms or growers (farm gate sales or consumption of unprocessed products)	9			
yes no don't kno	w			

### SECTION 6: FOLLOW UP AND EXCLUSIONS FOR CASE

Exclude all cases from work, school, childcare and swimming pools until 48 hours after a course of antibiotics has been completed and symptoms have resolved.

- ‡ Exclusion until clearance required for high risk cases (food handlers, carers of patients, carers of children, carers of the elderly, children below primary school age, and those unable to maintain personal hygiene and their carers)
- § Clearance is defined as: 2 consecutive negative stool cultures. These must be taken under the following conditions (a) specimens collected ≥48 hours after cessation of antibiotic therapy, (b) individual specimens taken ≥48 hrs apart.

Tick box that describes case:  Food handler  Carer of patients, children, elderly, or individuals unable to maintain their own hygiene  Child below primary school age  Person unable to maintain own hygiene  OR  None of these  If one of the above high risk groups is selected, please provide the following information:				
Name / address of related premises / institution:		d:/		
Movements of case at work	k / institution / premise	98:		
Date:/	Day:	Hours: Location:		
Date:/	Day:	Hours: Location:		
Date:/	Day:	Hours: Location:		
Date:/	Day:	Hours: Location:		
Date://	Day:	Hours: Location:		
Exclusion required <sup>‡</sup> ?	☐ Yes ☐ No	It is required that if the case is in a high risk setting / occupation, they be excluded from attendance / work until cleared. § If possible, they may return to work to undertake other duties (not handling food or caring for people) once they have been free of symptoms for 48 hours and provided they are continent and can undertake adequate hygiene practices.		
Exclusion discussed with case / guardian / next-of-kin.	☐ Yes ☐ No			
Letter sent to contacts at premises?	☐ Yes ☐ No	Date sent:/		
Environmental Health inspection required?	☐ Yes ☐ No	Contact date:// Contact name:  Action required:  Feedback received: no yes,		
Clearance stools taken§	☐ Yes ☐ No	#1: / / Detected		

Clearance urine taken (urine samples required in addition to stool samples if case originally had:  •A positive urine culture  •Concurrent schistosomiasis •A history of kidney stones.)	#1:/ Detected  Not Detected #2:/ Detected  Not Detected
--	---

#### Typhoid and paratyphoid fever

#### **Case Questionnaire**

#### SECTION 7: FOLLOW UP (AND EXCLUSIONS) FOR HOUSEHOLD / TRAVEL COMPANIONS OF CASE

§ If contact has compatible symptoms, they need to be tested to exclude typhoid / paratyphoid. ‡ Exclusion and screening required for high risk contacts ‡ Clearance is defined as: 2 consecutive negative stool cultures. These specimens must be taken individually and ≥24hours apart. Relationship Symptoms? Results Name and contact details High risk status / exclusion<sup>‡</sup> Screening required<sup>‡</sup> to case Name: Household contact ☐ Yes§ Yes<sup>‡</sup> No Stool 1. High risk? Travel companion ☐ No ☐ Yes ☐ No If 'Yes" indicate Other | via GP (provide name Address: If 'Yes" specify below & record detail in and contact details) Stool 2. / / notes Food handler Phone: Carer of patients, children, elderly, or via Pathology service individuals unable to maintain their own (provide details) hygiene Child below primary school age Person unable to maintain own hygiene Notes: Relationship Symptoms? Results Screening required<sup>‡</sup> Name and contact details High risk status / exclusion<sup>‡</sup> to case Stool 1. Name: Household contact | Yes‡ | No ☐ Yes§ High risk? Travel companion ☐ No ☐ Yes □ No If 'Yes" indicate Other ☐ via GP (provide name Address: If 'Yes" specify below & record detail in and contact details) Stool 2. / / notes Food handler Phone: Carer of patients, children, elderly, or individuals unable to maintain their own ☐ via Pathology service (provide details) hygiene Child below primary school age Person unable to maintain own hygiene Notes:

Name and contact details	Relationship to case	Symptoms?	High risk status / exclusion <sup>‡</sup>	Screening required <sup>‡</sup>	Results
Name:  Address:  Phone:	Household contact Travel companion Other	☐ Yes <sup>§</sup> ☐ No	High risk?  Yes No  If 'Yes" specify below & record detail in notes Food handler Carer of patients, children, elderly, or individuals unable to maintain their own hygiene Child below primary school age Person unable to maintain own hygiene	☐ Yes <sup>‡</sup> ☐ No  If 'Yes" indicate ☐ via GP (provide name and contact details) ☐ via Pathology service (provide details)	Stool 1. / /  Stool 2 . / /
Notes:					
Name and contact details	Relationship	Symptoms?			l
Name and contact details	to case	Symptoms	High risk status / exclusion <sup>‡</sup>	Screening required <sup>‡</sup>	Results
Name:	<u> </u>	☐ Yes <sup>§</sup>	High risk status / exclusion <sup>‡</sup> High risk? ☐ Yes ☐ No	☐ Yes <sup>‡</sup> ☐ No  If 'Yes" indicate	Stool 1. / /
Name: Address:	to case  Household contact Travel companion	☐ Yes <sup>§</sup>	High risk?  Yes No  If 'Yes" specify below & record detail in notes	☐ Yes‡ ☐ No	
Name:	to case  Household contact Travel companion	☐ Yes <sup>§</sup>	High risk?  Yes No  If 'Yes" specify below & record detail in	☐ Yes <sup>‡</sup> ☐ No  If 'Yes" indicate ☐ via GP (provide name	Stool 1. / /

SECTION 8: EDUCATION		
Hygiene and preventing transi	mission discussed with case	
□ No	□ N/A	Yes
□ No	□ N/A	Yes
□ No	□ N/A	☐ Yes ☐ Yes, date sent: //
Name of completing officer:		
Signature:		
Date://		
INVESTIGATION NOTES		
	A44_1	vo invocationation about it
	Attach ext	ra investigation sheets if necessary