

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

Local ID Number _____

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

LISTERIOSIS CASE REPORT

Red boxes indicate required fields

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Other: _____	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	
Address Number & Street - Residence			Apartment/Unit Number		
City/Town			State	Zip Code	
Census Tract		County of Residence		Country of Residence	
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone/Pager		Work/School Telephone	
E-mail Address		Other Electronic Contact Information			
Work/School Location		Work/School Contact			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, Est. Delivery Date (mm/dd/yyyy)			
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 7)		Other Describe/Specify			
Occupation (see list on page 7)		Other Describe/Specify			
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

Ethnicity (check one)

Hispanic/Latino
Non-Hispanic/Non-Latino
Unk

Race* (check all that apply, race descriptions on page 7)

African-American/Black
American Indian or Alaska Native
Asian (check all that apply)
Asian Indian Japanese
Cambodian Korean
Chinese Laotian
Filipino Thai
Hmong Vietnamese
Other: _____

Pacific Islander (check all that apply)
Native Hawaiian Samoan
Guamanian
Other: _____

White
Other: _____

Unk

*Comment: self-identity or self-reporting
 The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

First three letters of
patient's last name:

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SIGNS AND SYMPTOMS					
<i>Symptomatic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Onset Date (mm/dd/yyyy)</i>		<i>Date First Sought Medical Care (mm/dd/yyyy)</i>		<i>Duration of Acute Symptoms (days)</i>
Note: For Signs and Symptoms listed below, please review medical records. This is necessary for proper case classification. If the patient was hospitalized, please provide copy of discharge summary.					
<i>Signs and Symptoms</i>	<i>Yes</i>	<i>No</i>	<i>Unk</i>	<i>If Yes, Specify as Noted</i>	
Meningitis					
Bacteremia / sepsis					
Febrile gastroenteritis				<i>If Yes, highest temperature (specify °F/°C)</i>	
Amnionitis					
Miscarriage / stillbirth					
Pneumonia (neonate)					
Granulomatosis infantisepticum (neonate)					
<i>Other signs / symptoms (specify)</i>					
PAST MEDICAL HISTORY					
<i>Was the patient pregnant at onset?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			<i>If Yes, weeks gestation</i>		
<i>Does the patient take any medications regularly?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			<i>If Yes, specify medication(s)</i>		
<i>Does the patient have any medical conditions? (i.e., renal disease, diabetes, immune compromising conditions)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			<i>If Yes, specify medical condition(s)</i>		
HOSPITALIZATION					
<i>Did patient visit emergency room for illness?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<i>Was patient hospitalized?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<i>If Yes, how many total hospital nights?</i>	
<i>If there were any ER or hospital stays related to this illness, specify details below.</i>					
HOSPITALIZATION - DETAILS					
<i>Hospital Name 1</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>
<i>Hospital Name 2</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>

First three letters of patient's last name:

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OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
If patient was pregnant, outcome of fetus? <input type="checkbox"/> Stillborn <input type="checkbox"/> Born alive but died within seven days <input type="checkbox"/> Alive, with complications <input type="checkbox"/> Alive and well		

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type <input type="checkbox"/> Blood* <input type="checkbox"/> CSF* <input type="checkbox"/> Placenta <input type="checkbox"/> Stool Other: _____	* If pregnancy-associated, specify if Blood or CSF specimen is from mother or neonate <input type="checkbox"/> Mother <input type="checkbox"/> Neonate		
Collection Date (mm/dd/yyyy)	Results	Laboratory Name	Telephone Number
Was result confirmed by local public health lab? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Result (including subtype)		Local Lab ID Number
Was isolate sent to state lab for serotyping confirmation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Result (including serotype)		State Lab ID Number
Was PFGE requested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Pattern 1 #	Pattern 2 #	CDC Cluster ID # (if known)

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 28 DAYS PRIOR TO ILLNESS ONSET

EXPOSURES / RISK FACTORS

If NEONATE / INFANT: Was listeriosis confirmed in mother? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, explain
If NEONATE: Did birth mother have febrile illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, explain

DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?

Food Item	Yes	No	Unk	If Yes, Specify as Noted
Cold cuts sliced at a deli, (e.g., turkey breast, ham, pastrami)				Type(s) Where purchased
Pre-packaged cold cuts				Type(s) Brand(s) Where purchased
Hot dogs				Type(s) Brand(s)
				Eaten right out of the package? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Refrigerated pâté or meat spreads, not canned				Type(s) Brand(s) Where purchased
Refrigerated, smoked, or cured seafood (e.g., salmon, whitefish, trout), not canned				Type(s) Brand(s) Where purchased
Raw (unpasteurized) milk				Type(s) Brand(s) Where purchased
Raw milk products				Type(s) Brand(s) Where purchased
Mexican-style fresh cheese (queso fresco) or cheese from a street vendor				Unpasteurized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Brand(s) Location(s) Where Cheese Obtained

(continued on page 4)

First three letters of patient's last name:

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Food Item	Yes	No	Unk	If Yes, Specify as Noted
Soft cheese (e.g., Brie, feta, Camembert, goat, blue)				<i>Type(s)</i> <i>Brand(s)</i> <i>Where purchased</i>
Ready-to-eat deli style salads (e.g., potato salad, pasta salad, tuna salad)				<i>Type(s)</i> <i>Brand(s)</i> <i>Where purchased</i>
Pre-prepared dips (e.g., hummus)				<i>Type(s)</i> <i>Brand(s)</i> <i>Where purchased</i>
Other food exposures of interest				<i>Specify food item(s)</i>

FOOD HISTORY - GROCERIES

WHERE DID PATIENT SHOP FOR GROCERIES? (INCLUDE FARMER'S MARKETS, DELIS, SWAP MEETS, ETC.)

<i>Store / Location 1</i>	<i>Address / Cross-streets</i>		
	<i>City</i>	<i>State</i>	
<i>Store / Location 2</i>	<i>Address / Cross-streets</i>		
	<i>City</i>	<i>State</i>	
<i>Store / Location 3</i>	<i>Address / Cross-streets</i>		
	<i>City</i>	<i>State</i>	

FOOD HISTORY - OUTSIDE HOME

Did the patient consume food or drink prepared outside of the home during the incubation period?
Yes No Unk

If Yes, specify name of place (e.g., restaurant, concession stand, friend's house, etc.), location, date, and items consumed below.

FOOD HISTORY - OUTSIDE HOME - DETAILS

<i>Name of Place 1</i>	<i>Location (city, state)</i>		<i>Date (mm/dd/yyyy)</i>
	<i>Items Consumed</i>		
<i>Name of Place 2</i>	<i>Location (city, state)</i>		<i>Date (mm/dd/yyyy)</i>
	<i>Items Consumed</i>		
<i>Name of Place 3</i>	<i>Location (city, state)</i>		<i>Date (mm/dd/yyyy)</i>
	<i>Items Consumed</i>		
<i>Name of Place 4</i>	<i>Location (city, state)</i>		<i>Date (mm/dd/yyyy)</i>
	<i>Items Consumed</i>		

First three letters of patient's last name:

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TRAVEL HISTORY

Did patient travel outside county of residence during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates below.
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TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

ILL CONTACTS

Any contacts with similar illness (including household contacts)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify details below.
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ILL CONTACTS - DETAILS

Name 1	Age	Gender	Telephone Number		Type of Contact / Relationship		
	Street Address				Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)	
	City		State	Zip Code	Exposure Event		

Name 2	Age	Gender	Telephone Number		Type of Contact / Relationship		
	Street Address				Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)	
	City		State	Zip Code	Exposure Event		

NOTES / REMARKS

First three letters of
patient's last name:

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REPORTING AGENCY			
Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			
EPIDEMIOLOGICAL LINKAGE			
Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number		
DISEASE CASE CLASSIFICATION			
Case Classification (see case definition below) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect			
Neonatal or Non-Neonatal* <input type="checkbox"/> Neonatal <input type="checkbox"/> Non-Neonatal	*Note that infected pregnant women and/or their infected offspring are to be designated as "Neonatal" cases.		
Nosocomial or Community Acquired <input type="checkbox"/> Nosocomial <input type="checkbox"/> Community acquired	Specify if Foodborne <input type="checkbox"/> Foodborne		
OUTBREAK			
Part of known outbreak? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, extent of outbreak <input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
Mode of Transmission <input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	Vehicle of Outbreak	Pattern 1 ID number	Pattern 2 ID number
STATE USE ONLY			
State Case Classification <input type="checkbox"/> Confirmed <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information			
CASE DEFINITION			
<u>LISTERIOSIS (2010)</u>			
CLINICAL DESCRIPTION In adults, invasive disease caused by <i>Listeria monocytogenes</i> manifests most commonly as meningitis or bacteremia; infection during pregnancy may result in fetal loss through miscarriage or stillbirth, or neonatal meningitis or bacteremia. Other manifestations can also be observed.			
LABORATORY CRITERIA FOR DIAGNOSIS A. Isolation of <i>L. monocytogenes</i> from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid) B. In the setting of miscarriage or stillbirth, isolation of <i>L. monocytogenes</i> from placental or fetal tissue			
CASE CLASSIFICATION - Confirmed: A clinically compatible case that is laboratory-confirmed			
COMMENT The usefulness of other laboratory methods such as fluorescent antibody testing or polymerase chain reaction to diagnose invasive listeriosis has not been established.			

RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • Adult film actor/actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker 	<ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other/unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent/guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Volunteer • Other • Refused • Unknown