# Botulism Testing Request

## Screening Worksheet

### Patient Information

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>(Last)</th>
<th>(First)</th>
<th>(M.I.)</th>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Age</th>
<th>Gender</th>
<th>Male / Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County of Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Occupation or School, Day Care</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Patient’s Parent/ Guardian if patient is a minor</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Exposure Information (non-infant cases)

- Does patient have a history of consuming home canned food products? [Y] [N] [U]
  
  If yes, date and time consumed: ________________

- Does patient have a history of consuming a fresh, contaminated wound or injection drug use during past 2 weeks? [Y] [N] [U]
  
  If yes, describe _____________________________________________

- Has patient consumed ____________________________ product? [Y] [N] [U]
  
  If yes, date and time consumed: ________________

### Clinical Information

- Hospital or Clinic providing care
  
  Hospitalized? [Yes] [No] [Unk]
  
  Admission Date (mm/dd/yyyy)

- Physician's Name
  
  Office Telephone ( )

- Symptoms:
  
  Onset of illness (date & time of first symptoms)

### Non-Infant (Foodborne, Wound, other)

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>U</th>
</tr>
</thead>
</table>

- Descending paralysis
- Difficulty breathing
- Muscle weakness
- Double Vision
- Dizziness
- Blurred Vision
- Nausea
- Drooping eyelids
- Abdominal cramps
- Slurred speech
- Vomiting
- Dry mouth
- Diarrhea
- Difficulty swallowing
- Fever (highest temp. ________________)

### Infant Botulism

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>U</th>
</tr>
</thead>
</table>

- Constipation
- Poor feeding
- Lethargic
- Pooled oral secretions
- Weakness
- Poor muscle tone (especially in neck)
- Drooping eyelids
- Descending paralysis
- Altered or weak cry
- Fever (highest temp. ________________)

### Clinical Diagnostic Tests

- Which of the following tests have already been performed? [Y] [N] Pending Result(s)
  
  - CSF examination
    
    CSF protein _________ mgm%
    
    WBC total
  
  - Electromyography (EMG)
    
    BSAP noted?
  
  - Brain scan
  
  - Tension test

### Treatment

- Has anti-toxin been requested or given? [□] Requested [□] Given
  
  Date: ________________
  
  Date: ________________

- Has patient been intubated? [Yes] [No]
  
  Date: ________________

Please fax completed worksheet to WDPH-CDES epidemiologist using secure fax: 608-261-4976.

Communicable Diseases & Epidemiology Section

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