** Ontario Infant Botulism Investigation Tool**

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| **Legend** | **for interview with case ♦ System-Mandatory ❖ Required Personal Health Information** |

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| **Cover Sheet***Note that this page can be autogenerated in iPHIS* | | |
| Date Printed: YYYY-MM-DD  Bring Forward Date: YYYY-MM-DD  iPHIS Client ID #:  Enter number **♦** Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **♦** Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **♦** Investigator:  **Enter name \_ \_** **♦** DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **♦** Branch Office:  Enter office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **♦** Reported Date: YYYY-MM-DD  **❖**Diagnosing Health Unit:  Enter health unit Tel. 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **♦** Disease: BOTULISM Type: Home Mobile Work  **♦** Is this an outbreak associated case? Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes, *OB #* ####-####-###  No, *link to OB # 0000-2005-004 in iPHIS*  Is the client in a high-risk occupation/ environment?  Yes, specify: Specify  No | **♦** Client Name:  **Enter name \_ \_**  Alias:  **Enter alias \_ \_** | |
| **♦** Gender: Select an option | **♦** Age: **Age** |
| **♦** DOB:YYYY-MM-DD  Address:  **Enter address \_**  **Enter address \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Tel. 1:  **###-###-####**  Type:  Home  Mobile  Work  **Other, specify**  Tel. 2:  **###-###-####**  Type:  Home  Mobile  Work  **Other, specify**  Email 1: **Enter email address \_ \_**  Email 2:  **Enter email address \_ \_** | |
| Is the client homeless?  Yes  No  New Address:  **Enter address \_**  **♦** Language:  **Specify \_ \_**  Translation required*?*  Yes  No  **Proxy respondent**  Name:  **Enter name \_ \_**  Parent/Guardian  Spouse/Partner  Other  **Specify \_ \_** | **♦** Physician’s Name: **Enter name \_ \_**  **♦** Role**:**  Attending Physician  Family Physician  Specialist  Walk-In Physician  Other  Unknown  **OPTIONAL**  Additional Physician’s Name: **Enter name \_**  Address:  **Enter address \_**  Tel:  **###-###-####**  Fax:  **###-###-####**  Role:  **Enter role \_ \_** | |

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| **Verification of Client’s Identity & Notice of Collection** |
| Client’s identity verified?  Yes, *specify*:  DOB  Postal Code  Physician  No |
| **Notice of Collection**  *Please consult with local privacy and legal counsel about PHU-specific Notice of Collection requirements under*  *PHIPA s. 16*. *Insert Notice of Collection, as necessary.* |

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| **Record of File** | | | | | |
| **♦ Responsible Health Unit** | **Date** | **♦ Investigator’s Name** | **Investigator’s Signature** | **Investigator’s Initials** | **Designation** |
|  | **❖**Investigation Start Date |  |  |  | ☐ PHI ☐ PHN  ☐ Other \_\_\_\_\_\_\_ |
|  | Assignment Date |  |  |  | ☐ PHI ☐ PHN  ☐ Other \_\_\_\_\_\_\_ |

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| **Call Log Details** | | | | | | | |
|  | **Date** | **Start Time** | **Type of Call** | **Call To/From** | | **Outcome**  **(contact made, v/m, text, email, no answer, etc.)** | **Investigator’s initials** |
| Call 1 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 2 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 3 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 4 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 5 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 6 |  |  | Outgoing  Incoming |  |  |  |  |
| Date letter sent: | | | | | | | |

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| **Case Details** | | | | | | | |
| **♦ Aetiologic Agent** | Clostridium Botulinum | | | | | | |
| **Subtype** | ☐ Toxin A ☐ Toxin E  ☐ Toxin B ☐ Toxin F  ☐ Spore A ☐ Spore E  ☐ Spore B ☐ Spore F  ☐ Other  ☐ Unspecified | | | **Further Differentiation** *Enter this selection in the ‘free text’ field in iPHIS* | | ☐ Infant | |
| **♦ Classification** | ☐ Confirmed ☐ Person Under Investigation  ☐ Probable ☐ Does Not Meet Definition  *Do not close case as PUI* | | | | | **♦ Classification Date** | YYYY-MM-DD |
| **♦ Outbreak Case Classification** | ☐ Confirmed ☐ Person Under Investigation  ☐ Probable ☐ Does Not Meet Definition  *Do not close case as PUI* | | | | | **♦ Outbreak Classification Date** | YYYY-MM-DD |
| **♦ Disposition** | ☐ Complete ☐ Closed- Duplicate-Do Not Use  ☐ Entered In Error ☐ Lost to Follow Up  ☐ Does Not Meet Definition ☐ Untraceable | | | | | **♦ Disposition Date** | YYYY-MM-DD |
| **♦ Status** | ☐ Closed | |  | | | **♦ Status Date** | YYYY-MM-DD |
| ☐ Open (re-opened) | |  | | | **♦ Status Date** | YYYY-MM-DD |
| ☐ Closed | |  | | | **♦ Status Date** | YYYY-MM-DD |
| **♦ Priority** | ☐ High | ☐ Medium ☐ Low | | | *(At health unit’s discretion)* | | |

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| **Lab specimens** | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Specimen Type  e.g., blood, stool,  gastric aspirate,  food | Collection Date | Result Date | Result | Comments | |  | YYYY-MM-DD | YYYY-MM-DD |  |  | |  | YYYY-MM-DD | YYYY-MM-DD |  |  | |  | YYYY-MM-DD | YYYY-MM-DD |  |  | |  | YYYY-MM-DD | YYYY-MM-DD |  |  | |

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| **Symptoms** | | | | | | | | | |
| The incubation period of infant botulism is unknown since the time of spore germination, growth and toxin production is unknown. It is suggested that investigations focus on the month prior to onset of illness in an attempt to investigate the source of botulism. | | | | | | | | | |
| **♦ Symptoms** | **♦ Response** | | | | | **❖ Use as Onset**  *(choose one)* | **❖ Onset Date**  YYYY-MM-DD | **Onset Time**  24-HR Clock  HH:MM  *(discretionary)* | **❖ Recovery Date**  YYYY-MM-DD  *(choose one)* |
| **Yes** | **No** | **Don’t Know** | **Not Asked** | **Refused** |
| Anorexia [loss of appetite] |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD |
| Constipation |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD |
| Eyelid(s), drooping |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD |
| Infant, loss of head control |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD |
| Infant, poor muscle tone |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD |
| Infant, weak cry |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD | |
| Lethargy |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD | |
| Paralysis |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD | |
| Respiratory Failure |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD | |
| Swallowing difficulty [dysphagia] |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD | |
| Weak |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD | |
| Other (specify) |  |  |  |  |  |  | YYYY-MM-DD | YYYY-MM-DD | YYYY-MM-DD | |
| ***Note: This list is not comprehensive. There are additional symptoms listed in iPHIS.*** | | | | | | | | | | |

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| ♦ **Complications** |
| None  Other  Unknown |

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| **Hospitalization & Treatment** *Mandatory in iPHIS only if admitted to hospital* | | |
| Did you bring your child to an emergency room? | Yes  No | If yes, Name of hospital:  Date(s): **YYYY-MM-DD** |
| **♦** Was your child admitted to hospital as a result of their illness (not including stay in the emergency room)? | Yes  No  Don’t recall | If yes, Name of hospital:  ♦ Date of admission:  ❖ Date of discharge:  client remains in hospital  Unknown discharge date |
| *→ For iPHIS data entry – if the case is hospitalized, enter information under* ***Cases > Case > Interventions.*** | | |
| Was antitoxin administered? | Yes  No  Don’t know | If yes, date given: |
| Treatment of infant botulism requires Botulism Immune Globulin, Intravenous (BIG-IV) or BabyBIG ®. This can only be obtained through Health Canada’s Special Access Program (SAP).  For more information on placing a request for BabyBIG ®refer to the [*Botulism – Guide for Healthcare Professionals*](http://www.health.gov.on.ca/en/pro/publications/disease/docs/botulism.pdf)  *Treatment information can be entered in iPHIS under* ***Cases > Case > Rx/Treatments>Treatment*** *as per current iPHIS User Guide* | | |

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| **Date of Onset, Age and Gender**  *Complete this section if submission of pages 5-8 to Public Health Ontario is required* | | | | | |
| Date of Onset: |  | Age: | **Age** | Gender: | Select an option | |

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| **Preliminary Questions** | **Response** | | | **Details** |
| **Yes** | **No** | **Unsure** |
| Do you have any idea how your child became sick? |  |  |  |  |
| Was your child on any specific diet(s) in the 3 days prior to the onset of their illness (e.g. vegetarian, vegan, gluten-free, kosher, halal, etc.)? |  |  |  |  |
| Did you attend any special functions with your child such as weddings, parties, showers, family gatherings or group meals in the 3 days prior to the onset of your child’s illness? |  |  |  |  |

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| **Food History** | | | | | | | | | | | |
| **In the four weeks before your child became ill, can you list all of the food items that you would routinely or typically provide your child on any given day?**  **Could you also list all of the food items that you fed your child in the month before your child became ill that you do not typically or routinely feed your child?** | | | | | | | | | | | |
| **Day** | | | **Food consumed** | | | | | | | | |
| **Typical Day** | | |  | | | | | | | | |
| **Non-routine food items** | | |  | | | | | | | | |
| **Behavioural Social Risk Factors** | | | | | **❖ Response** | | | | | | **Details**  *iPHIS character limit: 50.* |
| **Yes** | **No** | | **Unknown** | | **Not asked** |
| **❖** Commercial jarred baby food | | | | |  |  | |  | |  |  |
| **❖** Consumption of honey  (Specify unpasteurized vs. pasteurized) | | | | |  |  | |  | |  |  |
| **❖** Contact or exposure to soil/ dust | | | | | |  |  | |  | |  |  | | |
| Home renovations | |  |  | |  | |  |  | | |
| **❖**Lives near construction site | |  |  | |  | |  |  | | |
| Close proximity to farms where soil is being disturbed (house is dusty from land being disturbed) | |  |  | |  | |  |  | | |
| **❖** Cookies/biscuits | | | | | |  |  | |  | |  |  | | |
| **❖** Dry infant cereal | | | | | |  |  | |  | |  |  | | |
| **❖** Home prepared baby food | | | | | |  |  | |  | |  |  | | |
| **❖** Other (specify) | | | | | |  |  | |  | |  |  | | |
| **❖** Solid food introduction in past 30 days | | | | | |  |  | |  | |  |  | | |
| **❖** Travel outside province in the 30 days prior to illness onset (specify) | | | | | |  |  | |  | |  |  | | |
| Within Canada | | |  |  | |  | |  | From: To:  Where: | | |
| Outside of Canada | | |  |  | |  | |  | From:  To:  Where:  Hotel/Resort: | | |
| **Behavioural Social Risk Factors** | | | | | | **❖ Response** | | | | **Details**  *iPHIS character limit: 50. Please use ‘Notes’ section if needed* | | | | |
| **Yes** | | **No** | |
| **❖** Unknown | | | | | |  | |  | | *→ For iPHIS data entry – check Yes for Unknown if all other Behavioural Risk Factors are No or Unknown* | | | | |
| **♦** CreateExposures  *Identify Exposures to be entered in iPHIS.*  *→ For iPHIS data entry – record details of exposure(s) in iPHIS Case Exposure Form as required.* | | | | | | | | | | | | | | |

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| **Premises Referral** | | |
| Has a food premises been identified as a possible source? | Yes    No | *If yes, refer premises to the Food Safety Program and create an exposure as appropriate.* |

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| **Education/Counselling** *Discuss the relevant sections with case* |
| ☐ Do not feed honey to infants less than one year of age |

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| **Outcome** *Mandatory in iPHIS only if Outcome is Fatal* | | | | | |
| **Outcome** | Unknown  ♦ Fatal  Ill  Pending  Residual effects  Recovered | | | ♦ **Cause(s) of** **Death?** *If fatal, complete disposition type and facility name in iPHIS* |  |
| *If fatal, complete section below under Outcome* | | | | | |
| ♦ **Type of Death** | Reportable Disease Contributed to but was Not the underlying cause of death  Reportable Disease was the Underlying cause of Death  Reportable Disease was Unrelated to the cause of Death  Unknown | | | | |
| **Outcome Date** | YYYY-MM-DD | **Date Accurate** | Yes Specify source (e.g., death certificate)  No | | |

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| **Thank you** |
| Thank you for your time. This information will be used to help prevent future cases of infant botulism. |

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| **Interventions** | | | | |
| **❖ Intervention Type** | **Intervention implemented (check all that apply)** | **Investigator’s initials** | ♦ **Start Date**  **YYYY-MM-DD** | **❖ End Date**  **YYYY-MM-DD** |
| Counselling |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Education  (e.g. disease fact sheet, general food safety chart/cooking temperature chart, hand washing information) |  |  | YYYY-MM-DD | YYYY-MM-DD |
| ER visit |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Exclusion |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Food Recall |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Hospitalization |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Letter - Client |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Letter - Physician |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Other (i.e., contacts assessed, PHI/PHN contact information) |  |  | YYYY-MM-DD | YYYY-MM-DD |
| *→**For iPHIS data entry – enter information under* ***Cases > Case > Interventions.*** | | | | |

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| **Progress Notes** |
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If you have any comments or feedback regarding this Investigation Tool, please email us at [ezvbd@oahpp.ca](mailto:ezvbd@oahpp.ca).