Santa Barbara County PUBLIC Health DEPARTMENT

HEALTH OFFICER REQUEST FOR BOTULINUM ANTITOXIN

Check one: ☐Wound ☐Foodborne ☐Other (specify):

I. PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*MRN*

Gender ☐Male ☐Female ☐Other	*DOB*	*Age* ☐Years ☐Months ☐Days	*Pregnant* ☐Yes ☐No	*If Yes, Est. Delivery Date*

II. CLINICAL INFORMATION

Physician 1	*Last Name*	*First Name*	
	Specialty	*Telephone Number*	*Fax Number*
	Hospital Name	*Address*	
Physician 2	*Last Name*	*First Name*	
	Specialty	*Telephone Number*	*Fax Number*
	Hospital Name	*Address*	
Hospital Pharmacy Contact	*Last Name*	*First Name*	
	Telephone Number	*Fax Number*	

A. PAST MEDICAL HISTORY

Prior botulism diagnosis? ☐Yes ☐No ☐Unk	*If yes, specify prior diagnosis date*
Prior neurological impairment? ☐Yes ☐No ☐Unk	*If yes, describe impairment*
Allergy to equine products? ☐Yes ☐No ☐Unk	*If yes, describe*
Immunocompromised? ☐Yes ☐No ☐Unk	*If yes, specify condition*
Other (specify)	

DID PATIENT USE ANY DRUGS THAT COULD CAUSE MUSCULAR PARALYSIS WITHIN 30 DAYS BEFORE ILLNESS ONSET?

Myobloc (toxin-type B)? ☐Yes ☐No ☐Unk	*Botox (toxin-type A)?* ☐Yes ☐No ☐Unk	*Aminoglycoside (gentamicin, tobramycin)?* ☐Yes ☐No ☐Unk	*Anticholinergic?* ☐Yes ☐No ☐Unk

Other (specify)

B. SIGNS AND SYMPTOMS

Symptomatic? ☐Yes ☐No ☐Unk	*Onset Date*	*Onset Time*	*Specify AM/PM*

Date of First Neurologic symptoms	*Date First sought Medical Care*

Signs and symptoms	Yes	No	Unk	Signs and symptoms	Yes	No	Unk
Nausea	✓			Change of sound of voice			
Vomiting				Hoarseness			
Abdominal Pain				Dry mouth			
Diarrhea				Dysphagia (trouble swallowing)			
Constipation				Shortness of breath/ trouble breathing			
Diplopia				Subjective weakness			
Dizziness				Fatigue			
Slurred speech				Paresthesia			
Thick tongue				Other signs/ symptoms (specify):			

C. PHYSICAL EXAM FINDINGS				
Observation	Yes	No	Unk	If Yes, Specify as Noted
Alert and oriented	☐	☐	☐	
Extraocular palsy	☐	☐	☐	*Is it bilateral?* ☐Yes ☐No ☐Unk
Ptosis	☐	☐	☐	*Is it bilateral?* ☐Yes ☐No ☐Unk
Pupil abnormality	☐	☐	☐	*Abnormality* ☐Dilated ☐Constricted ☐Non-reactive *Is it bilateral?* ☐Yes ☐No ☐Unk
Facial paralysis	☐	☐	☐	*Is it bilateral?* ☐Yes ☐No ☐Unk
Palatal weakness	☐	☐	☐	*Is it bilateral?* ☐Yes ☐No ☐Unk
Impaired gag reflex	☐	☐	☐	
Sensory deficit(s)	☐	☐	☐	*Specify*
Muscle weakness and / or paralysis	☐	☐	☐	*Progression of weakness/paralysis* ☐ Ascending, ending with cranial nerves ☐ Descending, beginning with cranial nerves ☐ Other (specify): *Is it bilateral?* ☐Yes ☐No ☐Unk
Ataxia	☐	☐	☐	
Abnormal deep tendon reflexes	☐	☐	☐	*Describe*
Other signs/ symptoms (specify)				

III. EPIDEMIOLOGIC INFORMATION

A. EXPOSURES/RISK FACTORS – WOUND AND DRUG USE				
Provide information regarding the patient's wound and drug use below				
Wound/Drug Use	Yes	No	Unk	If Yes, Describe
Wound or Abscess	☐	☐	☐	*Date of injury* *Description* *How wound occurred* *Did/Does would appear infected* ☐Yes ☐No ☐Unk
Injects black tar heroin (chiba)	☐	☐	☐	*Date last used* *Injection Method* ☐Intravenous ☐Intramuscular ☐Subcutaneous (skin-pop) ☐Unk ☐Other:
Injects other drugs	☐	☐	☐	*Drugs injected* ☐Heroine ☐Cocaine ☐Methamphetamine ☐Unk ☐Other: *Injection Method* ☐Intravenous ☐Intramuscular ☐Subcutaneous (skin-pop) ☐Unk ☐Other:
Sniffs/ snorts drugs	☐	☐	☐	*Drugs sniffed/snorted* ☐Heroine ☐Cocaine ☐Methamphetamine ☐Unk ☐Other:
Other drug use	☐	☐	☐	*Describe type of use and drugs*

B. EXPOSURES/RISK FACTORS – POTENTIAL HIGH RISK PRODUCTS				
ASK ABOUT HIGH RISK FOODS EVEN IF WOUND BOTULISM IS SUSPECTED (SUCH AS HOME CANNED OR SUSPICOUS COMMERICAL OR RESTAURANT FOODS)				
Provide information regarding potential high risk products consumed one week prior to illness onset.				
Food Product	Yes	No	Unk	If Yes, Describe
Home canned, jarred, or preserved food products	☐	☐	☐	
Fermented food products	☐	☐	☐	
Dried or smoked fish products	☐	☐	☐	
Marinated food products	☐	☐	☐	
Suspicious commercial products (i.e. bulging lids or cans, recalled products, "off-odor" food items)	☐	☐	☐	

C. EXPOSURES/RISK FACTORS – OTHER POTENTIAL EXPOSURES OF INTEREST	
Exposure 1	*Describe*
Exposure 2	*Describe*

D. CONTACTS/OTHER ILL PERSONS	
Any contacts with similar illness? ☐Yes ☐No ☐Unk	*If Yes, specify details below*

E. ILL CONTACTS - DETAILS						
Name 1	*Age*	*Gender*	*Telephone Number*		*Type of Contact/Relationship*	*Date of Contact*
	Street Address				*Exposure Event*	*Illness onset date*
	City		*State*	*ZIP*	*Date First Report to Public Health*	
Name 2	*Age*	*Gender*	*Telephone Number*		*Type of Contact/Relationship*	*Date of Contact*
	Street Address				*Exposure Event*	*Illness onset date*
	City		*State*	*ZIP*	*Date First Report to Public Health*	

F. EPIDEMIOLOGICAL LINKAGE	
Epi-linked to known case? ☐Yes ☐No ☐Unk	*Contact name / Case Number*
Notes/Remarks	

IV. REPORTING AGENCY

Health Officer	*Local Health Jurisdiction*	*Telephone Number*	*Date*
Date First Reported to Public Health		*First Reported by* ☐ Clinician ☐ Laboratory ☐Other (specify)	