Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

INFANT BOTULISM INVESTIGATIVE FORM

hpsc

REPORTING CLINICIAN'S DETAILS

Date of Notification to Public Health Department: ☐☐/☐☐/☐☐☐☐

Dr Name ☐ Dr Address ☐

Dr Telephone ☐ Fax ☐ Email ☐

SECTION 1: DEMOGRAPHIC INFORMATION

CIDR Event ID ☐☐☐☐☐☐☐ Surname ☐ Forename ☐

Address: ☐

HSE Area: ☐

Sex: F ☐ M ☐ NK ☐ Date of Birth: ☐☐/☐☐/☐☐☐☐ Age (years): ☐☐ Age (months): ☐☐

Ethnic Group

- ☐ White Irish
- ☐ White other
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Indian
- ☐ Not Known
- ☐ Black-African
- ☐ Black-Caribbean
- ☐ Black-Other
- ☐ Chinese
- ☐ Asian-Other
- ☐ Other _____

SECTION 2: BIRTH & DEVELOPMENT DETAILS

Interviewee:

☐ Mother (Name: _____) ☐ Father (Name: _____)

☐ Both ☐ Other _____

Mother's Occupation ☐ Father's Occupation ☐

What was infant's birth weight? ☐ lbs ☐ ounces

Was infant premature? Yes ☐ No ☐ Not Known ☐ If YES, gestational age: ☐ weeks

Type of delivery: Vaginal ☐ C-section ☐

SECTION 3: CLINICAL DETAILS

Hospital Name ☐

Clinician in charge ☐ Telephone no ☐

GP Name ☐ Address ☐

Telephone no ☐

SECTION 2: CLINICAL DETAILS (continued)

Preliminary History:

Parent/carer first noticed infant was ill on ☐☐/☐☐/☐☐☐☐ at ☐☐ weeks of age

First symptom ☐

Second symptom ☐

The initial visit to a doctor was on ☐☐/☐☐/☐☐☐☐ at ☐☐ weeks of age

The infant was hospitalised on ☐☐/☐☐/☐☐☐☐ at ☐☐ weeks of age

Did infant have constipation? Yes ☐ No ☐ Not Known ☐

If YES, how many bowel movements were occurring?

Two or more per day ☐ One per day ☐ One every other day ☐ Two to three per week ☐

One per week ☐ Less than one per week ☐ Other ☐

Clinical History:

Briefly describe history and general symptom progression

INFANT BOTULISM INVESTIGATIVE FORM

SECTION 3: CLINICAL DETAILS (continued)

Specific Symptom History:

	YES	NO	NK	Onset date	Onset time				
Altered cry*	☐	☐	☐			AM	☐	PM	☐
Irritable	☐	☐	☐			AM	☐	PM	☐
General muscle weakness*	☐	☐	☐			AM	☐	PM	☐
"Floppy"	☐	☐	☐			AM	☐	PM	☐
Poor head control	☐	☐	☐			AM	☐	PM	☐
Upper extremities	☐	☐	☐			AM	☐	PM	☐
Lower extremities	☐	☐	☐			AM	☐	PM	☐
Weak suckling*	☐	☐	☐			AM	☐	PM	☐
Loss of facial expression*	☐	☐	☐			AM	☐	PM	☐
Difficulty breathing	☐	☐	☐			AM	☐	PM	☐
Trouble swallowing	☐	☐	☐			AM	☐	PM	☐
Ptosis*	☐	☐	☐			AM	☐	PM	☐
Extraocular palsy	☐	☐	☐			AM	☐	PM	☐
Pupils	☐	☐	☐			AM	☐	PM	☐
Dilated*	☐	☐	☐			AM	☐	PM	☐
Constricted	☐	☐	☐			AM	☐	PM	☐
Sluggish reactivity*	☐	☐	☐			AM	☐	PM	☐
Constipation*	☐	☐	☐			AM	☐	PM	☐
Diarrhoea	☐	☐	☐			AM	☐	PM	☐
Altered consciousness	☐	☐	☐			AM	☐	PM	☐
Respiratory difficulty*	☐	☐	☐			AM	☐	PM	☐
Respiratory arrest	☐	☐	☐			AM	☐	PM	☐
Pneumonia	☐	☐	☐			AM	☐	PM	☐

Other ☐

Physical Examination Findings:

Abnormal deep tendon reflexes? Yes ☐ No ☐ Not Known ☐

If YES, then which? Absent ☐ Depressed ☐

Weakness or paralysis? Yes ☐ No ☐ Not Known ☐ Onset date ☐ Time ☐

If YES, then:

Upper extremities Yes ☐ No ☐ Not Known ☐ Bilateral Yes ☐ No ☐ Not Known ☐

Is weakness or paralysis: Upper distal ☐ Upper proximal ☐

Lower extremities Yes ☐ No ☐ Not Known ☐ Bilateral Yes ☐ No ☐ Not Known ☐

Is weakness or paralysis: Lower distal ☐ Lower proximal ☐

Describe the progression of the weakness Ascending ☐ Descending ☐ Unknown ☐

*** are typical signs of infant botulism**

SECTION 3: CLINICAL DETAILS (continued)

Diagnostic Tests:

A. Was a lumbar puncture (spinal tap) done? Yes ☐ No ☐ Not Known ☐

Date performed ☐☐/☐☐/☐☐☐☐ WBC ☐☐☐ RBC ☐☐☐ Protein (mg/dl) ☐☐☐ Glucose (mg/dl) ☐☐☐

B. Was a tensilon test (edrophonium chloride) done? Yes ☐ No ☐ Not Known ☐

Date performed ☐☐/☐☐/☐☐☐☐ Result: Positive ☐ Negative ☐ Equivocal ☐

C. Was electromyography (EMG) done? Yes ☐ No ☐ Not Known ☐

Date performed ☐☐/☐☐/☐☐☐☐

Nerve stimulated ☐☐☐☐☐☐☐☐☐☐ Stimulated frequency ☐☐☐☐☐☐☐☐☐☐

Amplitude: Increase ☐ Decrease ☐ Facilitation: Yes ☐ No ☐

Was rapid repetitive stimulation conducted? Yes ☐ No ☐ Not Known ☐

D. Was computed tomography (CT) done? Yes ☐ No ☐ Not Known ☐

Date performed ☐☐/☐☐/☐☐☐☐ Findings: ☐☐☐☐☐☐☐☐☐☐

Was magnetic resonance imaging (MRI) done? Yes ☐ No ☐ Not Known ☐

Date performed ☐☐/☐☐/☐☐☐☐ Findings: ☐☐☐☐☐☐☐☐☐☐

Laboratory Information:

Was a toxin assay done? Yes ☐ No ☐ Not Known ☐ If YES, date collected: ☐☐/☐☐/☐☐☐☐

Type of samle(s): Stool ☐ Serum ☐ Gastric aspirate ☐ Sputum ☐ Food ☐ Other ☐

Test results: Positive ☐ Negative ☐ Inconclusive ☐

Type: A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ Other ☐ _____

Was culture done? Yes ☐ No ☐ Not Known ☐ If YES, date collected: ☐☐/☐☐/☐☐☐☐

Type of samle(s): Stool ☐ Serum ☐ Gastric aspirate ☐ Sputum ☐ Food ☐ Other ☐

Test results: Positive ☐ Negative ☐ Inconclusive ☐

Type: A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ Other ☐ _____

SECTION 3: CLINICAL DETAILS (continued)

Treatment:

A. Respiratory assistance needed? Yes ☐ No ☐ Not Known ☐ If YES, number of days: ☐

Oxygen only Yes ☐ No ☐ Tracheostomy Yes ☐ No ☐

Intubation Yes ☐ No ☐ Ventilator Yes ☐ No ☐

B. Infant feeding tube? Yes ☐ No ☐ Not Known ☐ If YES, number of days:

C.

Antibiotics given	Route (circle one)	Dose (gms/day)	Duration (days)	Date started
	Oral/Parenteral			
	Oral/Parenteral			

D. Differential diagnosis ☐

E. Botulism immune globulin requested? Yes ☐ No ☐ Not Known ☐

F. Was botulism immune globulin (Baby BIG) given? Yes ☐ No ☐ Not Known ☐

If YES Date ☐ Time ☐

Route I.V. ☐ I.M. ☐ Both ☐ Unknown ☐ Amount ☐

G. Other specific therapeutic medicine given ☐

H. Patient outcome: Improving ☐ Recovered ☐ Dead ☐

If infant died, date of death ☐

SECTION 4: EXPOSURE HISTORY

Food History: (Before onset of present illness)

Before onset of present illness:

Was the infant ever breast fed? Yes ☐ No ☐ Not Known ☐

Was the infant ever formula fed? Yes ☐ No ☐ Not Known ☐

If YES, give name/brand of formula ☐

Did the infant use a soother/dummy? Often ☐ Sometimes ☐ Rarely ☐ No ☐

If a soother/dummy was used, was it ever dipped in: Syrup ☐ Honey ☐ Other ☐ Nothing ☐

In the 6 weeks before onset of symptoms, did the infant ever eat or taste:

Food/Liquid	Never	Once or a few times	Many times	Daily or most days	Principle type/brand
Formula	☐	☐	☐	☐	
Pasteurized milk	☐	☐	☐	☐	
Un pasteurized milk	☐	☐	☐	☐	
Fruit juices	☐	☐	☐	☐	
Cereal	☐	☐	☐	☐	
Bread	☐	☐	☐	☐	
Syrup/water	☐	☐	☐	☐	
Honey/water	☐	☐	☐	☐	
Sugar/water	☐	☐	☐	☐	
Tea/water	☐	☐	☐	☐	
Cooked fruits	☐	☐	☐	☐	
Raw fruits	☐	☐	☐	☐	
Cooked vegetables	☐	☐	☐	☐	
Raw vegetables	☐	☐	☐	☐	
Home-canned foods	☐	☐	☐	☐	
Baby food (jars)	☐	☐	☐	☐	

Was the infant on any medication? Yes ☐ No ☐ Not Known ☐

If YES, please name ☐

Were any food, medications or environmental samples tested? Yes ☐ No ☐ Not Known ☐

If YES, please list ☐

Results: Preformed toxin ☐ C. *botulinum* ☐ Both ☐ Neither ☐

SECTION 4: EXPOSURE HISTORY (continued)

Environmental History:

Has the infant had any exposure to aquatic pets (turtles, terrapins etc)? Yes ☐ No ☐ Not Known ☐

If YES In the home ☐ Elsewhere ☐ Please give details

Approximate dates: ____ to ____

Has the infant had any exposure to terrestrial reptiles (lizards, snakes etc)? Yes ☐ No ☐ Not Known ☐

If YES In the home ☐ Elsewhere ☐ Please give details

Approximate dates: ____ to ____

Has the infant had any exposure to domestic pets (cats, dogs etc)? Yes ☐ No ☐ Not Known ☐

If YES In the home ☐ Elsewhere ☐ Please give details

Approximate dates: ____ to ____

Has the infant had any exposure to farm animals? Yes ☐ No ☐ Not Known ☐

If YES In the home ☐ Elsewhere ☐ Please give details

Approximate dates: ____ to ____

Has the infant had any exposure to building/construction waste? Yes ☐ No ☐ Not Known ☐

If YES In the home ☐ Elsewhere ☐ Please give details

Approximate dates: ____ to ____

Has either parent handled soil/manure inside or outside the home? Yes ☐ No ☐ Not Known ☐

If YES In the home ☐ Elsewhere ☐ Please give details

Approximate dates: ____ to ____

Does the infant have any history of travel away from home in the 6 weeks prior to onset of illnes? Yes ☐ No ☐ Not Known ☐

If YES, please give details