



Gastroenteritis Outbreak

OUTBREAK INVESTIGATION

Organism laboratory Confirmed

Organism not laboratory Confirmed

OUTBREAK NAME:

Date:	/ /
Interviewer:	
Person Interviewed (if not case):	
Regional ID No:	
Interpreter used? language:	<input type="checkbox"/> No <input type="checkbox"/> Yes
PROBABLE SOURCE	
DHS USE ONLY	
NIDS Number	
NIDS Updated?	/ /

PRIVACY MESSAGE : The information you provide in this questionnaire is for the purpose of trying to prevent further cases of illness. We do this by trying to find out what is likely to have caused your illness and also by providing you with information to reduce the spread of illness to others. The data collected is kept confidential and identifying information will not be disclosed for any other purpose without your consent. You can access your information by contacting the Department of Human Services. A fact sheet is available ("Privacy Legislation & Notification of Infectious Diseases – Information for Patients") if you would like further information. **Information read?**

SECTION 1: DEMOGRAPHIC DATA

Surname / Family name : _____

Other names: _____

Street Address: _____

Suburb/Town: _____ Postcode: _____

Telephone: H: () _____ W: () _____ M: _____

Date of Birth: / / or Age: _____ Sex: Male / Female

Country of Birth: _____

Language Spoken at Home: _____

Occupation*: _____

Of Aboriginal or Torres Strait Islander Origin?

No

Aboriginal

Torres Strait Islander

Both Aboriginal and Torres Strait Islander

Name / Address of Employer or School or Child Care Attended: _____

Telephone: _____ Contact Person: _____

Date Last Attended Prior To Onset: / / **High Risk occupational group?*** no yes

- High risk occupations are food handlers, health care workers, child care workers, children in child care, and residents of institutions (i.e. aged care) 1

SECTION 2: TREATING DOCTOR / HOSPITAL

Name of Treating Dr:

Address:

Telephone: Facsimile:

Consent given by Doctor to interview: no yes Date: / /

Did case present to hospital (e.g. Emergency Dept)? no yes Name of Hospital:

Was case admitted to hospital? no yes Date of Admission: / /

Hospital UR No: Date of Discharge / Death: / /

SECTION 3: ILLNESS (SUMMARY)

★ Onset date of illness: ___/___/___ ★ Date of Specimen Collection: ___/___/___

Time of onset: am / pm Specimen Collection arranged by Council? no yes

SYMPTOMS	YES/NO
Fever	
Nausea	
Vomiting	
Abdominal pain	
Lethargy	
Headache	
Other (Specify)	

SYMPTOMS	YES/NO
Diarrhoea	
Bloody stools	
Watery stools	

Onset of diarrhoea:/...../.....

Max stools in 24 hours:

Duration of diarrhoea:..... days / hours

Total duration of illness:days

★ History of illness:

★ indicates both Doctor and Case should be asked this question

★ Treatment:

Were you given antibiotics to treat this illness? no yes → If yes: What antibiotics?

Are you still taking antibiotics? no yes What date did you last take the antibiotics? / /

Comments:

SECTION 4: CONTACT DATA

In the two weeks prior to onset of illness, has the case:

- had contact with a family member with a similar illness? no yes → give details in table below:
- had contact with a friend or work/school colleague with a similar illness? no yes → give details in table below:

Name	Relationship	Address and phone (if different to case)	Occupation/ childcare / school	Onset date	Faeces culture Y/N

How well did the case recall the information (Sections 2, 3 and 4 – doctors details, illness history and contact details)?

- Very Well Well Not well Not at all

SECTION 5: FOOD HISTORY

Attach Menu

Did the case eat or drink any of the following before becoming ill?

★ When using this Questionnaire please liaise with Communicable Diseases and/or Regional Environmental Health Officer in relation to additional questions that may need to be asked.

