CASE REPORT FORM — Toxic Shellfish Poisoning

Toxic Shellfish Poisoning EpiSurv No. _____

Disease Name

- ○ Paralytic shellfish poisoning
- ○ Neurologic shellfish poisoning
- ○ Amnesic shellfish poisoning
- ○ Diarrhoeic shellfish poisoning
- ○ Toxic shellfish poisoning - type unspecified

Reporting Authority

Name of Public Health Officer responsible for case _____

Notifier Identification

Reporting source* ○ General Practitioner ○ Hospital-based Practitioner ○ Laboratory ○ Self-notification ○ Outbreak Investigation ○ Other

Name of reporting source _____ **Organisation** _____

Date reported* _____ **Contact phone** _____

Usual GP _____ **Practice** _____ **GP phone** _____

GP/Practice address Number _____ Street _____ Suburb _____

Town/City _____ Post Code _____ ☐ GeoCode ____

Case Identification

Name of case* Surname _____ Given Name(s) _____

NHI number* _____ **Email** _____

Current address* Number _____ Street _____ Suburb _____

Town/City _____ Post Code _____ ☐ GeoCode ____

Phone (home) _____ **Phone (work)** _____ **Phone (other)** _____

Case Demography

Location TA* _____ **DHB*** _____

Date of birth* _____ **OR Age** _____ ○ Days ○ Months ○ Years

Sex* ○ Male ○ Female ○ Indeterminate ○ Unknown

Occupation* _____

Occupation location ○ Place of Work ○ School ○ Pre-school

Name _____

Address Number _____ Street _____ Suburb _____

Town/City _____ Post Code _____ ☐ GeoCode ____

Alternative location ○ Place of Work ○ School ○ Pre-school

Name _____

Address Number _____ Street _____ Suburb _____

Town/City _____ Post Code _____ ☐ GeoCode ____

Ethnic group case belongs to* (tick all that apply)

- ☐ NZ European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Tongan
- ☐ Other (such as Dutch, Japanese, Tokelauan) *(specify) _____

Toxic Shellfish Poisoning EpiSurv No. _____

Basis of Diagnosis

Date Interviewed* _____

Weight* _____ Kg

SEAFOOD EXPOSURE

Date and time seafood eaten* _____ _____ hrs

Onset date and time* _____ _____ hrs

Seafood eaten* (tick all that apply)

☐ Cockles ☐ Crabs ☐ Crayfish ☐ Kina ☐ Mussel

☐ Oysters ☐ Paua ☐ Pipis ☐ Prawns ☐ Pupu

☐ Scallops ☐ Shrimps ☐ Tuatuas ☐ Other (specify) _____

Seafood cooked/marinated before eating* ○ Yes ○ No ○ Unknown

If yes indicate method (tick all that apply)

☐ Marinated ☐ Boiled ☐ Steamed

☐ Baked ☐ Fried ☐ Other (specify) _____

Did case drink broth that seafood was cooked in?* ○ Yes ○ No ○ Unknown

Shellfish gut removed before cooking?* ○ Yes ○ No ○ Unknown

		Number eaten*	Weight of flesh consumed*
Type of seafood eaten*	**1.**		grams
	2.		grams
	3.		grams
	4.		grams
	5.		grams

Parts of the seafood eaten*

○ All ○ All except stomach and gut ○ Just the roe

○ Other specific part (specify)* _____

Source of the seafood*

☐ **Recreational*** (collected by case family, friends) Date Collected* _____

Exact location collected from* _____

Grid reference* _____

Nearest marine biotoxin sample station* _____

☐ **Purchased*** (including takeaways and eaten in restaurant) Date Purchased* _____

Name and address from where purchased* _____

Brand name and address of processor* _____

Marine farm number* _____

Batch No* _____

Date of packing* _____

Date of harvesting* _____

Basis of Diagnosis continued

Leftover sample from the same batch* ○ Yes ○ No ○ Unknown

HPO no. of samples* _____

Shellfish sample collected from the same site as case* ○ Yes ○ No ○ Unknown

If yes specify:*

HPO no. of samples* _____ Shellfish species* _____

Location* _____

Grid reference* _____

Distance from sample site to site of seafood collection* _____ km Date* _____

Phytoplankton results* _____

CLINICAL CRITERIA

Main symptoms of illness in case's words*

_____

Gastro-intestinal symptoms	**Yes**	**No**	**Unknown**	If yes, time from eating to onset*	If yes, duration of symptoms*
Nausea*	○	○	○	_____ hrs	_____ hrs
Vomiting*	○	○	○	_____ hrs	_____ hrs
Diarrhoea*	○	○	○	_____ hrs	_____ hrs
Stomach pains (cramps)*	○	○	○	_____ hrs	_____ hrs
Neurosensory symptoms					
Numbness of tongue, face, throat, lips*	○	○	○	_____ hrs	_____ hrs
Tingling of tongue, face, throat, lips*	○	○	○	_____ hrs	_____ hrs
Numbness of hands or feet*	○	○	○	_____ hrs	_____ hrs
Tingling of hands or feet*	○	○	○	_____ hrs	_____ hrs
Prickling feeling on skin during bath/shower or exposure to sun*	○	○	○	_____ hrs	_____ hrs
Difficulty distinguishing hot or cold objects, e.g., hot objects feeling cold, hot food tasting cold*	○	○	○	_____ hrs	_____ hrs
Neurocerebellar/Neuromotor symptoms					
Unsteady walking*	○	○	○	_____ hrs	_____ hrs
Clumsiness*	○	○	○	_____ hrs	_____ hrs
Tremor*	○	○	○	_____ hrs	_____ hrs
Double or blurred vision*	○	○	○	_____ hrs	_____ hrs
Difficulty swallowing*	○	○	○	_____ hrs	_____ hrs
Muscle weakness*	○	○	○	_____ hrs	_____ hrs
Difficulty rising from seat or bed because of weakness*	○	○	○	_____ hrs	_____ hrs
Difficulty breathing*	○	○	○	_____ hrs	_____ hrs
Paralysis*	○	○	○	_____ hrs	_____ hrs
Slurred / unclear speech*	○	○	○	_____ hrs	_____ hrs

Basis of Diagnosis continued

General neurological symptoms	**Yes**	**No**	**Unknown**	If yes, time from eating to onset*	If yes, duration of symptoms*
Drowsiness*	○	○	○	_____ hrs	_____ hrs
Dizziness*	○	○	○	_____ hrs	_____ hrs
Floating feeling*	○	○	○	_____ hrs	_____ hrs
Memory loss*	○	○	○	_____ hrs	_____ hrs
Confusion / disorientation*	○	○	○	_____ hrs	_____ hrs
Seizure*	○	○	○	_____ hrs	_____ hrs
Coma*	○	○	○	_____ hrs	_____ hrs
Other symptoms					
Skin rash*	○	○	○	_____ hrs	_____ hrs
Fever*	○	○	○	_____ hrs	_____ hrs
Lower back pain*	○	○	○	_____ hrs	_____ hrs
Headache*	○	○	○	_____ hrs	_____ hrs
Aching joints*	○	○	○	_____ hrs	_____ hrs
Aching muscles*	○	○	○	_____ hrs	_____ hrs
Other*	○	○	○	_____ hrs	_____ hrs

If yes, specify* _____

First symptom noticed*

Specify* _____

Ongoing Symptom* ○ Yes ○ No ○ Unknown

If yes, specify* _____

Past Medical History

Long term illness that requires regular visits to the doctor* ○ Yes ○ No ○ Unknown

If yes, specify* _____

Medication on a daily basis* ○ Yes ○ No ○ Unknown

If yes, specify* _____

Any other illness that could explain current symptoms* ○ Yes ○ No ○ Unknown

If yes, specify* _____

LABORATORY CRITERIA

Seafood linked to case tested for toxins* ○ Yes ○ No ○ Unknown

*If yes, type of seafood tested: _____

If yes, source of seafood tested:* ○ Leftovers ○ Same site ○ Same batch

HPO No. of seafood test sample* _____

Basis of Diagnosis continued

If yes, specify biotoxin tested for and results:*

Toxin tested:*		Toxin level*	Toxin dose*
NSP*	○ Yes ○ No ○ Awaiting results		
ASP*	○ Yes ○ No ○ Awaiting results		
DSP*	○ Yes ○ No ○ Awaiting results		
PSP*	○ Yes ○ No ○ Awaiting results		
Other*	○ Yes ○ No ○ Awaiting results		
(specify*)			

If case had diarrhoea, faecal microbiological culture performed* ○ Yes ○ No ○ Unknown

If yes, specify test and result*

Seafood linked to case tested for microbiological pathogens* ○ Yes ○ No ○ Unknown

If yes, specify test and result*

Other probable cause for illness identified by microbiological tests (other than biotoxin testing)* ○ Yes ○ No ○ Unknown

If yes, specify test and result*

STATUS* ○ Under Investigation ○ Suspect ○ Probable ○ Confirmed ○ Not a case

SUPPORTING CRITERIA

Others present at the meal when seafood was eaten* ○ Yes ○ No ○ Unknown

Name*	Ate Seafood*	Became Ill*
	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown
	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown
	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown
Animals fed with same seafood (or parts of) as case*	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown

If became ill, list the types of animals and describe their signs of illness*

Clinical Course and Outcome

Date of onset* ☐ Approximate ☐ Unknown

Hospitalised* ○ Yes ○ No ○ Unknown

Date hospitalised* ☐ Unknown

Hospital*

Died* ○ Yes ○ No ○ Unknown

Date died* ☐ Unknown

Was this disease the primary cause of death?* ○ Yes ○ No ○ Unknown

If no, specify the primary cause of death*

Outbreak Details

Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*

☐ Yes **If yes, specify Outbreak No.*** _____

*Comments