Ref No ☐☐☐☐ *IN STRICT MEDICAL CONFIDENCE*

Clostridium botulinum
Infant Botulism Questionnaire

Update: 12 December 2019

Please return completed questionnaires to:

GI Department/IDU Department, Public Health England, 61 Colindale Avenue, London, NW9 5EQ.

Email: Botulism@phe.gov.uk

Please tick boxes or write in the space(s) provided. **USE BLACK OR DARK BLUE BIRO/PEN.**

Interviewer's initials. . . . . **Date** . . . . . / . . . . . / . . . . . (dd/mm/yy)

PERSONAL DETAILS

No.	Questions	Answers *Please circle answers where appropriate*
Q.1	Patient name	Surname…… First name ……
Q.2	Sex	Male Female
Q.3	Date of birth	……/……/…… dd/mm/yyyy
Q.4	Age (months)	
Q.5	Address	…… …… ……
Q.6	Has the patient been exposed to pets or dust (e.g from home renovations or nearby factories, garden, park, farm, etc)? If yes, please specify:	Yes No
Q.7	Has the patient travelled away from home or overseas in the last month?	Yes No Specify place:…… Specify dates: From…… To……

NURSERY/CHILDMINDER
(**Please list all attended during the week before the onset of symptoms**).

Establishment	Address/Postcode	Manager/ Person-in-charge/	Contact number	E-mail

DO YOU KNOW OF ANY OTHER PERSONS WITH SIMILAR ILLNESS: YES ☐ NO ☐

Name …… **Tel:** ……

Address ……

CLINICAL DETAILS

No.	Questions	Answers *Please circle answers where appropriate*
Q.8	Hospital Name	
Q.9	Clinician in charge Name Tel no.	
Q.10	GP Name Address Tel no.	…… …… ……
Q.11	**Preliminary History:** A. Onset date of symptoms B. Date first seen by doctor C. Was patient hospitalised? **If yes:** date hospitalised D. Has the patient been admitted to intensive care? **If yes:** date admitted E. Has the patient been placed on a ventilator? **If yes:** date intubated:	Day Month Year ☐☐ ☐☐ ☐☐☐☐ ☐☐ ☐☐ ☐☐☐☐ Yes No DK ☐☐☐☐ Yes No DK ☐☐☐☐ Yes No DK ☐☐☐☐
Q.12	Was the patient on any of the following medications in the month prior to onset?	a. Phenothiazine Yes No DK b. Aminoglycoside Yes No DK c. Anticholinergic Yes No DK
Q.13	**Clinical History:** Briefly describe history and general symptom progression:	

CLINICAL DETAILS (CONTINUED)

No.	Questions	Answers *Please circle answers where appropriate*		
Q.14	**Specific symptom history:**			
	Abdominal pain	YES	NO	DK
	Drooping eyelid	YES	NO	DK
	Poor feeding (poor suck)	YES	NO	DK
	Diarrhoea	YES	NO	DK
	Constipation	YES	NO	DK
	Floppy head	YES	NO	DK
	Failure to thrive	YES	NO	DK
	Weak cry	YES	NO	DK
	Drooling saliva	YES	NO	DK
	Difficulty swallowing	YES	NO	DK
	Shortness of breath	YES	NO	DK
	Subjective weakness	YES	NO	DK
	Fatigue	YES	NO	DK
Q.15	**Vital signs on admission:**	Temperature (°C) ……..		
		Blood Pressure ……/……..		
		Heart Rate ……..		
		Respiratory Rate ……..		

CLINICAL DETAILS (CONTINUED)

	Questions	Answers *Please circle answers where appropriate*				
Q.16	**Physical Examination Findings:**					
	Extraocular palsy	*YES*	*BILATERAL*	*NO*		*DK*
	Ptosis	*YES*	*BILATERAL*	*NO*		*DK*
	Pupils Dilated	*YES*	*BILATERAL*	*NO*		*DK*
	Pupils constricted	*YES*	*BILATERAL*	*NO*		*DK*
	Pupils fixed	*YES*	*BILATERAL*	*NO*		*DK*
	Pupils reactive	*YES*	*BILATERAL*	*NO*		*DK*
	Facial paralysis	*YES*	*BILATERAL*	*NO*		*DK*
	Impaired gag reflex	*YES*	*BILATERAL*	*NO*		*DK*
	Sensory deficit(s)	*YES*	*BILATERAL*	*NO*		*DK*
	If yes, please describe deficit:	.....				
Q.17	**Deep tendon reflexes:**					
	Abnormal deep tendon reflexes	BRISK	NORMAL	REDUCED	ABSENT	DK
	Biceps/Triceps	BRISK	NORMAL	REDUCED	ABSENT	DK
	Brachial	BRISK	NORMAL	REDUCED	ABSENT	DK
	Patellar	BRISK	NORMAL	REDUCED	ABSENT	DK
	Ankle	BRISK	NORMAL	REDUCED	ABSENT	DK
Q.18	**Please indicate if weakness or paralysis was noted in the patient:**					
	a. Upper extremities	YES		NO		
	If yes: Distal weakness/paralysis	YES	BILATERAL	NO	DK	
	Proximal weakness/paralysis	YES	BILATERAL	NO	DK	
	b. Lower extremities	YES		NO		
	If yes: Distal weakness/paralysis	YES	BILATERAL	NO	DK	
	Proximal weakness/paralysis	YES	BILATERAL	NO	DK	
	If yes to any of the above please describe weakness/paralysis:					
	i. **Ascending** (beginning in the lower extremities, moving to upper extremities and then cranial nerves)	YES	BILATERAL	NO	DK	
	ii. **Descending** (beginning with cranial nerves, moving to upper then lower extremities)	YES	BILATERAL	NO	DK	

CLINICAL DETAILS (CONTINUED)

No.	Questions	Answers *Please circle answers where appropriate*
Q.19	**Laboratory Results:**	
	a. Was a lumbar puncture done?	YES NO DK
	If yes:	
	i. Date done:	……/……/……. dd/mm/yyyy
	ii. RBC	……..
	iii. WBC	……..
	iv. Protein	……..
	v. Glucose	……..
	b. Was a tensilon test (Edrophonium chloride) done?	YES NO DK
	If yes: i. Date done:	……/……/…….dd/mm/yyyy
	ii. Results:	…… ……
	c. Was electromyography (EMG) done?	YES NO DK
	If yes: i. Date done:	……/……/…….dd/mm/yyyy
	ii. Muscle group	……
	iii. Nerve conduction results	…… ……
	iv. Was rapid repetitive stimulation conducted?	YES NO DK
	If yes: Hertz:	……
	Result:	……
	d. Was brain imaging done?	YES NO DK
	If yes: Was a CT done?	YES NO DK
	If yes: i. Date done:	……/……/…….dd/mm/yyyy
	ii. Findings:	…… ……
	Was an MRI done?	YES NO DK
	If yes: i. Date done:	……/……/…….dd/mm/yyyy
	ii. Findings:	…… ……

CLINICAL DETAILS (CONTINUED)

No.	Questions	Answers *Please circle answers where appropriate*
Q.20	**Treatment** Was the patient treated with antimicrobial agents?	Yes No DK If yes, please state which agents were used ……
Q.21	**What samples have been sent to test for botulinum toxin?**	Serum ☐ Feaces ☐ Rectal washout ☐ Gastric aspirates ☐ Other ☐(please state)…… ……
Q.22	**Botulinum antitoxin:** Was the patient given Antitoxin? **If yes,** how many doses were given?: Dates given?	Yes No BabyBIG DK …… ……
Q.23	**Differential Diagnosis by Clinician:**	
Q.24	**Patient outcome/status:**	Still ventilated Still in hospital Discharged Died Date of outcome ……..

FOOD HISTORY

Now we are going to ask you about food eaten by the infant in the **7 DAYS** before he/she became ill.

27. Did the infant eat/drink any of the following in the **7 DAYS** before he/she became ill?

	Yes	No	Name and location
Breast milk	☐	☐	……
Bottle feeds	☐	☐	……
Honey	☐	☐	……
Gripe water	☐	☐	……
Medications	☐	☐	……
Herbal tea/infusion			
-Commercial	☐	☐	……
-Home prepared	☐	☐	……
Baby cereal/baby food	☐	☐	……
Other	☐	☐	……

Is there anything else that you think is important for us to know?

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THANK YOU FOR YOUR CO-OPERATION

Would it be all right for us to contact you again for additional information? Yes ☐ No ☐

If you have any specific questions about this investigation either now or in the future please email or write to:

Botulism@phe.gov.uk
GI Department/IDU Department
Public Health England, Colindale
London NW9 5EQ

Investigating Officers Comments

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