Reporting Centre:_____ Date of Report: YYYY/MM/DD

I. Patient information

Name:	Age (yrs)	Sex M F
Home address: Work address: Nature of duties:	Phone	Occupation

2. Clinical data

Date of onset:

Immunization history

Symptoms	Y N	Symptoms	Y N	Symptoms	Y N
Fever		Cough			
Malaise					
Anorexia					
Constipation					
Diarrhoea					

Number of doses

Date of last dose

Is/was this patient hospitalized?	Y N	Date(s)	Outcome of illness	
			Survived	
			Died	Date:

3. Exposure history

During the 3 weeks prior to onset:	Y N	Date:	Details
Known case			
Food			
Water			
Carrier			
In 4 weeks prior to onset: Travelling/visiting if considered risk Change of work environment Bathing in rivers/pools			

4. Laboratory data

Specimen	Date collected	Date received	Condition	Test	Result	Date sent	Comment
Blood			Culture				
Stool			Culture				
Stool			Culture				
Urine			Culture				

5. Final case classification

Laboratory confirmed

Discarded

Phage type:

Date reported:

To Whom:

Route:

Signature: