

## Non-*pestis* Yersiniosis Investigation Checklist for Local Health Departments

Local health department staff should follow these steps, not necessarily always in order, when investigating reports of yersiniosis. For more detailed information refer to the Non-*pestis* Yersiniosis Disease Chapter. Non-*pestis* Yersiniosis is a Priority Level 4 disease and critical details should be entered into the Communicable Disease Reporting and Surveillance System (CDRSS) within 14 days.

- Review laboratory details to confirm the test result. If the case has not been submitted via CDRSS, create a case.
- Assess the case-patient for high-risk activities (e.g., daycare attendee, food handler) and exclude from school or work in accordance with [NJDOH Exclusion Criteria](#).
- Interview the case-patient (parent/guardian if case-patient is a minor) via telephone using the “Yersiniosis Case Report Form”. Do not fax the form to the physician or mail to the home of the case for completion.
- Provide education to the case-patient; additional information can be found on the NJDOH and CDC disease pages.
- Enter critical details (demographics, signs/symptoms, clinical status, additional laboratory information, and industry/occupation) into the CDRSS case.
- Enter relevant exposures (food history especially consumption of unpasteurized dairy, meats, and contact with pets, livestock, or animals) into the *Sources of Infection and Risk Factors* section within the CDRSS case.
- Notify the appropriate local health department and document in CDRSS if a food establishment, restaurant, etc. from another jurisdiction is identified as a possible source of exposure.
- Inform the Foodborne and Waterborne Disease Unit at [cds.fwd.epi@doh.nj.gov](mailto:cds.fwd.epi@doh.nj.gov) if an outbreak is suspected or if an unpasteurized milk/dairy product is believed to be the source of infection.
- Enter any additional symptomatic contacts identified through the interview into the *Contact Tracing* section within CDRSS and follow case investigation as appropriate.
- Document dates/times of at least three attempts made to reach the case-patient into the *Sources of Infection and Risk Factors* section within CDRSS if they remain unreachable.
- Determine *Case Status* as outlined in the chapter and mark *Report Status* as “LHD CLOSED” in CDRSS.

**YERSINIOSIS SURVEILLANCE CASE REPORT FORM**  
**ENTER DATA FROM THE COMPLETED CASE REPORT FORM INTO CDRSS**

CDRSS CASE ID#

**Section 1: INTERVIEWER & PATIENT INFORMATION:**

1. State of residence: \_\_\_\_\_ 2. County: \_\_\_\_\_ 3. Zip code: \_\_\_\_\_

4. Interviewer Information  
 Name: \_\_\_\_\_ Contact Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Agency or Organization: \_\_\_\_\_ Date of Interview: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

6. Language interview conducted in  English  Spanish  Other (Specify): \_\_\_\_\_

7. Respondent was:  Self  Parent  Spouse  Other (Specify): \_\_\_\_\_  
 Not interviewed - *If not interviewed, why not?* \_\_\_\_\_

8. Patient outcome at time of interview:  Survived  Died  Unknown  
*If died, was this infection considered an underlying, contributing, or immediate cause of death?*  Yes  No  Unknown

**Section 2: DEMOGRAPHIC DATA:**

1. Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) 2. Age: \_\_\_\_\_ 3. Sex:  Male  Female

4. Hispanic or Latino origin?  Yes  No  Unknown

5. How would you describe your (your child's) race?  
 White  Black / African American  American Indian / Alaska Native  Unknown  
 Asian  Native Hawaiian / Other Pacific Islander  Other (specify): \_\_\_\_\_

**Section 3: CLINICAL INFORMATION:** Now I have a few questions about your (your child's) illness.

1. What date did you (your child) first feel sick? \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

2. How many days in total were you (your child) sick? \_\_\_\_\_ days  Unknown  Still sick

3. Prior to onset of symptoms, did you (your child) have any long-lasting or chronic illness or condition {an illness that has lasted longer than 1 month}?  
 Yes  No  Unknown  Refused *if yes, please specify* \_\_\_\_\_

| YES                      | Maybe                    | NO                       | DON'T KNOW               | Did you (your child) have any:   |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Diarrhea (defined as at least 3 loose stools in 24 hours)?<br>a. What date did it start? ____/____/____ (MM/DD/YYYY) <input type="checkbox"/> Unknown<br>b. What date did it stop? ____/____/____ (MM/DD/YYYY) <input type="checkbox"/> Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Abdominal pain/cramps?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Joint pain (arthralgia)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Rash?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Fever (or felt feverish)?<br>a. Temperature _____ degrees  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Other?<br>a. Specify: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. Were you treated with antibiotics for this illness?<br>a. Specify: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. Were you (your child) hospitalized overnight? ( <i>must enter MM/DD/YYYY</i> )<br>a. Hospital Name: _____<br>b. Admit Date: ____/____/____ Discharge Date: ____/____/____  |

**Section 4: FOOD HISTORY:** Now I'd like to ask you about specific food items.

**PORK AND MEAT ALTERNATIVES**

| YES  | Maybe                    | NO                       | Don't Know               |   |
|--|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | During the <b>10 days</b> before you (your child) got sick, did you (your child):   |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 1. Consume, handle, or prepare any raw pork or chitterlings (pig intestines)?<br>Type, variety, brand: _____ Place purchased/consumed: _____<br>Date purchased/consumed: ____/____/____ |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 2. Consume any tofu, tempeh, seitan, or other meat alternatives?<br>Type, variety, brand: _____ Place purchased/consumed: _____<br>Date purchased/consumed: ____/____/____              |

**DAIRY**

| YES  | Maybe                    | NO                       | Don't Know               |  |
|--|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | During the <b>10 days</b> before you (your child) got sick, did you (your child):  |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 3. Consume raw (unpasteurized) dairy products?<br>Type, variety, brand: _____ Place purchased/consumed: _____<br>Date purchased/consumed: ____/____/____ |

**Section 5: OTHER EXPOSURES:** Now I'd like to ask you about other exposures.

| YES  | Maybe                    | NO                       | Don't Know               |  |
|--|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | In the <b>10 days</b> before you (your child) became sick, did you (your child): |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 1. Have any contact with pigs?<br>Specify: _____ Place of exposure: _____        |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 2. Have any other animal contact?<br>Specify: _____ Place of exposure: _____     |
| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Have any blood transfusions?<br>Date: ____/____/____                          |

**Section 6: HIGH RISK OCCUPATIONS OR ACTIVITIES:** I would like to end by asking a few questions about yourself (your child).

| YES  | Maybe                    | NO                       | Don't Know               |   |
|--|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | In the <b>10 days</b> before you (your child) became sick, did you (your child):  |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 1. Handle or prepare food as part of your duties at work or as a volunteer?<br>Name/Location: _____   |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 2. Provide health care?<br>Name/Location: _____   |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 3. Attend, work, or volunteer in a daycare setting?<br>Name/Location: _____   |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 4. Live in, work at, visit, or volunteer in any long-term care/residential facilities?<br>Name/Location: _____  |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></span> <span>→</span> </div> |                          |                          |                          | 5. Have close contact with anyone with diarrhea or vomiting?<br>a. When did this person first become ill? <input type="checkbox"/> <24 hrs. before you <input type="checkbox"/> ≥ 24 hrs. before you <input type="checkbox"/> Unknown |

This is the end of the questionnaire.

Thank you very much for your time. These interviews are extremely valuable in helping us understand how and why people are getting sick. Depending on what we find out when we put these interviews together, we may need to talk to you again about a few details.

Would you like to provide any additional thoughts or perspective or mention foods or drink that you (your child) could have consumed in the 10 days before illness onset that we may not have covered in the interview?