



Additional Reportable Diseases

County _____

Case name (last, first) _____
 Birth date ___/___/___ Age at symptom onset _____ Years Months
 Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHM Case ID (optional) _____

LHM notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHM _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (*specify*: Amer Ind *and/or* AK Native) Asian Black or African American
 Native HI/Pacific Islander (*specify*: Native HI *and/or* Pacific Islander) White Patient declined to respond Unk

Additional race information:

Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
 Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
 Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
 Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
 Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
 Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
 Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
 South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
 Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
 Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
 Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
 Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
 Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
 Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
Employer _____ Work site _____ City _____
Student/Day care Yes No Unk
Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
School name _____ School address _____
City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
Name _____ Phone _____
Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk
Disease (Diseases in **bold** must be reported. Reporting is not required for items in *italics* unless specified by a local health officer)
 Acanthamoeba (Amebic meningitis) *African sleeping sickness (African trypanosomiasis)*
 Balamuthia mandrillaris (Amebic meningitis) **Baylisascariasis**
 Chagas disease (American trypanosomiasis) **Echinococcosis** *Hansen disease* **Histoplasmosis**
 Kawasaki disease *Leishmaniasis* *Lymphocytic choriomeningitis* **Naegleria fowleri (Amebic meningitis)**
 Orf *Schistosomiasis* **Smallpox** *Streptococcal disease, invasive, Group A*
 Streptococcal disease, invasive, Group B *Streptococcus pneumoniae, invasive* *Strongyloides* **Taeniasis**
 Taenia solium (Cysticercosis) *Toxic shock syndrome (Staph)* *Toxoplasmosis* **Typhus**
 Vancomycin-resistant Staphylococcus aureus *Other* _____

Clinical Features

Y N Unk
 Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F
 Cardiac involvement/complication
 Pneumonia
Diagnosed by X-Ray CT MRI Provider Only
Result Positive Negative Indeterminate Not tested Other _____
 Chest pain
 Cough
 Diarrhea (3 or more loose stools within a 24 hour period)
 Vomiting
 Abdominal pain
 Weight loss, nausea
 Liver abnormality or failure
 Kidney (renal) abnormality or failure
 Rash
 Rash observed by health care provider Describe _____
 Skin abscess or ulcer
 Bone or organ infection
 Vision abnormality
 Anemia
 Hemorrhage or bleeding
 Myalgia (muscle aches or pains)
 Headache
 Altered mental status
 Meningitis
 Encephalitis/meningoencephalitis
 Loss of coordination (Ataxia)
 Acute flaccid paralysis

- Paralysis or weakness
 - Ascending
 - Descending
 - Asymmetric
 - Symmetric
 - Acute
 - Seizure new with disease
 - Neurologic abnormality Specify _____
- Y N Unk**
- Scan/ X-rays abnormal
 - Sepsis syndrome
 - Any complication _____
 - Preliminary diagnosis established _____
 - Final diagnosis established _____

Predisposing Conditions

- Y N Unk**
- Immunosuppressive therapy, condition, or disease _____

Hospitalization

- Y N Unk**
- Hospitalized at least overnight for this illness Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
 - Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
 - Still hospitalized As of ___/___/___

- Y N Unk**
- Died of this illness Death date ___/___/___ Please fill in death date information on Person Screen
 - Autopsy performed
 - Death certificate lists disease as a cause of death or a significant contributing condition
 - Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)
 Inpatient ward ICU Other _____

RISK AND RESPONSE

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

- Y N Unk**
- Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____
 - Contact with recent foreign arrival Country _____ Date(s) of contact ___/___/___
 - Does the case know anyone else with similar symptoms or illness Ill contact's onset date ___/___/___
Contact setting/relationship to case Common Event Common meal Day care Female sexual partner
 Male sexual partner Friend Household contact Workplace
 Travel contact Other _____
 - Suspected person-to-person transmission
 - Congregate living
 Barracks Corrections Long term care Dormitory Boarding school Camp Shelter
 Other _____
 - Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
 - Any recreational water exposure (e.g., lake, river, pool, waterpark)
 - Rodent, raccoon, canid (e.g., dog, fox), bird or other exposure to animals or their feces _____
- Y N Unk**
- Insect bite Date of exposure ___/___/___
Type Tick Mosquito Flea Louse Deer fly Other _____
Location of exposure Multiple exposures Other country Other state Unk WA county _____
Specify location _____
 - Blood, organ or tissue transplant recipient Date ___/___/___
 - (Potential) Occupational exposure Date ___/___/___
 Lab worker
 Other _____
 - Bioterrorism related

Exposure and Transmission Summary

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Foodborne Waterborne Animal related Vectorborne Person to person Sexual
 Blood products IDU Health care associated Unk Other _____

Describe _____

Suspected exposure setting Day care/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____

Describe _____

Exposure summary

Suspected transmission type (check all that apply) Foodborne Waterborne Animal related Vectorborne
 Person to person Sexual Blood products IDU Health care associated Unk
 Other _____

Describe _____

Suspected transmission setting (check all that apply) Day care/Childcare School (not college) Doctor's office
 Hospital ward Hospital ER Hospital outpatient facility Home Work College Military
 Correctional facility Place of worship Laboratory Long term care facility Homeless/shelter
 International travel Out of state travel Transit Social event Large public gathering Restaurant
 Hotel/motel/hostel Other _____

Describe _____

Public Health Issues

Y N Unk

- Does patient have contact with a day care
- Non-occupational food handling (e.g., potlucks, receptions) during contagious period
- Employed as a food handler
- Employed in childcare or preschool
- Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis Agency and location _____
Date ___/___/___ Specify type of donation _____

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y N Unk

- Notified blood or tissue bank (if recent donation)
- Isolation precautions
- Prophylaxis of appropriate contacts recommended
 - Household members
 - Roommates
 - Carpools
 - Coworkers
 - Teammates
 - Child care contacts
 - Playmates
 - Other children
 - EMTs
 - Medical personnel
 - Other patients
 - Other close contacts _____
- Exclude case from sensitive occupations (HCW, food, childcare) or situations (childcare) until diarrhea ceases
- Letter sent Date ___/___/___ Batch date ___/___/___
- Any other public health action _____

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

Settings and details (check all that apply)

- Day care School Airport Hotel/Motel/Hostel Transit Health care Home Work College
 Military Correctional facility Place of worship International travel Out of state travel LTCF
 Homeless/shelter Social event Large public gathering Restaurant Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

TREATMENT

Y N Unk

Did patient receive prophylaxis/treatment

Specify medication _____ Antibiotic Fungal/Parasitic Antiviral Immune globulin/Antitoxin
 Other _____

Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___

Prescribed dose _____ g mg ml Frequency _____ Duration _____ Days Weeks Months

Indication PEP PrEP Treatment for disease Incidental Other _____

Did patient take medication as prescribed Yes No - Why not _____ Unk

Prescribing provider _____

NOTES

LAB RESULTS

Lab report information

Lab report reviewed – LHJ

WDRS user-entered lab report note

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen

Specimen identifier/accession number _____

Specimen collection date ___/___/___ **Specimen received date** ___/___/___

WDRS specimen type _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result

WDRS test performed _____

WDRS test result, coded _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary *Comparator* and *Unit of measure*) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed Pending

Test result status Final results; Can only be changed with a corrected result

Preliminary results

Record coming over is a correction and thus replaces a final result

Results cannot be obtained for this observation

Specimen in lab; results pending

Result date ___/___/___

Upload document

Ordering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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