



Plague

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 _____ LHJ Case ID (optional) _____

LHJ 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 _____ LHJ _____

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

Clinical Features

Primary clinical syndrome Bubonic Pneumonic Septicemic

Secondary clinical syndrome Bubonic Pneumonic Septicemic

Y N Unk

Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F

Chills or rigors

Pharyngitis (sore throat)

Headache

Fatigue

Malaise

Myalgia (muscle aches or pain)

Arthralgia (joint pain)

Bloody sputum

Chest pain

Cough

Dyspnea (shortness of breath)

Respiratory distress

Pneumonia

Secondary pneumonia

Confusion

Regional lymphadenitis (bubo)

Septicemia

Shock

Skin abscess or ulcer

Amputation/limb ischemia

Cardiac arrest

Disseminated intravascular coagulopathy (DIC)

Multisystem organ failure (failure of 2 or more organs)

Renal failure (Cr > 2.0 mg/dl)

Intubation

Predisposing Conditions

Y N Unk

Cardiovascular disease

Pulmonary disease

Chronic kidney disease

Diabetes mellitus

Cancer

Immunosuppressive therapy, condition, or disease

Other underlying medical condition _____

Physician Reporting/Patient Health Care

Date first seen by health care provider ___/___/___ Location where first seen _____

Heart rate when first seen _____

Blood pressure when first seen ___/___/___

Vaccination

Y N Unk

Vaccination for plague

Vaccine information available Yes No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

Vaccine lot number _____ Administering provider _____

Clinical Testing

Date initial blood tests ___/___/___

Y N Unk

White blood cell count obtained (white blood cell count x 10³)

Percent bands _____ Percent segments _____ Percent lymphocytes _____

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____

Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Disposition Another acute care hospital Facility name _____

Died in hospital

Long term acute care facility Facility name _____

Long term care facility Facility name _____

Non-healthcare (home) Unk Other _____

Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Mechanical ventilation or intubation required

Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ *Please fill in the death date information on the 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 (Ask about exposures 1-7 days before symptom onset)

Travel

Y N Unk

	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 _____

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 _____

Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)

Activity Outdoor recreation Cabin Hunting Lawn mowing Other _____

Where At home property Elsewhere _____

Any contact with pet animals at home or elsewhere

Cats or kittens

Dogs or puppies

Rats, mice, gerbils or hamsters

Pocket or "exotic" pets (ferrets, pygmy hedgehogs, sugar gliders, guinea pigs, prairie dogs, etc.)

Specify _____

Other pets _____

Have any pets been ill or died Describe _____

Have any pets brought home any dead animals Describe _____

Pets free roaming

Y N Unk

- Wildlife or wild animal exposure _____
- Handled sick or dead animals Date(s) ___/___/___ Exposure(s) _____
- Handled tissue of infected animals Date(s) ___/___/___ Exposure(s) _____
- Observe any animals or insects/evidence of animals or insects (e.g., droppings) around home/work
 - Fleas Rodents
- Wild rodent or wild rodent excreta exposure
- Slept in places with evidence of rodents (e.g., animals, nest, excreta)
- Slept in cabin or outside
- 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 _____
- (Potential) Occupational exposure
 - Lab worker
 - Veterinarian
 - Other _____

Exposure and Transmission Summary

Y N Unk

- Epidemiologic link to a confirmed human case**
- 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** Animal related Vectorborne Person to person Health care associated Unk
 - Other _____
 - Describe _____
- Suspected exposure setting Day care/Childcare School (not college) 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 _____

Exposure summary

- Suspected transmission type Person to person Health care associated Unk Other _____
 - Describe _____
- Suspected transmission setting Day care/Childcare School (not college) Home Work College Military
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Public Health Issues

Y N Unk

- Illness resulted in any secondary cases
 - Attended social gatherings or crowded settings
 - Potential bioterrorism exposure
 - Notify FBI or public safety
- If needed, enter detailed information in the Transmission Tracking Question Package*

Public Health Interventions/Actions

Y N Unk

- Isolation while symptomatic (pulmonary or pharyngeal)
- Chemoprophylaxis or quarantine (for 7 days) of contacts, including medical personnel
- Education on rodent control
- Letter sent Date ___/___/___ Batch date ___/___/___

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 antibiotic _____

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 PendingTest 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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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