Washington State Department of HEALTH

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 _____ 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 childs) 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

Case Name _____ LHJ Case ID _____

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 _____ºF
☐	☐	☐	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 abormal
☐ ☐ ☐ 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:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ 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

Case Name _____ LHJ Case ID _____

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 _____

Case Name _____ LHJ Case ID _____

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)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ 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 _____