



Unexplained Critical Illness or Death

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

Clinical Features

Y N Unk

- Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____ °F
- Endocarditis
- Myocarditis
- Pericarditis or pericardial effusion
- Respiratory infection
- Respiratory failure
- Diarrhea (3 or more loose stools within a 24 hour period)
- Nausea
- Vomiting
- Abdominal pain or cramps
- Liver abnormality or failure
- Renal failure
- Neurologic abnormality
- Acute CNS event
- Meningitis/meningoencephalitis
- Encephalitis or encephalomyelitis
- Acute flaccid paralysis
- Paralysis or weakness
 - Ascending
 - Descending
 - Asymmetric
 - Symmetric
 - Acute
- Botulism-like syndrome
- Rash observed by health care provider
 - Generalized
 - Localized
 - Bullous
 - Macular
 - Papular
 - Pustular
 - Vesicular
 - On palms and soles
- Regional lymphadenitis (bubo)
 - Axillary
 - Cervical
 - Femoral
 - Inguinal
 - Pharyngeal
 - Other location _____
- Erythematous
- Tender
- Size _____

Y N Unk

- Shock
- Sepsis syndrome
- Hemorrhagic signs
- Blood in vomitus, stool, urine
- Epistaxis (nose bleed)
- Gum bleeding
- Petechiae
- Positive tourniquet test
- Positive urinalysis
- Vaginal bleeding
- Other _____
- Disseminated intravascular coagulopathy
- Histopathologic evidence of an acute infectious process
- Final diagnosis established _____

Predisposing Conditions

Y N Unk

- Chronic heart disease
 - Chronic lung disease
 - Chronic liver disease
 - Chronic kidney disease
 - Diabetes mellitus
 - HIV infection
 - Immunosuppressive therapy, condition or disease
 - Spleen removed (asplenic)
 - Evidence of toxic ingestion or exposure
 - Nosocomial infectious prior to the onset of illness
 - Cancer, solid tumors, or hematologic malignancies _____
 - Trauma thought to be related to illness
 - Preexisting medical condition which may have contributed to the current illness or death
- No known predisposing conditions (previously healthy) True False Unk

Clinical Testing

Y N Unk

- Leukocytosis (white blood cell county above normal)

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 _____

Y N Unk

- 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 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 (Note that the questions below are intended to cover general exposures of risk. If other exposures of concern are raised during the interview, collect information including locations, dates, and details of exposure)

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 _____
- 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 _____
- Congregate living
 Barracks Corrections Long term care Dormitory Boarding school Camp Shelter
 Other _____
- Invasive medical procedure Describe _____
- Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
- Injected drugs not prescribed by a doctor, even if only once or a few times Describe _____
- Any contact with wild animals at home or elsewhere
- Wildlife or wild animal exposure
- 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 _____

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 Interventions/Actions

Y N Unk

- Potential bioterrorism exposure
- Notified FBI or Public Safety
- Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING (Complete if person-to-person transmission or common exposure is suspected)

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 RESULTSLab 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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