Washington State Department of Health

Brucellosis

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other 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
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

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

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

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 _____

REPORT SOURCE

Initial report source _____
LHJ _____
Reporter organization _____
Reporter name _____
Reporter phone _____

All reporting sources (list all that apply)
_____
_____
_____

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 _____

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** If yes, Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	**Recurring fever**
☐	☐	☐	**Anorexia (loss of appetite)**
☐	☐	☐	**Arthralgia (joint pain)**
☐	☐	☐	**Arthritis**
☐	☐	☐	**Endocarditis**
☐	☐	☐	**Fatigue**
☐	☐	☐	**Headache**
☐	☐	☐	**Hepatomegaly**
☐	☐	☐	**Myalgia (muscle aches or pain)**
☐	☐	☐	**Meningitis**
☐	☐	☐	Osteomyelitis (Bone infection)

☐ ☐ ☐ **Splenomegaly**
☐ ☐ ☐ **Spondylitis**
☐ ☐ ☐ **Night sweats**
☐ ☐ ☐ **Weight loss with illness**
☐ ☐ ☐ Miscarriage or stillbirth

MALE ONLY
Y N Unk
☐ ☐ ☐ **Epididymitis**
☐ ☐ ☐ **Orchitis unexplained by another more likely diagnosis**

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 ___/___/___
☐ ☐ ☐ 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

Pregnancy
Pregnancy status at time of symptom onset
☐ Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____
OB name, phone, address _____
Outcome of pregnancy ☐ Still pregnant ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk
☐ Postpartum (Estimated) delivery date ___/___/___
OB name, phone, address _____
Outcome of pregnancy ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk
☐ Neither pregnant nor postpartum ☐ Unk

RISK AND RESPONSE (Ask about exposures 5 days to 5 months before symptom onset)

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 _____
☐ ☐ ☐ 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 _____
☐ ☐ ☐ **(Potential) Occupational exposure**
☐ ☐ ☐ Lab worker
☐ ☐ ☐ Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse)
Specify occupation _____
☐ ☐ ☐ **Did case have a known Brucella exposure (e.g., laboratory exposure)** Date of exposure ___/___/___
☐ ☐ ☐ Was PEP recommended
Did case complete the PEP course ☐ Yes, partial ☐ Yes, full
☐ No, unaware ☐ No, unavailable ☐ No, allergic ☐ No, pregnant
☐ Unk ☐ Other _____
Type ☐ Clinical specimen ☐ Isolate ☐ Vaccine ☐ Unk ☐ Other _____
What was exposure status ☐ High risk ☐ Low risk ☐ Unk
Where did exposure happen _____

Case Name _____ LHJ Case ID _____

Y N Unk

☐ ☐ ☐ **Brucella vaccine exposure** Date of exposure ___/___/___
Type of exposure ☐ Needle stick ☐ Eye splash ☐ Mucous membrane ☐ Other _____
Vaccine strain ☐ S19 ☐ RB51 ☐ Rev1 ☐ Other _____

☐ ☐ ☐ **Unpasteurized dairy products (e.g., raw milk, soft cheese from raw milk, queso fresco or food made with these cheeses)**
Type of product ☐ Milk ☐ Queso fresco ☐ Soft cheese ☐ Other _____
Dairy animal ☐ Cow ☐ Goat ☐ Sheep ☐ Other _____
Location acquired _____ Brand _____

☐ ☐ ☐ **Any contact with animals**

	Y N Unk	Type of contact (select all that apply)	Who own animals (select all that apply)
Cow/calf	☐ ☐ ☐	☐ Birthing products ☐ Skinning/slaughter/butcher ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Deer	☐ ☐ ☐	☐ Birthing products ☐ Skinning/slaughter/butcher ☐ Hunting ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Dog	☐ ☐ ☐	☐ Birthing products ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Donkey	☐ ☐ ☐	☐ Birthing products ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Goat	☐ ☐ ☐	☐ Birthing products ☐ Skinning/slaughter/butcher ☐ Hunting ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Horse/pony	☐ ☐ ☐	☐ Birthing products ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Pigs or swine	☐ ☐ ☐	☐ Birthing products ☐ Skinning/slaughter/butcher ☐ Hunting ☐ Mucous membranes or tissue ☐ Caretaker ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Sheep	☐ ☐ ☐	☐ Birthing products ☐ Skinning/slaughter/butcher ☐ Hunting ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Other (specify)	☐ ☐ ☐	☐ Birthing products ☐ Skinning/slaughter/butcher ☐ Hunting ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____
Wildlife or wild animal exposure	☐ ☐ ☐	☐ Birthing products ☐ Skinning/slaughter/butcher ☐ Hunting ☐ Mucous membranes or tissue ☐ Caretaker ☐ Veterinarian ☐ Other _____	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____

Y N Unk

☐ ☐ ☐ Case or household member lives or works on farm or dairy

INFANT ONLY

Y N Unk

☐ ☐ ☐ If infant, confirmed infection in birth mother
☐ ☐ ☐ Breast fed
☐ ☐ ☐ Neonatal infection

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ **Epidemiologic link to a confirmed human or animal case**
☐ ☐ ☐ Animal
☐ ☐ ☐ Co-worker
☐ ☐ ☐ Household contact
☐ ☐ ☐ Neighbor
☐ ☐ ☐ Other _____

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

Case Name _____ LHJ Case ID _____

Suspected exposure type ☐ Foodborne ☐ Animal related ☐ Person to person ☐ Sexual ☐ Unk
☐ Other _____
Describe _____
Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel
☐ Out of state travel ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other _____
Describe _____
Exposure summary

Suspected transmission type (check all that apply) ☐ Person to person ☐ Sexual ☐ 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 ☐ Other_____
Describe _____

Public Health Issues

Y N Unk

☐ ☐ ☐ 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_____
☐ ☐ ☐ Potential bioterrorism exposure
☐ ☐ ☐ Notify FBI or Public Safety

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Notified blood or tissue bank (if recent donation)
☐ ☐ ☐ Did possible laboratory exposure occur
Number of high risk exposed persons taking PEP _____
Number of high risk exposures _____
Number of low risk exposed persons taking PEP _____
Number of low risk exposures _____
☐ ☐ ☐ Did possible clinical/surgical staff exposure occur (e.g., bone saw use or other aerosolizing procedure)
Number of high risk exposed persons taking PEP _____
Number of high risk exposures _____
Number of low risk exposed persons taking PEP _____
Number of low risk exposures _____
☐ ☐ ☐ Investigation of raw milk dairy
☐ ☐ ☐ Investigation of raw cheese producer
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action _____

TREATMENT

Y N Unk

☐ ☐ ☐ Did patient receive prophylaxis/treatment
Specify medication _____ ☐ Antibiotic ☐ Other _____
Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___
Prescribed dose _____ ☐ g ☐ mg ☐ ml Frequency _____ Duration _____ ☐ Days ☐ Weeks ☐ Months
Indication ☐ PEP ☐ 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 _____