



Brucellosis

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 If yes, Temp measured? Yes No Highest measured temp _____°F

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:	<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 _____

(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 _____

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 _____

Y N Unk

Any contact with animals

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

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 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 _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.