Washington State Department of Health

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 _____ 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

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 _____

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	☐ ☐ ☐	☐ 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

Case Name _____ LHJ Case ID _____

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 ☐ 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 _____

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