Washington State Department of Health

Psittacosis

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** Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	**Chills or rigors**
☐	☐	☐	**Cough** Onset date ___/___/___
☐	☐	☐	Dyspnea (shortness of breath)
☐	☐	☐	**Headache**
☐	☐	☐	**Myalgia (muscle aches or pain)**
☐	☐	☐	Photophobia (eyes sensitive to light)
☐	☐	☐	**Pneumonia**

Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other _____

☐	☐	☐	Rash
☐	☐	☐	Endocarditis
☐	☐	☐	Hepatitis

Psittacosis required variables are in **bold.** Answers are: Yes, No, Unknown to case

Y N Unk
☐ ☐ ☐ Neurological complications _____

Predisposing Conditions

Y N Unk
☐ ☐ ☐ Immunosuppressive therapy or 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 ___/___/___
☐ ☐ ☐ 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 5-28 days 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 _____

☐ ☐ ☐ **Contact with Psittacine bird (e.g., cockatoo, cockatiel, macaw, parakeet, parrot)**
☐ ☐ ☐ **Contact with other pet bird** Specify bird type _____
☐ ☐ ☐ **Contact with domestic fowl (e.g., chicken, turkey)**
☐ ☐ ☐ **Contact with wild bird** Specify bird type _____
☐ ☐ ☐ **Bird dropping or feather exposure without direct contact**
☐ ☐ ☐ **Pet shop visit**
☐ ☐ ☐ **Zoo visit**
☐ ☐ ☐ **Source bird identified** Species _____
☐ ☐ ☐ Was source bird ill
Bird tested for psittacosis ☐ Yes – Positive test result ☐ Yes – Negative test result ☐ Not tested
Origin of infected bird ☐ Private home ☐ Private aviary ☐ Commercial aviary ☐ Pet shop ☐ Bird loft
☐ Poultry establishment ☐ Unk ☐ Other _____
Address of origin location _____
☐ ☐ ☐ **(Potential) Occupational exposure** Specify _____

Exposure and Transmission Summary

Y N Unk
☐ ☐ ☐ **Epidemiologic link to a confirmed or presumptive avian case**
☐ ☐ ☐ **Epidemiologic link to a confirmed or presumptive human case**

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 ☐ Animal related ☐ Person to person ☐ 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 ☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Exposure summary

Public Health Interventions/Actions

Y	**N**	**Unk**	
☐	☐	☐	Quarantine or treat infected birds
☐	☐	☐	Initiate trace-back investigation
☐	☐	☐	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 _____