Psittacosis

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**   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

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 ___________________________________

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