Washington State Department of Health

Q Fever

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

Identified as acute or chronic ☐ Acute ☐ Chronic ☐ Unk

Y	N	Unk	
☐	☐	☐	**Any fever, subjective or measured** If yes, Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	**Chills or rigors**
☐	☐	☐	Cough
☐	☐	☐	Fatigue
☐	☐	☐	Malaise
☐	☐	☐	Diarrhea *(3 or more loose stools within a 24 hour period)*
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Headache
☐	☐	☐	**Severe retrobulbar headache**
☐	☐	☐	Rash
☐	☐	☐	Sweats

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

Y N Unk
☐ ☐ ☐ Myalgia (muscle aches or pain)
☐ ☐ ☐ **Pneumonia**
Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other _____
☐ ☐ ☐ **Elevated liver enzyme levels**
☐ ☐ ☐ **Acute hepatitis**
☐ ☐ ☐ **Chronic hepatitis**
☐ ☐ ☐ **Chronic osteoarthritis**
☐ ☐ ☐ **Chronic osteomyelitis**
☐ ☐ ☐ **Chronic pneumonitis**
☐ ☐ ☐ **Culture-negative endocarditis** (particularly in a patient with previous valvulopathy or compromised immune system)
☐ ☐ ☐ Hepatomegaly
☐ ☐ ☐ Splenomegaly
☐ ☐ ☐ **Suspected infection of a vascular aneurysm**
☐ ☐ ☐ **Suspected infection of a vascular prosthesis**
☐ ☐ ☐ Meningitis/meningoencephalitis

Predisposing Conditions

Y N Unk
☐ ☐ ☐ Immunosuppressive therapy or condition, or disease Specify _____
☐ ☐ ☐ Valvular heart disease or vascular graft

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 3-30 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 _____
☐ ☐ ☐ Household contact of person with occupational exposure

Y N Unk

☐ ☐ ☐ **Unpasteurized milk (cow)**
☐ ☐ ☐ **Other unpasteurized dairy** Specify _____
☐ ☐ ☐ **Any contact with pet animals at home or elsewhere**
☐ ☐ ☐ **Cats or kittens**
☐ ☐ ☐ **Other pets** _____
☐ ☐ ☐ **Any contact with farm animals, including chickens or ducks**
☐ ☐ ☐ **Cows or calves**
☐ ☐ ☐ **Goats**
☐ ☐ ☐ **Sheep**

☐ ☐ ☐ **Other animal contact** _____
☐ ☐ ☐ **Farm or dairy residence or work**
☐ ☐ ☐ **Wildlife or wild animal exposure**
☐ ☐ ☐ **Zoo, farm, fair or pet shop visit**
☐ ☐ ☐ **Other exposure to animals** _____
☐ ☐ ☐ Source animal or bird identified Specify _____
☐ ☐ ☐ Blood transfusion or blood products (e.g., IG, factor concentrates) recipient Date of receipt ___/___/___
☐ ☐ ☐ Organ or tissue transplant recipient Date of receipt ___/___/___
☐ ☐ ☐ **(Potential) Occupational exposure**
☐ ☐ ☐ **Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse)**
Specify animal _____
☐ ☐ ☐ Animal birthing/placentas
☐ ☐ ☐ Animal research
☐ ☐ ☐ Dairy
☐ ☐ ☐ Farm
☐ ☐ ☐ Laboratory
☐ ☐ ☐ Medical research
☐ ☐ ☐ Rancher
☐ ☐ ☐ Slaughterhouse
☐ ☐ ☐ Tanning or rendering
☐ ☐ ☐ Veterinary
☐ ☐ ☐ Wool, felt, hair, or hides

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ Epidemiologic link to a confirmed 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 ☐ Foodborne ☐ Animal related ☐ Vectorborne ☐ Person to person ☐ Sexual
☐ Blood products ☐ Unk ☐ Other _____
Describe _____

Suspected exposure setting ☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Laboratory
☐ Long term care facility ☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Social event
☐ Large public gathering ☐ Other _____
Describe _____

Exposure summary

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
☐ ☐ ☐ Follow-up to assess exposure of laboratorians to specimen

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Notified blood or tissue bank (if recent donation)
☐ ☐ ☐ 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 _____