



Relapsing Fever

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 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

Clinical Features

Y N Unk

- Any fever, subjective or measured** Temp measured? Yes No **Highest measured temp** _____ °F
 Fever onset date ___/___/___
- Recurring fever** Number of attacks _____ Days between attacks _____
- Chills or rigors**
- Headache**
- Myalgia (muscle aches or pain)**
- Arthralgia (joint pain)
- Arthritis
- Other symptoms consistent with this illness _____
- Any complication _____

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

Hospitalization

Y N Unk

- Hospitalized at least overnight for this illness** Facility name _____
- 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
- Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)
 Inpatient ward ICU Other _____

RISK AND RESPONSE (Ask about exposures 2-18 days 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 ____ / ____ / ____

Common exposure setting/activity _____

Slept in places with evidence of rodents (e.g., animals, nest, excreta)

Slept in cabin or outside

Tick bite Date ____ / ____ / ____ Specify location _____

Location WA County _____ Other state Other country Multiple exposures Unk

Infant Only

Birth mother had febrile illness

Exposure and Transmission Summary

Y N Unk

Epi-linked to a confirmed 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 Vectorborne Blood products Other _____

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 _____

Public Health Interventions/Actions

Y N Unk

Education on pest control

Environmental health notified

Environmental investigation

Letter sent Date ____ / ____ / ____ Batch date ____ / ____ / ____

TREATMENT

Y N Unk

Did patient receive prophylaxis/treatment

Specify antibiotic _____

Number of days actually taken _____ Treatment start date ____ / ____ / ____ Treatment end date ____ / ____ / ____

NOTES

LAB RESULTSLab 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 _____

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