Tularemia

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
☐ ☐ ☐ Sweats
☐ ☐ ☐ Malaise
☐ ☐ ☐ Headache
☐ ☐ ☐ **Conjunctivitis**
☐ ☐ ☐ Cough
☐ ☐ ☐ Chest pain
☐ ☐ ☐ **Dyspnea (shortness of breath)**
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Myalgia (muscle aches or pain)
☐ ☐ ☐ Abdominal pain or cramps

Y N Unk

☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Diarrhea (*3 or more loose stools within a 24 hour period)*
☐ ☐ ☐ **Lymphadenopathy**
Location ☐ Cervical ☐ Hilar ☐ Preauricular ☐ Regional
☐ ☐ ☐ **Cutaneous ulcer**
☐ ☐ ☐ Bleeding/DIC
☐ ☐ ☐ **Pharyngitis (sore throat)**
☐ ☐ ☐ **Tonsillitis**
☐ ☐ ☐ **Stomatitis**
☐ ☐ ☐ Pleuropneumonitis
☐ ☐ ☐ **Pneumonia**
Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other ______________________________
☐ ☐ ☐ Shock
☐ ☐ ☐ **Bacteremia**
☐ ☐ ☐ **Sepsis syndrome**
Primary syndrome ☐ Pneumonic ☐ Ulceroglandular ☐ Glandular ☐ Oculoglandular ☐ Oropharyngeal ☐ Intestinal ☐ Typhoidal ☐ Unk
Secondary syndrome (select all that apply) ☐ Pneumonic ☐ Ulceroglandular ☐ Glandular ☐ Oculoglandular ☐ Oropharyngeal ☐ Intestinal ☐ Typhoidal ☐ Unk
☐ ☐ ☐ Acute respiratory distress syndrome (ARDS) Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider only
☐ ☐ ☐ Amputation/ischemia
☐ ☐ ☐ Cardiac arrest
☐ ☐ ☐ Disseminated intravascular coagulopathy (DIC)
☐ ☐ ☐ Multisystem organ failure (failure of 2 or more organs)
☐ ☐ ☐ Renal failure (Cr > 2.0 mg/dl)
☐ ☐ ☐ Secondary pneumonia
☐ ☐ ☐ Any other complication ____

Predisposing Conditions

Y N Unk

☐ ☐ ☐ Cancer
☐ ☐ ☐ Cardiac disease
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ Immunosuppresive therapy or condition, or disease Specify ________________________________
☐ ☐ ☐ Pulmonary disease

Vaccination

Y N Unk

☐ ☐ ☐ History of tularemia vaccination
Vaccine information available ☐ Yes ☐ No
Date of vaccine administration ___/___/___ Administering provider ____________________________

Clinical testing

X-ray result ☐ Clear/normal ☐ Hilar adenopathy ☐ Infiltrates bilateral ☐ Interstitial changes ☐ Pleural effusion ☐ Abscess ☐ Nodules ☐ Ukn ______________________________

Physician Reporting/Patient Health Care

Date first seen by healthcare provider ___/___/___ Location where first seen ______________________________

Hospitalization

Y N Unk

☐ ☐ ☐ **Hospitalized at least overnight for this illness** Facility name ______________________________
Hospital admission date ___/___/___ Discharge ___/___/___ HRN ____________________
Disposition ☐ Another acute care hospital Facility name ______________________________
☐ Died in hospital
☐ Long term acute care facility Facility name ______________________________
☐ Long term care facility Facility name ______________________________
☐ Non-healthcare (home) ☐ Unk ☐ Other ______________________________
☐ ☐ ☐ 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

Y N Unk

☐ ☐ ☐ 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 1-14 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 ________________________________

☐ ☐ ☐ **Illness associated with other human tularemia case**

☐ ☐ ☐ Did case have a known *F. tularensis* exposure (e.g., laboratory 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 ☐ Unk ☐ Other ________________________________

What was exposure status ☐ High risk ☐ Low risk ☐ Unk

Where did exposure happen ________________________________

☐ ☐ ☐ **Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)**

Activity ☐ Outdoor recreation ☐ Cabin ☐ Hunting ☐ Lawn mowing ☐ Other ________________________

Habitat ☐ Wooded/brushy ☐ Grassy ☐ Other ________________________________

Where ☐ At home property ☐ Elsewhere ________________________________

☐ ☐ ☐ **Hunted or skinned animals**

☐ ☐ ☐ Ate uncooked wild game

☐ ☐ ☐ Contact or ingestion of soil

☐ ☐ ☐ Inhalation of dust from soil, grain or hay

☐ ☐ ☐ **(Potential) Occupational exposure**

☐ ☐ ☐ **Lab worker**

☐ ☐ ☐ **Work with animals or animal products (e.g., research, veterinary medicine, slaughterhouse)**

Specify animal ________________________________

☐ ☐ ☐ **Veterinarian**

☐ ☐ ☐ Other Occupation ________________________________

Water Exposure

Y N Unk **Describe**

☐ ☐ ☐ Source of drinking water known

☐ ☐ ☐ Bottled water ________________________________

☐ ☐ ☐ Public water system ________________________________

☐ ☐ ☐ Individual well ________________________________

☐ ☐ ☐ Shared well ________________________________

☐ ☐ ☐ Other ________________________________

☐ ☐ ☐ Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring) ________________________________

☐ ☐ ☐ **Recreational water exposure (e.g., lake, river, pool, waterpark)** ________________________________

Animal Exposure

Y N Unk

☐ ☐ ☐ **Any contact with pet animals at home or elsewhere**

☐ ☐ ☐ Cats or kittens

☐ ☐ ☐ Dogs or puppies

☐ ☐ ☐ Rats, mice, gerbils or hamsters

☐ ☐ ☐ Pocket or "exotic" pets (ferrets, pygmy hedgehogs, sugar gliders, guinea pigs, prairie dogs, etc.)

Specify ________________________________

☐ ☐ ☐ Pet birds such as parakeets, parrots, cockatiels ________________________________

☐ ☐ ☐ Other pets ________________________________

Y N Unk
☐ ☐ ☐ Have any pets been ill or died Describe ________________________________
☐ ☐ ☐ Have any pets brought home any dead animals Describe ________________________________
☐ ☐ ☐ Pets free roaming
☐ ☐ ☐ Exposed to domestic or wild rabbits
☐ ☐ ☐ Wildlife or wild animal exposure ________________________________
☐ ☐ ☐ Wild animals dead or sick
☐ ☐ ☐ Other exposure to animals ________________________________
☐ ☐ ☐ **Insect bite** Date of exposure ___/___/___
Type ☐ Tick ☐ Mosquito ☐ Flea ☐ Louse ☐ Deer fly ☐ Other ________________________________
Location of exposure ☐ Multiple exposures ☐ Other country ☐ Other state ☐ Unk ☐ WA county ___________
Specify location ________________________________

Exposure and Transmission Summary

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 ☐ Waterborne ☐ Animal related ☐ Vectorborne ☐ Unk
☐ Other ________________________________
Describe ________________________________

Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ 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 ☐ Restaurant
☐ Hotel/motel/hostel ☐ 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 specimens Number of persons exposed _______

Public Health Interventions/Actions

Y N Unk
☐ ☐ ☐ Notified blood or tissue bank (if recent donation)
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

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 ________________________________