Washington State Department of Health

Tularemia

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

☐ ☐ ☐ 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)

Y N Unk
☐ ☐ ☐ 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**

Case Name _____ LHJ Case ID _____

Y N Unk

☐ ☐ ☐ 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 _____
Exposure 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

Case Name _____ LHJ Case ID _____

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 _____