



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 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 Illness is still ongoing Yes No Unk

Clinical Features**Y N Unk**

Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F
 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 OnlyResult 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
- Immunosuppressive 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 Unk _____

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:	<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 ___/___/___
- 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**

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 |
|--|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Source of drinking water known |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Bottled water _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Public water system _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Individual well _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Shared well _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring) _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 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 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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