# Unexplained Critical Illness or Death

**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
☐ ☐ ☐ Endocarditis
☐ ☐ ☐ Myocarditis
☐ ☐ ☐ Pericarditis or pericardial effusion
☐ ☐ ☐ Respiratory infection
☐ ☐ ☐ Respiratory failure
☐ ☐ ☐ Diarrhea *(3 or more loose stools within a 24 hour period)*
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Abdominal pain or cramps
☐ ☐ ☐ Liver abnormality or failure
☐ ☐ ☐ Renal failure
☐ ☐ ☐ Neurologic abnormality
☐ ☐ ☐ Acute CNS event
☐ ☐ ☐ Meningitis/meningoencephalitis

☐ ☐ ☐ Encephalitis or encephalomyelitis
☐ ☐ ☐ Acute flaccid paralysis
☐ ☐ ☐ Paralysis or weakness
☐ ☐ ☐ Ascending
☐ ☐ ☐ Descending
☐ ☐ ☐ Asymmetric
☐ ☐ ☐ Symmetric
☐ ☐ ☐ Acute
☐ ☐ ☐ Botulism-like syndrome
☐ ☐ ☐ Rash observed by health care provider
☐ ☐ ☐ Generalized
☐ ☐ ☐ Localized
☐ ☐ ☐ Bullous
☐ ☐ ☐ Macular
☐ ☐ ☐ Papular
☐ ☐ ☐ Pustular
☐ ☐ ☐ Vesicular
☐ ☐ ☐ On palms and soles
☐ ☐ ☐ Regional lymphadenitis (bubo)
☐ ☐ ☐ Axillary
☐ ☐ ☐ Cervical
☐ ☐ ☐ Femoral
☐ ☐ ☐ Inguinal
☐ ☐ ☐ Pharyngeal
☐ ☐ ☐ Other location ___________________________________
☐ ☐ ☐ Erythematous
☐ ☐ ☐ Tender
Size ___________________________________
☐ ☐ ☐ Shock
☐ ☐ ☐ Sepsis syndrome
☐ ☐ ☐ Hemorrhagic signs
☐ ☐ ☐ Blood in vomitus, stool, urine
☐ ☐ ☐ Epistaxis (nose bleed)
☐ ☐ ☐ Gum bleeding
☐ ☐ ☐ Petechiae
☐ ☐ ☐ Positive tourniquet test
☐ ☐ ☐ Positive urinalysis
☐ ☐ ☐ Vaginal bleeding
☐ ☐ ☐ Other ___________________________________
☐ ☐ ☐ Disseminated intravascular coagulopathy
☐ ☐ ☐ Histopathologic evidence of an acute infectious process
☐ ☐ ☐ Final diagnosis established ___________________________________

**Predisposing Conditions**

**Y N Unk**
☐ ☐ ☐ Chronic heart disease
☐ ☐ ☐ Chronic lung disease
☐ ☐ ☐ Chronic liver disease
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ HIV infection
☐ ☐ ☐ Immunosuppressive therapy, condition or disease
☐ ☐ ☐ Spleen removed (asplenic)
☐ ☐ ☐ Evidence of toxic ingestion or exposure
☐ ☐ ☐ Nosocomial infectious prior to the onset of illness
☐ ☐ ☐ Cancer, solid tumors, or hematologic malignancies ___________________________________
☐ ☐ ☐ Trauma thought to be related to illness
☐ ☐ ☐ Preexisting medical condition which may have contributed to the current illness or death
No known predisposing conditions (previously healthy) ☐ True ☐ False ☐ Ukn

**Clinical Testing**

**Y N Unk**
☐ ☐ ☐ Leukocytosis (white blood cell county above normal)

**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 ___________________________________

**Y N Unk**

☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ 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 (Note that the questions below are intended to cover general exposures of risk. If other exposures of concern are raised during the interview, collect information including locations, dates, and details of exposure)**

**Travel**

| | Setting 1 | Setting 2 | Setting 3 |
|---|---|---|---|
| **Travel out of:** | ☐ County/City ______________<br>☐ State ______________<br>☐ Country ______________<br>☐ Other ______________ | ☐ County/City ______________<br>☐ State ______________<br>☐ Country ______________<br>☐ Other ______________ | ☐ County/City ______________<br>☐ State ______________<br>☐ Country ______________<br>☐ 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 ________________________________
☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care ☐ Dormitory ☐ Boarding school ☐ Camp ☐ Shelter
☐ Other ________________________________
☐ ☐ ☐ Invasive medical procedure Describe ________________________________
☐ ☐ ☐ Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
☐ ☐ ☐ Injected drugs not prescribed by a doctor, even if only once or a few times Describe ________________________
☐ ☐ ☐ Any contact with wild animals at home or elsewhere
☐ ☐ ☐ Wildlife or wild animal exposure
☐ ☐ ☐ 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 ☐ Person to person ☐ Sexual
☐ Blood products ☐ IDU ☐ Health care associated ☐ Unk ☐ Other ________________________________
Describe ________________________________________________________________

Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient facility ☐ 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

Suspected transmission type (check all that apply) ☐ Foodborne ☐ Waterborne ☐ Animal related ☐ Vectorborne
☐ Person to person ☐ Sexual ☐ Blood products ☐ IDU ☐ Health care associated ☐ Unk
☐ Other ________________________________
Describe ________________________________________________________________

Case Name ________________________________ LHJ Case ID ________________________________

Suspected transmission setting (check all that apply) ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ 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 ________________________________________________________________

**Public Health Interventions/Actions**

**Y N Unk**

☐ ☐ ☐ Potential bioterrorism exposure
☐ ☐ ☐ Notified FBI or Public Safety
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

## TRANSMISSION TRACKING (Complete if person-to-person transmission or common exposure is suspected)

Visited, attended, employed, or volunteered at any public settings while contagious ☐ Yes ☐ No ☐ Unk
Settings and details (check all that apply)
☐ Day care ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Health care ☐ Home ☐ Work ☐ College
☐ Military ☐ Correctional facility ☐ Place of worship ☐ International travel ☐ Out of state travel ☐ LTCF
☐ Homeless/shelter ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other

| | Setting 1 | Setting 2 | Setting 3 | Setting 4 |
|---|---|---|---|---|
| Setting Type (as checked above) | | | | |
| Facility Name | | | | |
| Start Date | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |
| End Date | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |
| Time of Arrival | | | | |
| Time of Departure | | | | |
| Number of people potentially exposed | | | | |
| Details (hotel room #, HC type, transit info, etc.) | | | | |
| Contact information available for setting (who will manage exposures or disease control for setting) | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk |
| Is a list of contacts known? | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk |

*If list of contacts is known, please fill out Contact Tracing Form Question Package*

## TREATMENT

**Y N Unk**

☐ ☐ ☐ Did patient receive prophylaxis/treatment
Specify medication ________________________ ☐ Antibiotic ☐ Fungal/Parasitic ☐ Antiviral ☐ Immune globulin/Antitoxin
☐ Other ________________________________
Number of days actually taken _______ Treatment start date ___/___/___ Treatment end date ___/___/___
Prescribed dose _______ ☐ g ☐ mg ☐ ml Frequency _______ Duration _______ ☐ Days ☐ Weeks ☐ Months
Indication ☐ PEP ☐ PrEP ☐ 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 ________________________________