Unexplained Critical Illness or Death

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
☐ ☐ ☐ 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 ______________________

Y N Unk

☐ ☐ ☐ 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 ____________ ☐ State ____________ ☐ Country ____________ ☐ Other ____________	☐ County/City ____________ ☐ State ____________ ☐ Country ____________ ☐ Other ____________	☐ County/City ____________ ☐ State ____________ ☐ Country ____________ ☐ Other ____________
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Case Name ________________________________ LHJ Case ID ________________________________

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 ________________________________

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 ___/___/___

Case Name ________________________________ LHJ Case ID ________________________________

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 ________________________________

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