Plague

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 ____________
Contact name ____________________
Contact phone ____________________

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___
Illness duration _______ ☐ Days ☐ Weeks ☐ Months ☐ Years

Clinical Features

Primary clinical syndrome ☐ Bubonic ☐ Pneumonic ☐ Septicemic
Secondary clinical syndrome ☐ Bubonic ☐ Pneumonic ☐ Septicemic

Y	N	Unk	
☐	☐	☐	**Any fever, subjective or measured** Temp measured? ☐ Yes ☐ No Highest measured temp _______ºF
☐	☐	☐	**Chills or rigors**
☐	☐	☐	**Pharyngitis (sore throat)**
☐	☐	☐	**Headache**
☐	☐	☐	Fatigue
☐	☐	☐	**Malaise**
☐	☐	☐	Myalgia (muscle aches or pain)
☐	☐	☐	Arthralgia (joint pain)
☐	☐	☐	Bloody sputum
☐	☐	☐	Chest pain

Case Name ________________________________ LHJ Case ID ________________________________

Y N Unk

☐ ☐ ☐ Cough
☐ ☐ ☐ Dyspnea (shortness of breath)
☐ ☐ ☐ Respiratory distress
☐ ☐ ☐ **Pneumonia**
☐ ☐ ☐ **Secondary pneumonia**
☐ ☐ ☐ Confusion
☐ ☐ ☐ **Regional lymphadenitis (bubo)**
☐ ☐ ☐ **Septicemia**
☐ ☐ ☐ Shock
☐ ☐ ☐ Skin abscess or ulcer
☐ ☐ ☐ Amputation/limb ischemia
☐ ☐ ☐ Cardiac arrest
☐ ☐ ☐ Disseminated intravascular coagulopathy (DIC)
☐ ☐ ☐ Multisystem organ failure (failure of 2 or more organs)
☐ ☐ ☐ Renal failure (Cr > 2.0 mg/dl)
☐ ☐ ☐ Intubation

Predisposing Conditions

Y N Unk

☐ ☐ ☐ Cardiovascular disease
☐ ☐ ☐ Pulmonary disease
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ Cancer
☐ ☐ ☐ Immunosuppressive therapy, condition, or disease
☐ ☐ ☐ Other underlying medical condition ________________________________

Physician Reporting/Patient Health Care

Date first seen by health care provider ___/___/___ Location where first seen ________________________________
Heart rate when first seen _______
Blood pressure when first seen _______/_______

Vaccination

Y N Unk

☐ ☐ ☐ Vaccination for plague

Vaccine information available ☐ Yes ☐ No
Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________
Vaccine lot number ______________________________ Administering provider ______________________________

Clinical Testing

Date initial blood tests ___/___/___

Y N Unk

☐ ☐ ☐ **White blood cell count obtained (white blood cell count x 10^3)**
Percent bands _______ Percent segments _______ Percent lymphocytes _______

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
☐ ☐ ☐ 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 ________________________________

Case Name ________________________________ LHJ Case ID ________________________________

RISK AND RESPONSE (Ask about exposures 1-7 days before symptom onset)

Travel

Y N Unk

	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 ____________________

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

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

Where ☐ At home property ☐ Elsewhere ____________________

☐ ☐ ☐ **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 ____________________

☐ ☐ ☐ Other pets ____________________

☐ ☐ ☐ Have any pets been ill or died Describe ____________________

☐ ☐ ☐ Have any pets brought home any dead animals Describe ____________________

☐ ☐ ☐ Pets free roaming

☐ ☐ ☐ Wildlife or wild animal exposure ____________________

☐ ☐ ☐ Handled sick or dead animals Date(s) ___/___/___ Exposure(s) ____________________

☐ ☐ ☐ Handled tissue of infected animals Date(s) ___/___/___ Exposure(s) ____________________

☐ ☐ ☐ Observe any animals or insects/evidence of animals or insects (e.g., droppings) around home/work

☐ Fleas ☐ Rodents

☐ ☐ ☐ Wild rodent or wild rodent excreta exposure

☐ ☐ ☐ Slept in places with evidence of rodents (e.g., animals, nest, excreta)

☐ ☐ ☐ Slept in cabin or outside

☐ ☐ ☐ 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 ____________________

☐ ☐ ☐ (Potential) Occupational exposure

☐ ☐ ☐ Lab worker

☐ ☐ ☐ Veterinarian

☐ ☐ ☐ Other ____________________

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ **Epidemiologic link to a confirmed human case**

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 ☐ Animal related ☐ Vectorborne ☐ Person to person ☐ Health care associated ☐ 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 ____________________

Case Name ______________________________ LHJ Case ID ______________________________

Exposure summary

Suspected transmission type ☐ Person to person ☐ Health care associated ☐ Unk ☐ Other ______________________

Describe ____

Suspected transmission 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 ________________________

Public Health Issues

Y N Unk
☐ ☐ ☐ Illness resulted in any secondary cases
☐ ☐ ☐ Attended social gatherings or crowded settings
☐ ☐ ☐ Potential bioterrorism exposure
☐ ☐ ☐ Notify FBI or public safety

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y N Unk
☐ ☐ ☐ Isolation while symptomatic (pulmonary or pharyngeal)
☐ ☐ ☐ Chemoprophylaxis or quarantine (for 7 days) of contacts, including medical personnel
☐ ☐ ☐ Education on rodent control
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING

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 antibiotic ______________________

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 ___________________________________