Plague

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

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
☐	☐	☐	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 ______________________________

Case Name ________________________________ LHJ Case ID ________________________________

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 ________________________________

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

Y N Unk

☐ ☐ ☐ 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 ______________________________

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 ___/___/___

Case Name ________________________________ LHJ Case ID ________________________________

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 ___/___/___

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Ordering Provider
WDRS ordering provider ______________________________

Ordering facility
WDRS ordering facility name ______________________________

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