Washington State Department of Health

Yellow Fever

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 Illness is still ongoing ☐ Yes ☐ No ☐ Unk

Clinical Features
Primary clinical syndrome ☐ Asymptomatic ☐ Uncomplicated fever ☐ Meningitis ☐ Encephalitis/meningoencephalitis
☐ Other neuroinvasive ☐ Hepatitis/jaundice ☐ Multi-organ failure
☐ Kidney (renal) abnormality or failure ☐ Unk
☐ Other clinical syndrome ____________________

Y N Unk
☐ ☐ ☐ Asymptomatic (no clinical illness)
☐ ☐ ☐ **Any fever, subjective or measured** If yes, Temp measured? ☐ Yes ☐ No Highest measured temp _______ºF
If no, **Y N Unk**
☐ ☐ ☐ Has immunosuppressive condition (e.g., HIV/AIDS)
Specify ____________________
☐ ☐ ☐ Used OTC medications that reduce fever
☐ ☐ ☐ Used treatments that suppress the immune system
☐ ☐ ☐ Other potential reason for lack of fever ____________________

Y N Unk
☐ ☐ ☐ **Chills or rigors**
☐ ☐ ☐ Hemorrhagic diathesis (gastrointestinal bleeding)
☐ ☐ ☐ Hemorrhagic signs
☐ ☐ ☐ Blood in vomitus, stool, urine
☐ ☐ ☐ Epistaxis (nose bleed)
☐ ☐ ☐ Gum bleeding
☐ ☐ ☐ Petechiae
☐ ☐ ☐ Positive tourniquet test
☐ ☐ ☐ Positive urinalysis
☐ ☐ ☐ Purpura/ecchymosis
☐ ☐ ☐ Vaginal Bleeding
☐ ☐ ☐ Other ________________________________
☐ ☐ ☐ **Pale stool, dark urine, yellowing of skin or eyes (jaundice)**
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Back pain
☐ ☐ ☐ **Myalgia (muscle aches or pain)**
☐ ☐ ☐ **Severe headache**
☐ ☐ ☐ Seizure new with disease
☐ ☐ ☐ Liver failure
☐ ☐ ☐ Proteinuria
☐ ☐ ☐ Kidney (renal) abnormality or failure
☐ ☐ ☐ Viral encephalitis in past (e.g., dengue, SLE, West Nile virus)

Hospitalization

Y N Unk
☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name ________________________________
Hospital admission date ___/___/___ Discharge ___/___/___ HRN ____________________
☐ ☐ ☐ 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

Pregnancy

Pregnancy status at time of symptom onset
☐ Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _______
OB name, phone, address ____
Outcome of pregnancy ☐ Still pregnant ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other ________________________________
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk
☐ Postpartum (Estimated) delivery date ___/___/___
OB name, phone, address ____
Outcome of pregnancy ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other ________________________________
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk
☐ Neither pregnant nor postpartum ☐ Unk

Vaccination

Y N Unk
☐ ☐ ☐ **Japanese encephalitis or yellow fever vaccination**

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

Clinical testing

Y N Unk
☐ ☐ ☐ **Albuminuria**
☐ ☐ ☐ Leukopenia
☐ ☐ ☐ Cross-reaction to other flaviviruses
☐ ☐ ☐ **Total bilirubin $\geq$ 3 mg/dl**

Case Name ___________________________________ LHJ Case ID ___________________________________

RISK AND RESPONSE (Ask about exposures 3-9 days before symptom onset)

Travel

Y N Unk

☐ ☐ ☐ **During the previous two weeks prior to onset of illness, travel to or residence in an area with a risk of yellow fever**

	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 ____________________

Habitat ☐ Wooded/brushy ☐ Grassy ☐ Other ____________________

Where ☐ At home property ☐ Elsewhere ____________________

☐ ☐ ☐ In area with mosquito activity or remember bite Date ___/___/___

Location of exposure ☐ Multiple exposures ☐ Other country ☐ Other state ☐ Unk ☐ WA county ___________

Specify location ____________________

☐ ☐ ☐ Blood transfusion or blood products (e.g., IG, factor concentrates) recipient Date ___/___/___

☐ ☐ ☐ Organ or tissue transplant recipient Date ___/___/___

☐ ☐ ☐ (Potential) Occupational exposure

☐ ☐ ☐ Lab worker

☐ ☐ ☐ Veterinarian

☐ ☐ ☐ Other Occupation ____________________

Infant Only

☐ ☐ ☐ Birth mother had febrile illness

☐ ☐ ☐ Breast fed

☐ ☐ ☐ Confirmed infection in birth mother

☐ ☐ ☐ Neonatal infection

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ **Epi-linked to a confirmed 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 ☐ Vectorborne ☐ Blood products ☐ Unk ☐ 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____________________

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Breastfeeding education provided
☐ ☐ ☐ Notified blood or tissue bank (if recent donation)
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action ___________________________________

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 ___________________________________