



Yellow Fever

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 _____ LHMJ _____

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 child's) 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

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

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 _____°F
 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 ≥ 3 mg/dl**

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:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> 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 _____

Y N Unk

- 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 RESULTSLab 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 PendingTest 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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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