Rare Disease of Public Health Importance

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 ___
Name ___ 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

Disease ☐ Acanthamoeba ☐ African sleeping sickness (African trypanosomiasis) ☐ Balamuthia mandrillaris
☐ Chagas disease (American trypanosomiasis) ☐ Cysticercosis ☐ Hansen disease ☐ Histoplasmosis
☐ Kawasaki disease ☐ Leishmaniasis ☐ Lymphocytic choriomeningitis ☐ Monkeypox ☐ Naegleria fowleri
☐ Orf ☐ Ricin poisoning ☐ Schistosomiasis ☐ Smallpox ☐ Streptococcal disease, invasive, Group A
☐ Streptococcal disease, invasive, Group B ☐ Streptococcus pneumoniae, invasive ☐ Strongyloides
☐ Taenia solium ☐ Toxic shock syndrome ☐ Toxoplasmosis ☐ Typhus ☐ Other ___

Clinical Features

Y N Unk
☐ ☐ ☐ Any fever, subjective or measured Temp measured? ☐ Yes ☐ No Highest measured temp ___ ºF
☐ ☐ ☐ Cardiac involvement/complication
☐ ☐ ☐ Pneumonia
Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other ___
☐ ☐ ☐ Diarrhea *(3 or more loose stools within a 24 hour period)*
☐ ☐ ☐ Vomiting

Y N Unk

☐ ☐ ☐ Liver abnormality or failure
☐ ☐ ☐ Kidney (renal) abnormality or failure
☐ ☐ ☐ Rash
☐ ☐ ☐ Rash observed by health care provider Describe ________________________________
☐ ☐ ☐ Skin abscess or ulcer
☐ ☐ ☐ Bone or organ infection
☐ ☐ ☐ Anemia
☐ ☐ ☐ Hemorrhage or bleeding
☐ ☐ ☐ Myalgia (muscle aches or pains)
☐ ☐ ☐ Headache
☐ ☐ ☐ Altered mental status
☐ ☐ ☐ Meningitis
☐ ☐ ☐ Encephalitis/meningoencephalitis
☐ ☐ ☐ Acute flaccid paralysis
☐ ☐ ☐ Paralysis or weakness
☐ ☐ ☐ Ascending
☐ ☐ ☐ Descending
☐ ☐ ☐ Asymmetric
☐ ☐ ☐ Symmetric
☐ ☐ ☐ Acute
☐ ☐ ☐ Seizure new with disease
☐ ☐ ☐ Neurologic abnormality Specify ________________________________
☐ ☐ ☐ Sepsis syndrome
☐ ☐ ☐ Any complication ________________________________
☐ ☐ ☐ Preliminary diagnosis established ________________________________
☐ ☐ ☐ Final diagnosis established ________________________________

Predisposing Conditions

Y N Unk

☐ ☐ ☐ Immunosuppressive therapy, condition, or disease ________________________________

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 ___/___/___
☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk

☐ ☐ ☐ Died of this illness Death date ___/___/___ *Please fill in death date information on 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

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 ___/___/___

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country ________________________________
☐ ☐ ☐ Contact with recent foreign arrival Country ________________________ Date(s) of contact ___/___/___
☐ ☐ ☐ 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 ________________________________
☐ ☐ ☐ Suspected person-to-person transmission
☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care ☐ Dormitory ☐ Boarding school ☐ Camp ☐ Shelter
☐ Other ________________________________
☐ ☐ ☐ Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
☐ ☐ ☐ Any recreational water exposure (e.g., lake, river, pool, waterpark)
☐ ☐ ☐ Rodent, bird or other animal exposure ________________________________

Y N Unk

☐ ☐ ☐ 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 ___________________________________

☐ ☐ ☐ Blood, organ or tissue transplant recipient Date ___/___/___

☐ ☐ ☐ (Potential) Occupational exposure Date ___/___/___

☐ ☐ ☐ Lab worker

☐ ☐ ☐ Other ___________________________________

☐ ☐ ☐ Bioterrorism related

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 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___________________________________

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

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Notified blood or tissue bank (if recent donation)

☐ ☐ ☐ Isolation precautions

☐ ☐ ☐ Prophylaxis of appropriate contacts recommended

☐ ☐ ☐ Household members

☐ ☐ ☐ Roommates

☐ ☐ ☐ Carpools

☐ ☐ ☐ Coworkers

☐ ☐ ☐ Teammates

☐ ☐ ☐ Child care contacts

☐ ☐ ☐ Playmates

☐ ☐ ☐ Other children

☐ ☐ ☐ EMTs

☐ ☐ ☐ Medical personnel

☐ ☐ ☐ Other patients

☐ ☐ ☐ Other close contacts ___________________________________

☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

☐ ☐ ☐ Any other public health action ___________________________________

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 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 ___________________________________