Cryptococcus gattii

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 Source ☐ Medical record ☐ Other ____________
Illness duration _______ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk
Diagnosis date ___/___/___ *First date diagnosis known to be a cryptococcal infection, not necessarily known to be C. gattii*

Clinical Features

Y N Unk
☐ ☐ ☐ **Asymptomatic**
☐ ☐ ☐ **Any fever, subjective or measured** If yes, Temp measured? ☐ Yes ☐ No Highest measured temp _______ºF
☐ ☐ ☐ Chills or rigors
☐ ☐ ☐ Sweats
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Headache
☐ ☐ ☐ Myalgia (muscle aches or pain)
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Anorexia (loss of appetite)
☐ ☐ ☐ Weight loss with illness

Y N Unk
- ☐ ☐ ☐ **Altered mental status**
- ☐ ☐ ☐ **Cough**
- ☐ ☐ ☐ **Dyspnea (shortness of breath)**
- ☐ ☐ ☐ **Chest pain**
- ☐ ☐ ☐ Nuchal rigidity (stiff neck)
- ☐ ☐ ☐ Photophobia (eyes sensitive to light)
- ☐ ☐ ☐ Blurred vision
- ☐ ☐ ☐ **Meningitis** *diagnosed by CSF culture or antigen*
- ☐ ☐ ☐ Seizure new with disease
- ☐ ☐ ☐ Papilloedema
- ☐ ☐ ☐ Skin abscess or ulcer
- ☐ ☐ ☐ Subcutaneous nodules Explain ___________________________________
- ☐ ☐ ☐ Organ involvement Specify ___________________________________

Outcome of C. gattii illness ☐ Died from C. gattii infection ☐ Died with C. gattii, but from unrelated cause
☐ Alive, progressive worsening of C. gattii infection ☐ Alive, stable C. gattii infection (no change)
☐ Alive, partial response (partial improvement) ☐ Alive, complete response (recovered)

Date of outcome ___/___/___

Time from initiation of therapy to outcome ☐ 1 week ☐ 2 weeks ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks ☐ Other _________

Y N Unk
- ☐ ☐ ☐ Still symptomatic at report date
- ☐ ☐ ☐ Any additional infections (opportunistic or otherwise) that occurred during the period of C. gattii infection
  - How long after starting therapy did the infection develop ___________________________________
  - Outcome of infection ___________________________________
  - Type of infection ___________________________________
- ☐ ☐ ☐ Any form of surgery (e.g., lobectomy, shunt insertion, drainage) performed as part of the management of C. gattii infection
  - Date of surgery ___/___/___ Indication for surgery ___________________________________
  - Type of surgery ___________________________________
- ☐ ☐ ☐ Developed cranial nerve palsies
  - Time from initiation of therapy to onset of cranial nerve palsies ___________________________________
- ☐ ☐ ☐ Ocular disorders Explain ___________________________________
- ☐ ☐ ☐ Metastatic foci of infection Site of infection ___________________________________

Predisposing Conditions

Y N Unk
- ☐ ☐ ☐ Allogenic stem cell transplant Date ___/___/___
- ☐ ☐ ☐ Autologous stem cell transplant Date ___/___/___
- ☐ ☐ ☐ Cancer, solid tumors, or hematologic malignancies Specify ___________________________________
- ☐ ☐ ☐ Cardiovascular conditions Specify ___________________________________
- ☐ ☐ ☐ Chronic kidney disease
- ☐ ☐ ☐ Chronic lung disease (e.g., COPD, emphysema) Specify ___________________________________
- ☐ ☐ ☐ Connective tissue disorder Specify ___________________________________
- ☐ ☐ ☐ Current tobacco smoker
- ☐ ☐ ☐ Former tobacco smoker
- ☐ ☐ ☐ Diabetes mellitus
- ☐ ☐ ☐ HIV infection
- ☐ ☐ ☐ Immunosuppressive therapy before illness onset
- ☐ ☐ ☐ Systemic oral steroids (e.g., cortisone, prednisone) in the year before onset Specify ______________________________
- ☐ ☐ ☐ Liver disease
- ☐ ☐ ☐ Organ transplant Specify ___________________________________
- ☐ ☐ ☐ Rheumatologic disease

No known predisposing conditions (previously healthy) ☐ True ☐ False ☐ Ukn

Clinical Testing

Y N Unk
- ☐ ☐ ☐ Scan/X-rays normal
- ☐ ☐ ☐ CD4 count obtained within 1 month of diagnosis CD4 count _______
- ☐ ☐ ☐ Neutropenic in last 30 days (ANC<1.0x10^9/L) Total peripheral white cell count _______
- ☐ ☐ ☐ **Cryptococcoma**
  - Diagnosed by ☐ Chest X-ray ☐ Head CT/MRI ☐ Thoracic CT scan Date of scan/X-ray ___/___/___
  - Number _______ Site (enter all) ___________________________________
- ☐ ☐ ☐ **Lymphadenopathy**
  - **Diagnosed by** ☐ Chest X-ray ☐ Head CT/MRI ☐ Thoracic CT scan Date of scan/X-ray ___/___/___
- ☐ ☐ ☐ **Pleural effusion**
  - **Diagnosed by** ☐ Chest X-ray ☐ Head CT/MRI ☐ Thoracic CT scan Date of scan/X-ray ___/___/___

☐ ☐ ☐ **Pneumonia**
Diagnosed by ☐ Chest X-ray ☐ Head CT/MRI ☐ Thoracic CT scan ☐ Clinic only
Date of scan/X-ray ___/___/___
☐ ☐ ☐ **Encephalitis**
Diagnosed by ☐ Chest X-ray ☐ Head CT/MRI ☐ Thoracic CT scan Date of scan/X-ray ___/___/___

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

RISK AND RESPONSE (Ask about exposures 2-13 months before symptom onset)

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 ____________________________
☐ ☐ ☐ Camping or hiking Explain ________________________________
☐ ☐ ☐ Construction using lumber Explain ________________________________
☐ ☐ ☐ Yard landscaping (more than maintenance) Type ☐ Home ☐ Professionally
If Professionally, Location ________________________________
☐ ☐ ☐ Changed residence during past 13 months Explain ________________________________
☐ ☐ ☐ Homeless
☐ ☐ ☐ No home of record
☐ ☐ ☐ Case residence <1 mile from a crop farm
☐ ☐ ☐ Case residence <1 mile from a soil disturbance (excavation, construction, pipe laying, etc.)
☐ ☐ ☐ Case residence <1 mile from animal farm What type of farm ________________________________
☐ ☐ ☐ Case residence <1 mile from logging/vegetation clearing
☐ ☐ ☐ Case residence <1 mile from wooded area
☐ ☐ ☐ Logging/clearing of lots
☐ ☐ ☐ Cutting individual trees Explain ________________________________
Type of trees ________________________
☐ ☐ ☐ Handle wood on a regular basis (sawing, chopping, stacking, etc.) Type of wood ____________________________
☐ ☐ ☐ Involved in close proximity to other activities that disturbed trees/soil Explain ____________________________
☐ ☐ ☐ Moving or digging earth, or gardening Explain ________________________________
☐ ☐ ☐ Spreading bark mulch/wood chips Explain ________________________________
☐ ☐ ☐ Was wood (e.g., for burning) or other vegetation brought into the home
☐ ☐ ☐ Were any of your pets diagnosed with cryptococcal infection Explain ________________________________
☐ No risk factors or likely exposures could be identified

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 setting ☐ Day care/Childcare ☐ School (not college) ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel
☐ Out of state travel ☐ Other ________________________________
Describe ____

Case Name ________________________________ LHJ Case ID ________________________________

Exposure summary

Public Health Interventions/Actions

Y N Unk

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

☐ ☐ ☐ Any other public health action ________________________________

TREATMENT

Y N Unk

☐ ☐ ☐ Did patient receive prophylaxis/treatment

Specify medication ______________________ ☐ Antibiotic ☐ Fungal/Parasitic

☐ 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 ________________________________