



Cryptococcus gattii

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 _____ LHM Case ID (optional) _____

LHM 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 _____ LHM _____

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 LHM Cluster ID _____ Cluster Name _____

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 _____ °F
 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 _____

Y N Unk

- 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 Unk

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<1.0x10⁹/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:	<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 _____
- 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 _____

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 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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