Washington State Department of HEALTH

# 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** _____ 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** _____ LHJ _____

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 childs) 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

Case Name _____ LHJ Case ID _____

## 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 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 _____

Case Name _____ LHJ Case ID _____

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 ☐ 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 _____<br>☐ State _____<br>☐ Country _____<br>☐ Other _____ | ☐ County/City _____<br>☐ State _____<br>☐ Country _____<br>☐ Other _____ | ☐ County/City _____<br>☐ State _____<br>☐ Country _____<br>☐ Other _____ |
| Destination name | | | |
| Start and end dates | ___/___/___ to ___/___/___ | ___/___/___ to ___/___/___ | ___/___/___ to ___/___/___ |

Case Name _____ LHJ Case ID _____

**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 _____

Case Name _____ LHJ Case ID _____

## 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 _____

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