



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

Highly antibiotic resistant organism
(CRE, other gram negative, Staph, Strep and Candida)

County _____

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 LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived
Diagnosis date ___/___/___ Date of first positive case defining lab ___/___/___
Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk
Organism type/Genus/Species
 Candida auris
 CRA Acinetobacter Baumannii
 CRE Escherichia Coli
 Klebsiella Oxytoca Pneumoniae Aerogenes Other _____
 Enterobacter Aerogenes Cloacae Other _____
 Citrobacter Brakkii Freundi Other _____
 Serratia Marcescens Other _____
 Proteus Mirabilis Penneri Other _____
 CRP Pseudomonas Aeruginosa
 MRSA
 Other _____

Specimen Information

Types of infection associated with specimen(s) None (colonized) Abscess, not skin AV fistula/graft infection
 Bacteremia Bursitis Catheter site infection (CVC) Cellulitis/skin Decubitus/pressure ulcer
 Empyema Endocarditis Meningitis Osteomyelitis Peritonitis Pneumonia Pyelonephritis
 Septic arthritis Septic emboli Sepsis Skin abscess Surgical incision infection
 Surgical site infection (internal) Traumatic wound Ulcer/wound (not decubitus)
 Urinary tract infection (lower tract) Unk Other _____
County/State of facility where specimen collected _____
Type of Specimen Clinical Screening Unk
Physical location type of the patient when the specimen was collected Morgue Hospital Long-term acute care hospital
 Long-term care facility Outpatient Unknown Other _____
Y N Unk
 Was this patient EVER positive for the SAME organism and resistance mechanism
Earliest known date ___/___/___
 Does this patient have a history of infection or colonization with another MDRO (select all that apply)
 CRAB CRE CRPA C. difficile MRSA VRE Other _____

Predisposing Conditions

No known predisposing conditions (previously healthy) True False Unk
Y N Unk
 AIDS (CD4 count <200)
 HIV (not AIDS)
 Alcohol abuse
 Cancer Type (select all that apply) Solid tumor (metastatic) Solid tumor (non-metastatic) Hematologic
 Chronic GI disease Type (select all that apply) Hepatic Biliary Other _____
 Chronic lung disease (e.g., COPD, emphysema)
 Chronic kidney disease
 Chronic skin breakdown
 Congestive heart failure (pre-existing)

Y N Unk

- Connective tissue disorder
- Current tobacco smoker
- CVA/stroke
- Cystic fibrosis
- Decubitus/pressure ulcer
- Dementia/chronic cognitive defect
- Diabetes mellitus
- Heart attack
- Hemiplegia/paraplegia
- Immunosuppressive therapy (past 6 months)
- Injection drug use, e.g. heroin
- Neurological problems
- Obesity Height (in inches) _____ Weight (in pounds) _____
- Peripheral vascular disease
- Premature at birth Specify gestational age in weeks _____
- Spina bifida
- Transplant recipient
- Urinary tract abnormality
- Other underlying medical condition _____

Hospitalization

Y N Unk

- Hospitalized at least overnight for this illness Facility name _____
 Facility location _____
 Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
 Disposition Another acute care hospital Facility name/location _____
 Died in hospital
 Long term acute care facility Facility name/location _____
 Long term care facility Facility name/location _____
 Non-health care (home) Unk Other _____
- 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 12 months prior to specimen collection date unless otherwise specified)

Travel – Make sure to list all international travel within 12 months of specimen collection date

	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 ___/___/___
Patient was hospitalized while visiting state/country	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Patient received any health care while visiting state/country	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

Risk and Exposure Information

Y N Unk

- Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country _____
- Case first identified through surveillance screen
- Specimen collected >3 calendar days after hospital admission
- Central venous catheter in place at any time in the 2 calendar days prior to the specimen collection date
- Urinary catheter in place at any time in the 2 calendar days prior to the specimen collection date
 Type Indwelling urethral catheter Suprapubic catheter Condom catheter
 Other _____
- Any OTHER indwelling device in place at any time in the 2 calendar days prior to the specimen collection date
 Type Dialysis catheter ET/NT Tube Gastrostomy tube NG tube Nephrostomy tube
 Peripheral IV catheter Tracheostomy Other _____
 Was tracheostomy tube in place at the time of specimen collection (*C. auris* only) Yes No Unk
- Was the patient on a ventilator at the time of specimen collection (*C. auris* only)

Y N Unk

- Hospitalized within 12 months before the specimen collection date
Date admitted ___/___/___ Prior HRN _____
Facility name _____ Facility location _____
- Did hospitalization include ICU stay
- Surgery within 12 months before the specimen collection date Date of surgery ___/___/___
Facility name _____ Facility location _____
- Admitted to a long term care facility within 12 months before the specimen collection date
Admit date ___/___/___ Discharge date ___/___/___
Facility name _____ Facility location _____
- Admitted to a long term care facility within 90 days before the specimen collection date (*C. auris* only)
Type of facility Assisted living facility Group home Inpatient rehabilitation facility
 Long-term acute care hospital Nursing home/skilled nursing facility with ventilator beds
 Nursing home/Skilled nursing facility without ventilator beds or ventilator bed status unknown
 Other _____
- Admitted to a long term acute care hospital within 12 months before the specimen collection date
Admit date ___/___/___ Discharge date ___/___/___
Facility name _____ Facility location _____
- On dialysis within 12 months of the specimen collection date
Facility name _____ Facility location _____
- Current chronic dialysis
Facility name _____ Facility Location _____
Type of dialysis Peritoneal Hemodialysis Unk
Hemodialysis access AV fistula/graft CVC None Unk

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 Person to person Health care associated Unk Other _____
Describe _____
- Suspected exposure setting Doctor's office Hospital ward Hospital ER Hospital outpatient facility Home
 Long term care facility International travel Out of state travel Other _____
Describe _____
- Exposure summary _____

- Suspected transmission type (check all that apply) Person to person Health care associated Unk
 Other _____
Describe _____
- Suspected transmission setting (check all that apply) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Long term care facility International travel Out of state US travel
 Other _____
Describe _____

Public Health Issues**Y N Unk**

- Patient currently in health care facility
Facility name _____ Facility location _____
- Fill out the Transmission Tracking Section if concern for potential transmission to other patients. Focus particularly on 30 days prior to the specimen collection date.*

Public Health Interventions/Actions**Y N Unk**

- Contact precautions implemented Start date ___/___/___ End Date ___/___/___
Facility name _____ Facility location _____
- Contact investigation
- Surveillance specimens collected from appropriate patients
Who was tested Roommates Other epi-linked patients Point prevalence survey
 Other _____
How many patients tested _____

Y N Unk

Patient education provided Method Verbal Written Letter
 Who provided Health care provider Local public health State public health
 Letter sent Date ___/___/___ Batch date ___/___/___
 Any other public health action _____

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type	Health care	Health care	Health care	Health care
Facility Name				
Details (floor, ward, wing, room number)				
Start (admit) Date	___/___/___	___/___/___	___/___/___	___/___/___
End (discharge) Date	___/___/___	___/___/___	___/___/___	___/___/___
Dates not on contact precautions	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___
Dates shared room	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___
Dates shared health care staff	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___
Number of people potentially exposed				
Facility Infection Preventionist aware	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

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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