Washington State Department of Health

Coccidioidomycosis

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 _____
Contact name _____
Contact 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

Clinical Features

Y	N	Unk	
☐	☐	☐	**Any fever, subjective or measured** Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	Night sweats
☐	☐	☐	Fatigue
☐	☐	☐	**Cough**
☐	☐	☐	**Chest pain**
☐	☐	☐	Dyspnea (shortness of breath)
☐	☐	☐	**Pneumonia** Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other _____
☐	☐	☐	**Other pulmonary lesion diagnosed by imaging** Describe _____
☐	☐	☐	**Headache**
☐	☐	☐	**Myalgia (muscle aches or pain)**

Y N Unk
☐ ☐ ☐ **Arthralgia (joint pain)**
☐ ☐ ☐ **Erythema nodosum or erythema multiforme rash**
☐ ☐ ☐ Rash observed by healthcare provider

Y N Unk
☐ ☐ ☐ Nuchal rigidity (stiff neck)
☐ ☐ ☐ Meningitis
☐ ☐ ☐ **Disseminated to other site**
Site(s) (select all that apply) ☐ Bone ☐ Joint ☐ Lymph node ☐ Skin ☐ Other _____
☐ ☐ ☐ Weight loss with illness

Predisposing Conditions

Y N Unk
☐ ☐ ☐ Cardiovascular disease
☐ ☐ ☐ Chronic lung disease (e.g., COPD, emphysema)
☐ ☐ ☐ Liver disease
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Malignancy Type _____
☐ ☐ ☐ **Immunosuppressive therapy before illness onset**
☐ ☐ ☐ Chemotherapy
☐ ☐ ☐ Corticosteroids (e.g., prednisone, cortisone)
☐ ☐ ☐ TNF-a inhibitors
☐ ☐ ☐ Other _____
☐ ☐ ☐ Organ or stem cell transplant recipient Organ transplanted _____ Year _____
☐ ☐ ☐ HIV positive/AIDS
☐ ☐ ☐ **Diabetes mellitus**
☐ ☐ ☐ Other underlying medical conditions Specify _____

Pregnancy

Pregnancy status at time of symptom onset

☐ Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____
OB name, phone, address _____
Outcome of pregnancy ☐ Still pregnant ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk

☐ Postpartum (Estimated) delivery date ___/___/___
OB name, phone, address _____
Outcome of pregnancy ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk

☐ Neither pregnant nor postpartum ☐ Unk

Healthcare and Hospitalization

Y N Unk
☐ ☐ ☐ Presented to ER for this illness Date ___/___/___ Facility name _____
☐ ☐ ☐ **Hospitalized at least overnight for this illness** Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
Disposition ☐ Another acute care hospital Facility name _____
☐ Died in hospital
☐ Long term acute care facility Facility name _____
☐ Long term care facility Facility name _____
☐ Non-healthcare (home) ☐ Unk ☐ Other _____
☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ Mechanical ventilation or intubation required

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
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 (Ask about exposures 7-21 days before symptom onset)

Travel

Y N Unk
☐ ☐ ☐ **Ever (lifetime) traveled to southwestern US, Mexico, Central/South America**
Destination _____ Start date ___/___/___ End date ___/___/___
Comments _____

Case Name _____ LHJ Case ID _____

For travel 3 weeks prior to onset

	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 _____

☐ ☐ ☐ Exposed to dust/wind storm, earthquake, or substantial soil disturbance

Location(s) of soil disturbance exposure ☐ Home ☐ Less than 1 mile from home ☐ Work ☐ Other _____

Date ___/___/___

Source ☐ Wind/dust storm/earthquake ☐ Construction ☐ Excavation ☐ Landscaping (large scale) ☐ Other _____

☐ ☐ ☐ Moving or digging in soil (e.g., gardening) Location _____ Date ___/___/___

☐ ☐ ☐ Participate in dust generating recreational activity Location _____ Date ___/___/___

Type ☐ 4-wheeling/ATV riding ☐ Horseback riding ☐ Soccer/other sports ☐ Mountain biking ☐Other _____

☐ ☐ ☐ Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)

Activity ☐ Outdoor recreation ☐ Cabin ☐ Hunting ☐ Lawn mowing ☐ Other _____

Habitat ☐ Wooded/brushy ☐ Grassy ☐ Other _____

Where ☐ At home property ☐ Elsewhere _____

☐ ☐ ☐ (Potential) Occupational exposure Specify _____

☐ ☐ ☐ If in-state exposure site identified, environmental sampling conducted

☐ ☐ ☐ Were any of your pets diagnosed with coccidioidomycosis

Pet(s) (enter all that apply) ☐ Dog ☐ Cat ☐ Unk ☐ Other _____

☐ 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 ☐ 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 ___/___/____

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

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 _____