



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

Coccidioidomycosis

County _____

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 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 ___/___/___
 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 _____ °F
 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 _____

For travel 3 weeks prior to onset

	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 _____
 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 _____

Y N Unk

- (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 _____

NOTES

LAB RESULTSLab 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 _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.