Viral Hemorrhagic Fever

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
Viral hemorrhagic fever agent ______________

Clinical Features

Y N Unk
☐ ☐ ☐ **Any fever, subjective or measured** Temp measured? ☐ Yes ☐ No Highest measured temp _______ºF
Fever onset date ___/___/___
☐ ☐ ☐ **Abdominal pain or cramps**
☐ ☐ ☐ Chest pain
☐ ☐ ☐ **Myalgia (muscle aches or pain)**
☐ ☐ ☐ Pharyngitis (sore throat)
☐ ☐ ☐ **Diarrhea** *(3 or more loose stools within a 24 hour period)* Onset date ___/___/___
☐ ☐ ☐ **Nausea**
☐ ☐ ☐ **Vomiting** Onset date ___/___/___
☐ ☐ ☐ Rash Type ☐ Maculopapular ☐ Petechial ☐ **Eschar** ☐ Other ______________
Description ______________ Location ______________
☐ ☐ ☐ **Severe headache**

☐ ☐ ☐ **Unexplained bleeding** (e.g., petechiae, bruises) Describe ________________________________
☐ ☐ ☐ Proteinuria
☐ ☐ ☐ Evidence of organ failure (liver, kidney, CNS)
☐ ☐ ☐ Took malaria chemoprophylaxis
☐ ☐ ☐ Other final diagnosis established ________________________________

Hospitalization

Y N Unk
☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name ________________________________
Hospital admission date ___/___/___ Discharge ___/___/___ HRN ____________________
☐ ☐ ☐ 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

Vaccination

Y N Unk
☐ ☐ ☐ Pre-travel typhoid vaccine
☐ ☐ ☐ Pre-travel yellow fever vaccine

Vaccine information available ☐ Yes ☐ No
Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ________________________________ Administering provider ________________________________
Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ________________________________ Administering provider ________________________________

Clinical testing

Creatinine level _______
Hgb/Hct _______
PT/PTT _______

Y N Unk
☐ ☐ ☐ Elevated AST or ALT values
☐ ☐ ☐ Thrombocytopenia

RISK AND RESPONSE (Ask about exposures 2-21 days before symptom onset)

Travel

	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 ________________________________
☐ ☐ ☐ Exposure to semen from a VHF case who recovered from VHF in the past year
☐ ☐ ☐ Exposed to any bats, wild animals, laboratory animals, or bush meat from endemic area
☐ ☐ ☐ Contact with blood or other body fluids of a patient with VHF in the past 3 weeks
If any known exposure, date of first exposure ___/___/___ Date of last exposure ___/___/___

High Risk

Y N Unk
☐ ☐ ☐ Direct contact with dead body in highly affected area without PPE
☐ ☐ ☐ Direct skin contact with body fluids or excreta of VHF case without PPE
☐ ☐ ☐ Percutaneous or mucous membrane exposure to blood/body fluids (blood, urine, vomit, feces, sweat, semen, breast milk) of VHF case
☐ ☐ ☐ Processing VHF specimen without PPE or Laboratory biosafety

Some Risk

☐ ☐ ☐ Close contact with symptomatic Ebola case in household, healthcare, or other setting (prolonged time within 3 feet) without PPE
☐ ☐ ☐ Direct contact with dead body with PPE
☐ ☐ ☐ Direct patient contact with appropriate PPE in highly affected area
Describe PPE ________________________________

Low Risk

Y N Unk

☐ ☐ ☐ Brief contact or proximity to Ebola case without PPE
☐ ☐ ☐ In area not highly affected: direct contact with PPE with symptomatic Ebola case
☐ ☐ ☐ Travel or residence in highly affected area
☐ ☐ ☐ Exposures during travel: health care
☐ ☐ ☐ Exposures during travel: lab work
☐ ☐ ☐ Exposures during travel: care for ill person
☐ ☐ ☐ Exposures during travel: animal or bush meat contact
☐ ☐ ☐ Other ________________________________
☐ ☐ ☐ Shared transport with symptomatic case

Overall risk assessment ☐ High ☐ Some ☐ Low

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 ☐ Animal related ☐ Vectorborne ☐ Person to person ☐ Sexual ☐ Blood products ☐ IDU
☐ Health care associated ☐ Unk ☐ Other ________________________________
Describe ________________________________

Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Place of worship
☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Transit
☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other ________________________________
Describe ________________________________

Exposure summary

Suspected transmission type (check all that apply) ☐ Person to person ☐ Sexual ☐ Blood products ☐ IDU
☐ Health care associated ☐ Unk ☐ Other ________________________________
Describe ________________________________

Suspected transmission setting (check all that apply) ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter
☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant
☐ Hotel/motel/hostel ☐ Other________________________________
Describe ________________________________

Public Health Issues

Y N Unk

☐ ☐ ☐ Case donated blood products, organs or tissue
☐ ☐ ☐ Could have exposed others while symptomatic Date (record all) ___/___/___ Location ________________________
☐ ☐ ☐ Health care/EMS
☐ ☐ ☐ Home
☐ ☐ ☐ Travel
☐ ☐ ☐ Other ________________________________
☐ ☐ ☐ Contact with mammals while symptomatic Type (record all) ________________________________

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Monitor contacts daily for 21 days
☐ ☐ ☐ Health care/EMS
☐ ☐ ☐ Home
☐ ☐ ☐ Travel
☐ ☐ ☐ Other contacts ________________________________
☐ ☐ ☐ Isolation precautions in health care setting
☐ ☐ ☐ Controlled movement in community
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING

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

Settings and details (check all that apply)
☐ Day care ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Health care ☐ Home ☐ Work ☐ College
☐ Military ☐ Correctional facility ☐ Place of worship ☐ International travel ☐ Out of state travel ☐ LTCF
☐ Homeless/shelter ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other

Case Name ________________________________ LHJ Case ID ________________________________

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

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

TREATMENT

Y N Unk

☐ ☐ ☐ Did patient receive prophylaxis/treatment

Specify medication ________________________ ☐ Antibiotic ☐ Fungal/Parasitic ☐ Antiviral ☐ Immune globulin/Antitoxin ☐ 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 ☐ 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 ________________________________