Washington State Department of HEALTH

Viral Hemorrhagic Fever

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 Diagnosis date ___/___/___
Illness duration _____ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk

Disease (report dengue, hantavirus or Yellow fever on their respective forms)
☐ Crimean-Congo hemorrhagic fever virus ☐ Ebola ☐ Guanarito virus ☐ Junin virus ☐ Lujo virus
☐ Machupo virus ☐ Marburg virus ☐ Sabia virus

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	
☐	☐	☐	Ebola virus vaccine
☐	☐	☐	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

Y	N	Unk	
☐	☐	☐	Close contact with symptomatic VHF 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 VHF case without PPE
☐	☐	☐	In area not highly affected: direct contact with PPE with symptomatic VHF 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

Case Name _____ LHJ Case ID _____

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 ___/___/___

Case Name _____ LHJ Case ID _____

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

	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

Case Name _____ LHJ Case ID _____

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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