Washington State Department of Health

Burkholderia

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 _____
Name _____ 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
☐	☐	☐	Flu-like symptoms
☐	☐	☐	**Headache**
☐	☐	☐	**Myalgia (muscle aches or pain)**
☐	☐	☐	**Chest pain**
☐	☐	☐	Pneumonia Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other _____
☐	☐	☐	**Respiratory distress**
☐	☐	☐	**Abdominal pain or cramps**
☐	☐	☐	**Weight loss with illness**
☐	☐	☐	Urinary tract infection
☐	☐	☐	Joint pain

☐ ☐ ☐ **Nodule**
☐ ☐ ☐ Meningitis/meningoencephalitis
☐ ☐ ☐ **Seizure new with disease**
☐ ☐ ☐ **Skin abscess or ulcer**
☐ ☐ ☐ **Tissue or organ abscess**
☐ ☐ ☐ **Bacteremia**
☐ ☐ ☐ **Osteomyelitis (bone infection)**
☐ ☐ ☐ **Septic arthritis**

Predisposing Conditions

Y N Unk

☐ ☐ ☐ Alcoholism
☐ ☐ ☐ Chronic heart disease
☐ ☐ ☐ Chronic lung disease (e.g., COPD, emphysema)
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ Immunosuppressive therapy, condition, or disease _____
☐ ☐ ☐ Thalassemia
☐ ☐ ☐ Any other underlying medical conditions _____

Hospitalization

Y N Unk

☐ ☐ ☐ 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
☐ ☐ ☐ 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
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 1-28 days before acute 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 _____
☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness
☐ ☐ ☐ Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
Activity ☐ Outdoor recreation ☐ Cabin ☐ Hunting ☐ Lawn mowing ☐ Other _____
☐ ☐ ☐ Soil or water contact in endemic country Country _____
☐ ☐ ☐ Any contact with animals

	Y N Unk	Who owns (select all)	Type of contact (select all)
Donkey/mule	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	
Goat	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	
Horse/pony	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	☐ Birthing products ☐ Skinning/slaughter ☐ Hunting ☐ Mucous membrane/tissue ☐ Caretaker ☐ Other _____
Monkey	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	

Case Name _____ LHJ Case ID _____

	Y N Unk	Who owns (select all)	Type of contact (select all)
Pigs or swine	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	☐ Birthing products ☐ Skinning/slaughter ☐ Hunting ☐ Mucous membrane/tissue ☐ Caretaker ☐ Other _____
Rodent	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	
Sheep	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	☐ Birthing products ☐ Skinning/slaughter ☐ Hunting ☐ Mucous membrane/tissue ☐ Caretaker ☐ Other _____
Wildlife/wild animals	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	☐ Birthing products ☐ Skinning/slaughter ☐ Hunting ☐ Mucous membrane/tissue ☐ Caretaker ☐ Other _____
Other _____	☐ ☐ ☐	☐ Case ☐ Private ☐ Wild ☐ Commercial ☐ Unk ☐ Other _____	

Y N Unk

☐ ☐ ☐ Contact with animal carcass Date ___/___/___
☐ ☐ ☐ Hunted or skinned animals
☐ ☐ ☐ Inhalation of dust from soil, grain, or hay
☐ ☐ ☐ Known exposure to B. pseudomallei as a result of intentional release or occupational risk (lab exposure)
☐ ☐ ☐ (Potential) Occupational exposure
☐ ☐ ☐ Lab worker
☐ ☐ ☐ Agricultural worker
☐ ☐ ☐ Work with animals or animal products (e.g., research, veterinary medicine, slaughterhouse)
Animal _____
☐ ☐ ☐ Wildlife worker
☐ ☐ ☐ Veterinarian
☐ ☐ ☐ Other _____
☐ ☐ ☐ Military service Dates stationed _____ Where stationed _____

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ Epidemiologic link to a confirmed human case
☐ ☐ ☐ Epidemiologic link to a documented exposure

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 ☐ Waterborne ☐ Animal related ☐ Health care ☐ Unk ☐ Other _____
Describe _____

Suspected exposure setting ☐ Laboratory ☐ Other _____
Describe _____

Exposure summary

Suspected transmission type ☐ Health care ☐ Unk ☐ Other _____
Describe _____

Suspected transmission setting ☐ Laboratory ☐ Other _____
Describe _____

Public Health Issues

Y N Unk

☐ ☐ ☐ Did possible clinical/surgical staff exposure occur (e.g., bone saw use or other aerosolizing procedure)
Date ___/___/___
Facility name/location _____ Type of activity _____
Number exposed _____
Number of high risk exposures _____ Number of high risk exposures taking PEP _____
Number of low risk exposures _____ Number of low risk exposures taking PEP _____

☐ ☐ ☐ Laboratory exposure to case's specimens Date ___/___/___
Lab name/location _____ Type of activity _____
Number exposed _____
Number of high risk exposures _____ Number of high risk exposures taking PEP _____
Number of low risk exposures _____ Number of low risk exposures taking PEP _____

Y N Unk
☐ ☐ ☐ Follow-up to assess exposure of laboratorians to specimen
☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis
☐ ☐ ☐ Attended social gatherings or crowded settings

Public Health Interventions/Actions

Y N Unk
☐ ☐ ☐ Notified blood or tissue bank (if recent donation)
☐ ☐ ☐ Potential bioterrorism exposure
☐ ☐ ☐ Notified FBI or public safety
☐ ☐ ☐ Educate on proper disposal of animal carcass
☐ ☐ ☐ Biohazard issue identified
☐ ☐ ☐ Biohazard protocol followed
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

TREATMENT

Y N Unk
☐ ☐ ☐ Did patient receive prophylaxis/treatment
Specify antibiotic _____ Number of days actually taken _____
Treatment start date ___/___/___ Treatment end date ___/___/___
Prescribed dose _____ ☐ g ☐ mg ☐ ml Duration _____ ☐ Days ☐ Weeks ☐ Months
Indication ☐ PEP ☐ 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 _____