Burkholderia

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

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 _______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 ______________________

Y	N	Unk	
☐	☐	☐	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 ___________________________

Y	N	Unk	
☐	☐	☐	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 ________________	
	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

Y N Unk
☐ ☐ ☐ 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 ___________________________________

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