



# 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 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
  - 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
<b>Travel out of</b>	<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 ____/____/____		

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> Other	
Goat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> Other	
Horse/pony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> Birthing products <input type="checkbox"/> Skinning/slaughter <input type="checkbox"/> Hunting <input type="checkbox"/> Mucous membrane/tissue <input type="checkbox"/> Caretaker <input type="checkbox"/> Other
Monkey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> Other	
	<b>Y</b>	<b>N</b>	<b>Unk</b>	<b>Who owns (select all)</b>	<b>Type of contact (select all)</b>
Pigs or swine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> Birthing products <input type="checkbox"/> Skinning/slaughter <input type="checkbox"/> Hunting <input type="checkbox"/> Mucous membrane/tissue <input type="checkbox"/> Caretaker <input type="checkbox"/> Other
Rodent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> Other	
Sheep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> Birthing products <input type="checkbox"/> Skinning/slaughter <input type="checkbox"/> Hunting <input type="checkbox"/> Mucous membrane/tissue <input type="checkbox"/> Caretaker <input type="checkbox"/> Other
Wildlife/wild animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> Birthing products <input type="checkbox"/> Skinning/slaughter <input type="checkbox"/> Hunting <input type="checkbox"/> Mucous membrane/tissue <input type="checkbox"/> Caretaker <input type="checkbox"/> Other
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Case <input type="checkbox"/> Private <input type="checkbox"/> Wild <input type="checkbox"/> Commercial <input type="checkbox"/> Unk <input type="checkbox"/> 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  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 document**Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_

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