Washington State Department of Health

Tickborne Diseases (excludes Lyme, Relapsing)

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

Specify condition ☐ Anaplasmosis ☐ Babesiosis ☐ Ehrlichiosis ☐ Ehrlichiosis/Anaplasmosis ☐ Neorickettsiosis
☐ Rickettsiosis ☐ STARI ☐ Tick paralysis

Specify species/strain ☐ Anaplasma phagocytophilum ☐ Babesia divergens ☐ Babesia duncani ☐ Babesia microti
☐ Ehrlichia chaffeensis ☐ Ehrlichia ewingii ☐ Ehrlichia muris ☐ Neorickettsia ☐ Rickettsia africae
☐ Rickettsia rickettsii ☐ Rickettsia coronii ☐ Rickettsia other _____

Y	N	Unk	
☐	☐	☐	Asymptomatic (no clinical illness)
☐	☐	☐	**Any fever, subjective or measured** Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	**Chills or rigors**
☐	☐	☐	**Sweats**
☐	☐	☐	Abdominal pain or cramps
☐	☐	☐	**Anemia**

Y N Unk

☐ ☐ ☐ Cough
☐ ☐ ☐ Diarrhea *(3 or more loose stools within a 24 hour period)*
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Malaise
☐ ☐ ☐ **Headache**
☐ ☐ ☐ Hypotension
☐ ☐ ☐ Lymphadenopathy
☐ ☐ ☐ **Myalgia (muscle aches or pain)**
☐ ☐ ☐ Arthralgia (joint pain)
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting Onset date ___/___/___
☐ ☐ ☐ Nuchal rigidity (stiff neck)
☐ ☐ ☐ Renal failure
☐ ☐ ☐ **Rash** Type ☐ Maculopapular ☐ Petechial ☐ **Eschar** ☐ Other _____
Description _____ Location _____
☐ ☐ ☐ Myocardial infarction
☐ ☐ ☐ Acute respiratory distress syndrome (ARDS) Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider only
☐ ☐ ☐ Congestive heart failure
☐ ☐ ☐ Disseminated intravascular coagulopathy (DIC)
☐ ☐ ☐ Liver failure
☐ ☐ ☐ Splenomegaly
☐ ☐ ☐ Hepatomegaly
☐ ☐ ☐ Pale stool, dark urine, yellowing of skin or eyes (jaundice)
☐ ☐ ☐ Meningitis/encephalitis
☐ ☐ ☐ Other symptoms consistent with this illness _____
☐ ☐ ☐ Any other complication _____

Predisposing Conditions

Y N Unk

☐ ☐ ☐ Asplenic (no spleen)
☐ ☐ ☐ Cancer
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Renal failure (pre-existing)
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ Immunosuppressive therapy or condition, or disease _____
☐ ☐ ☐ Other immunosuppressive condition _____

Pregnancy

Pregnancy status at time of symptom onset

☐ Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____
OB name, phone, address _____
Outcome of pregnancy ☐ Still pregnant ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk

☐ Postpartum (Estimated) delivery date ___/___/___
OB name, phone, address _____
Outcome of pregnancy ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk

☐ Neither pregnant nor postpartum ☐ Unk

Clinical Testing

Y N Unk

☐ ☐ ☐ **Leukopenia** Lowest white blood cell count _____
☐ ☐ ☐ **Thrombocytopenia** Lowest platelet count _____
☐ ☐ ☐ **Elevated hepatic transaminases**

Hospitalization

Y N Unk

☐ ☐ ☐ **Hospitalized at least overnight for this illness** Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
Disposition ☐ Another acute care hospital ☐ Died in hospital ☐ Long term acute care facility
☐ Long term care facility ☐ Non-healthcare (home) ☐ Unk
☐ Other _____
Facility name _____

Case Name _____ LHJ Case ID _____

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 3-32 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 _____
☐ ☐ ☐ **Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)**
Activity ☐ Outdoor recreation ☐ Cabin ☐ Hunting ☐ Lawn mowing ☐ Other _____
Where ☐ At home property ☐ Elsewhere _____
☐ ☐ ☐ **Has been in a wooded, brushy, or grassy area (i.e., potential tick habitat) in the 14 days prior to onset**
☐ ☐ ☐ Handled sick or dead animal
☐ ☐ ☐ Observe any animals or insects/evidence or animals or insects (e.g., droppings) around home/work
☐ ☐ ☐ Cat
☐ ☐ ☐ Dog
☐ ☐ ☐ Fleas
☐ ☐ ☐ Opossum
☐ ☐ ☐ Rodent
☐ ☐ ☐ Ticks
☐ ☐ ☐ Other _____
☐ ☐ ☐ Exposure to pets or animals Specify _____
☐ ☐ ☐ Exposure to wildlife
☐ ☐ ☐ **Tick bite** Date ___/___/___ Specify location _____
Location ☐ WA County _____ ☐ Other state ☐ Other country ☐ Multiple exposures ☐ Ukn

In last 12 months before symptom onset

Y N Unk

☐ ☐ ☐ **Blood transfusion or organ transplant** Date ___/___/___ Reason _____
Location _____ Products _____

Babeosis Only

Y N Unk

☐ ☐ ☐ Is case an involved blood donor
☐ ☐ ☐ **Donated RBC or platelet components transfused into epi-linked recipient**
☐ ☐ ☐ **Plausibility that blood component was a source of infection in recipient is equal to or greater than that of blood from other involved donors**
☐ ☐ ☐ Is case an involved transfusion recipient
☐ ☐ ☐ **Received one or more RBC or platelet transfusions within one year before the collection date of a specimen with laboratory evidence of babesia infection**
☐ ☐ ☐ **At least one of these blood components was donated by epi-linked donor**
☐ ☐ ☐ **Transfusion-associated infection is considered at least as plausible as tickborne transmission**

☐ No risk factors or likely exposures could be identified

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 ☐ Vectorborne ☐ Blood products ☐ Other _____
Exposure summary

Public Health Issues

Y N Unk

☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis
Date ___/___/___ Agency and location _____

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ 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 ___/___/___

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 _____