



Tickborne Diseases
(excludes Lyme, Relapsing)

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) _____

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

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 conorii Rickettsia parkeri Rickettsia philipii Rickettsia rickettsii
 Rickettsia typhi Rickettsia other _____

Y N Unk

- Asymptomatic (no clinical illness)
- Any fever, subjective or measured** Temp measured? Yes No Highest measured temp _____°F
- Chills or rigors**
- Sweats**
- Abdominal pain or cramps
- 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)
- Ascending, flaccid paralysis or numbness in the legs
- 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

- Anemia**
- 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 _____

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:	<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 ___/___/___	___/___/___ 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**

Y N Unk

- 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 Unk

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 RESULTSLab 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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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