ANTHRAX INVESTIGATION FORM

STOP: PRIOR TO CREATING THIS INVESTIGATION, YOU MUST NOTIFY & CONSULT WITH CENTRAL OFFICE (800) 338-8374 (24-HOUR COVERAGE)

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

SIGNS AND SYMPTOMS

Did the patient have a fever (≥100.4°F)? ☐No ☐Unknown ☐Yes Was the patient septic? ☐No ☐Unknown ☐Yes

Cutaneous Anthrax:

☐Eschar, location: _____ ☐Lymphadenopathy ☐Malaise ☐Papule that became vesicular

Inhalation Anthrax:

☐Acute respiratory distress ☐Dypsnea (short of breath) ☐Mediastinal widening ☐Shock
☐Cyanosis ☐Hypoxia ☐Pleural effusion ☐Viral respiratory-like illness

Intestinal Anthrax:

☐Abdominal swelling ☐Bloody Diarrhea ☐Nausea ☐Vomiting
☐Anorexia ☐Hematemesis (bloody vomit) ☐Severe abdominal pain

Oropharyngeal Anthrax:

☐Cervical adenopathy ☐Edema ☐Painless oral mucosal lesion ☐Pharyngitis

Meningeal Anthrax:

☐Coma ☐Convulsions ☐Meningeal signs (e.g., meningitis)

EXPOSURES

What is the patient's primary occupation? _____ Name and location of employer: _____

In the 7 days prior to onset of symptoms did patient have exposure to or contact with any of the following?

Livestock: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____

Animal skins, fur, or hair: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____

ARBOVIRAL INVESTIGATION FORM

PATIENT DEMOGRAPHIC INFORMATION

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ E-mail: _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

TREATMENT & OUTCOME

Physician Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes, hospital:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __ Age at Onset: _____ ☐days ☐months ☐unknown ☐years

Does the physician feel the patient has WNV/SLE/CVV/La Crosse/EEE/VEE/WEE? (other than arboviral infection) ☐No ☐Unknown ☐Yes

Did patient die as a result of (or complication from) arboviral infection? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Where was the disease acquired? ☐Indigenous (within county) ☐In State (out of county) ☐Out of Country ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Probable ☐Not a Case ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

Select "Yes" only if case meets Confirmed or Probable Case Status: Is this case report published in ArboNET? ☐Yes ☐No

TYPE OF ARBOVIRUS

☐CHIK Chikungunya	☐EEE Eastern Equine Encephalitis	☐Non-LaCrosse California Serogroup†	☐VEE Venezuelan Equine Encephalitis
☐CV Cache Valley	☐JE Japanese Encephalitis	☐POW Powassan	☐WNV West Nile Virus
☐LAC LaCrosse	☐SLE St Louis Encephalitis	☐WEE Western Equine Encephalitis	☐Other Arbovirus

† *California, Jamestown, Canyon, Keystone, Snowshoe hare, & Trivittatus*

GENERAL COMMENTS

_____

_____

_____

SUPERVISOR REVIEW (PHA 4)

Date Due: __ __ / __ __ /__ __ __ __ Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete) ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CLINICAL

Signs & Symptoms

Any reported Fever or Chills? ☐No ☐Unknown ☐Yes

Neuroinvasive Signs & Symptoms (i.e., Encephalitis)

Abnormal neuroimaging:	☐No ☐Unknown ☐Yes	Limb weakness:	☐No ☐Unknown ☐Yes
Acute Flaccid Paralysis (AFP):	☐No ☐Unknown ☐Yes	Aseptic Meningitis:	☐No ☐Unknown ☐Yes
Altered mental status:	☐No ☐Unknown ☐Yes	Stiff neck:	☐No ☐Unknown ☐Yes
Cerebrospinal pleocytosis (↑ wbc):	☐No ☐Unknown ☐Yes	Seizures:	☐No ☐Unknown ☐Yes
Cranial nerve palsy:	☐No ☐Unknown ☐Yes		
Encephalitis:	☐No ☐Unknown ☐Yes		

Non-Neuroinvasive Signs & Symptoms (i.e., West Nile Fever)

Fever:	☐No ☐Unknown ☐Yes	Nausea/Vomiting:	☐No ☐Unknown ☐Yes	Paresis or Paralysis:	☐No ☐Unknown ☐Yes
Headache:	☐No ☐Unknown ☐Yes	Diarrhea:	☐No ☐Unknown ☐Yes	Arthralgia or Arthritis:	☐No ☐Unknown ☐Yes
Rash:	☐No ☐Unknown ☐Yes	Myalgia:	☐No ☐Unknown ☐Yes		

Clinical Syndrome

☐Asymptomatic (i.e., no fever or symptoms) ☐Encephalitis/Meningoencephalitis ☐Other Clinical
☐Uncomplicated Fever ☐Meningitis ☐Unknown

RISK FACTORS

Blood

Was the patient identified by blood donor screening? ☐No ☐Unknown ☐Yes
Has this patient donated blood within **30 days** of illness onset? ☐No ☐Unknown ☐Yes Donation Date: __ __ / __ __ /__ __ __ __
Has this patient received a blood product within **30 days** of illness onset? ☐No ☐Unknown ☐Yes

Organ

Has the patient donated an organ within **30 days** of illness to onset? ☐No ☐Unknown ☐Yes
Has the patient received an organ transplant within **30 days** of illness onset? ☐No ☐Unknown ☐Yes

Infant

Is the patient a breast fed infant/child? ☐No ☐Unknown ☐Yes
Is the patient an infant infected in utero (i.e., mother infected while pregnant)? ☐No ☐Unknown ☐Yes

Occupation

Does the patient work with arboviral agents in a laboratory? ☐No ☐Unknown ☐Yes
Does the patient work in an outside setting? ☐No ☐Unknown ☐Yes Time worked outside: _____hrs/day

BABESIOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTGIATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Where was the disease acquired? ☐Indigenous within jurisdiction ☐Out of Country ☐Out of jurisdiction, from another jurisdiction ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

SIGNS AND SYMPTOMS

Objective

Fever (≥100.4°F): ☐No ☐Unknown ☐Yes Anemia: ☐No ☐Unknown ☐Yes Thrombocytopenia: ☐No ☐Unknown ☐Yes

Subjective:

Arthralgia (joint pain): ☐No ☐Unknown ☐Yes Headache: ☐No ☐Unknown ☐Yes Sweats: ☐No ☐Unknown ☐Yes

Chills: ☐No ☐Unknown ☐Yes Myalgia (muscle pain): ☐No ☐Unknown ☐Yes

EXPOSURES

Transfusion

Did the patient donate blood during the **21 days** before illness onset? ☐No ☐Unknown ☐Yes Donation Date: __ __ / __ __ /__ __ __ __

Did the patient receive a blood or plasma transfusion during the **1 year** prior to specimen collection? ☐No ☐Unknown ☐Yes

Transfusion Date: __ __ / __ __ /__ __ __ __ Was the transfusion epi-linked to a confirmed or probable case? ☐No ☐Unknown ☐Yes

Tick Habitiat

During the **21 days** before illness onset, was patient exposed to a potential tick habitat (wooded/brushy/grassy area)? ☐No ☐Unknown ☐Yes

BOTULISM INVESTIGATION FORM

☐ FOODBORNE BOTULISM ☐ INFANT BOTULISM ☐ WOUND BOTULISM ☐ OTHER BOTULISM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

FOODBORNE BOTULISM INVESTIGATION QUESTIONS *(skip to PHEP Project Section if not Foodborne)*

Symptoms

Abdominal Pain: ☐No ☐Unknown ☐Yes
Diarrhea: ☐No ☐Unknown ☐Yes
Photophobia: ☐No ☐Unknown ☐Yes
Muscle Weakness: ☐No ☐Unknown ☐Yes
Dyspnea: ☐No ☐Unknown ☐Yes
Urinary Retention: ☐No ☐Unknown ☐Yes
Paresthesias: ☐No ☐Unknown ☐Yes
Convulsions: ☐No ☐Unknown ☐Yes

Nausea: ☐No ☐Unknown ☐Yes
Blurred vision: ☐No ☐Unknown ☐Yes
Dysphasia: ☐No ☐Unknown ☐Yes
If yes to muscle weakness, specify: _____
Fatigue: ☐No ☐Unknown ☐Yes
Constipation: ☐No ☐Unknown ☐Yes
If yes to paresthesias,specify where: _____
Other Symptoms: _____

Vomiting: ☐No ☐Unknown ☐Yes
Diplopia: ☐No ☐Unknown ☐Yes
Dysphonia: ☐No ☐Unknown ☐Yes
Dry Mouth: ☐No ☐Unknown ☐Yes
Dizziness: ☐No ☐Unknown ☐Yes

Signs

Ptosis: ☐No ☐Unknown ☐Yes
Fixed pupils: ☐No ☐Unknown ☐Yes
Decreased corneal reflex: ☐No ☐Unknown ☐Yes
Symmetrical facial paralysis: ☐No ☐Unknown ☐Yes
Weakness/paralysis of extremities: ☐No ☐Unknown ☐Yes
Decreased ability to protrude tongue: ☐No ☐Unknown ☐Yes
Sensory findings: ☐No ☐Unknown ☐Yes
Ataxia: ☐No ☐Unknown ☐Yes
DTRs: ☐No ☐Unknown ☐Yes
Nystagmus: ☐No ☐Unknown ☐Yes
Tracheostomy: ☐No ☐Unknown ☐Yes
Abnormal mental status: ☐No ☐Unknown ☐Yes

Extraocular palsy: ☐No ☐Unknown ☐Yes
If 'yes' to fixed pupils specify: _____
Facial paralysis: ☐No ☐Unknown ☐Yes
Decreased gag reflex: ☐No ☐Unknown ☐Yes
If 'yes' to weakness/paralysis specify: _____
If 'yes' to sensory findings, specify: _____
Symmetrical ataxia: ☐No ☐Unknown ☐Yes
If yes to DTR's, specify: _____
Respiratory impairment: ☐No ☐Unknown ☐Yes
Vital capacity: ☐No ☐Unknown ☐Yes
Fever (>100.4°F) ☐No ☐Unknown ☐Yes

Wound Information

Does the patient have a wound? ☐No ☐Unknown ☐Yes
When was the wound sustained? _____
If yes, where is the wound? _____
How was the wound treated? _____

Drugs Taken Information

Did this patient take antibiotics, anticholinergics, or phenothiazines during the last week? ☐No ☐Unknown ☐Yes
List meds: _____

Differential Diagnosis:

Stroke (CVA)	☐No	☐Unknown	☐Yes	If yes, what test was done: _____	Results: _____
Guillain-Barre Syndrome	☐No	☐Unknown	☐Yes	If yes, what test was done: _____	Results: _____
Myasthenia gravis	☐No	☐Unknown	☐Yes	If yes, what test was done: _____	Results: _____
Tick paralysis	☐No	☐Unknown	☐Yes	If yes, what test was done: _____	Results: _____
Lambert-Eaton syndrome	☐No	☐Unknown	☐Yes	If yes, what test was done: _____	Results: _____
Toxic exposures	☐No	☐Unknown	☐Yes	If yes, what kind of exposure _____	Results: _____
Poliomyelitis	☐No	☐Unknown	☐Yes	If yes, what test was done: _____	Results: _____

Notified:

State epidemiologist:	☐ No	☐Unknown	☐Yes	Date: __ __ / __ __ /__ __ __ __
BCL	☐ No	☐Unknown	☐Yes	Date: __ __ / __ __ /__ __ __ __
CDC	☐ No	☐Unknown	☐Yes	Date: __ __ / __ __ /__ __ __ __
CDC Infant Botulism	☐ No	☐Unknown	☐Yes	Date__ __ / __ __ /__ __ __ __
FDA	☐ No	☐Unknown	☐Yes	Date__ __ / __ __ /__ __ __ __
USDA	☐ No	☐Unknown	☐Yes	Date__ __ / __ __ /__ __ __ __

Diagnosis

Tentative diagnosis: _____

Current status of Patient _____

What diagnose have been ruled out _____

Recommendations by EIS Officer

Induce emesis: ☐No ☐Unknown ☐Yes
Antibiotics: ☐No ☐Unknown ☐Yes
Purgation: ☐No ☐Unknown ☐Yes
Surgery: ☐No ☐Unknown ☐Yes
Antitoxin: ☐No ☐Unknown ☐Yes
Other recommendations: ☐No ☐Unknown ☐Yes

Clinical Criteria for Case Classification

Does the patient have diplopia, blurred vision, and bulbar weakness and is symmetric descending paralysis present? ☐No ☐Unknown ☐Yes

Did the patient ingest the same food as another patient with a laboratory-confirmed case? ☐No ☐Unknown ☐Yes

Did the patient have any other epidemiologic link without laboratory confirmation? ☐No ☐Unknown ☐Yes

Description of link: _____

Laboratory Criteria for Case Classification

Was botulinum toxin detected in serum, stool, or patient's food? ☐No ☐Unknown ☐Yes

Was *Clostridium botulinum* isolated from stool? ☐No ☐Unknown ☐Yes

PHEP PROJECT - GENERAL

Date of presumptive diagnosis: __ __ / __ __ /__ __ __ __

Method of initial report to Public Health: ☐ELR ☐Email ☐Fax ☐Mail ☐Online REPORT card ☐Phone

Which reporter type (or designee) provided initial report to Public Health?: ☐Day care director ☐Dentist ☐Physician ☐Hospital administrator ☐Lab director ☐Medical examiner ☐Nurse ☐Nursing home administrator ☐Other state health department or CDC ☐Patient/family ☐School principal

PHEP PROJECT - CONTROL MEASURES IMPLEMENTED (Answer all)

Date first control measures initiated: __ __ / __ __ /__ __ __ __ Other measures: _____

Education case/contacts:	☐No ☐Unk ☐Yes ☐N/A	Exclusions from food handling:	☐No ☐Unk ☐Yes ☐N/A
Exclusions from healthcare:	☐No ☐Unk ☐Yes ☐N/A	Exclusions from daycare/school:	☐No ☐Unk ☐Yes ☐N/A
Immunization:	☐No ☐Unk ☐Yes ☐N/A	Prophylaxis:	☐No ☐Unk ☐Yes ☐N/A
Identification of exposed individuals:	☐No ☐Unk ☐Yes ☐N/A	Identification of additional cases:	☐No ☐Unk ☐Yes ☐N/A
Identification of likely source of infection:	☐No ☐Unk ☐Yes ☐N/A	Collection of food:	☐No ☐Unk ☐Yes ☐N/A

Notify state/federal partner agencies/organizations: ☐No ☐Unknown ☐Yes ☐N/A

DAY CARE

Attend a day care center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes

Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____

What type of day care facility? ☐Adult day health care ☐Adult day social care ☐Alzheimer's specific day care ☐Child care center ☐Child care provided by friend, relative, neighbor ☐In-home care giver

Is food prepared at this facility? ☐No ☐Unknown ☐Yes Does this facility care for diapered persons? ☐No ☐Unknown ☐Yes

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated? ☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated? ☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the 7 days prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐CSF leak
☐Alcohol abuse
☐Burns
☐Cirrhosis/liver failure
☐Deaf/profound hearing loss
☐Gastric surgery (type): _____
☐Immunodeficiency (type): _____
☐Leukemia
☐None
☐Other malignancy (type): _____
☐Peptic ulcer
☐Splenectomy/asplenia
☐Hodgkin's disease
☐Asthma
☐Cerebral vascular accident (CVA) stroke
☐Cochlear implant
☐Diabetes mellitus (insulin-dependent)
☐Heart failure
☐Immunoglobulin deficiency
☐Multiple myeloma
☐Organ transplant (organ): _____
☐Other prior illness (type): _____
☐Renal failure/dialysis
☐Systemic lupus erythematosus (SLE)
☐IVDU
☐Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐Chronic GI illness/diarrhea
☐Current smoker
☐Emphysema/COPD
☐Hematologic disease (type): _____
☐Immunosuppressive therapy (steroids, chemotherapy)
☐Nephrotic Syndrome
☐Other liver disease (type): _____
☐Other renal disease (type): _____
☐Sickle cell anemia
☐Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further? ☐No ☐Unknown ☐Yes

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

OTHER CLINICAL DATA

Was botulism laboratory confirmed from a patient specimen? ☐No ☐Unknown ☐Yes

Was *C. botulinum* isolated in culture from a patient specimen? ☐No ☐Unknown ☐Yes

If food is known or thought to be the source:

Please specify food type: ☐Commercial ☐Home canned ☐Other:_____ ☐Other home cooked

Was food tested? ☐No ☐Unknown ☐Yes

If food was positive, what was its toxin type: ☐A ☐B ☐E ☐F ☐Other:_____

State Epidemiologist's Recommendations:

_____

_____

_____

_____

Create the appropriate ALNBS investigation: 1. Botulism, foodborne, 2. Botulism, infant, 3. Botulism, other/unspecified, or 4. Botulism, wound.

Clinical syndrome

The clinical syndrome of botulism, whether foodborne, infant, wound, or intestinal colonization, is dominated by the neurologic symptoms and signs resulting from a toxin-induced blockade of the voluntary motor and autonomic cholinergic junctions and is quite similar for each cause and toxin type. Incubation periods for foodborne botulism are reported to be as short as 6 hours or as long as 10 days, but generally the time between toxin ingestion and onset of symptoms ranges from 18 – 36 hours.

Types of Botulism: Foodborne, Wound, Infant, Child or adult botulism from intestinal colonization.

<u>Diagnosis/Signs & Symptoms Adult</u>

- **Acute onset of gastrointestinal autonomic (ex. Dry mouth, difficulty focusing)**
- **Cranial nerve (diplopia, dysarthria, dysphagia) dysfunction**
- **Descending peripheral muscle weakness**
- **Ventilatory compromise**

<u>Diagnosis/Signs & Symptoms Infant/Child</u>

- **Poor feeding, diminished suckling and crying ability**
- **Constipation is often seen in infants and in some has preceded the onset of neurologic abnormalities by many days.**
- **Neck and Peripheral weakness (floppy babies)**
- **Loss of facial expression**
- **Extraocular muscle paralysis, dilated pupils**
- **Depression of deep tendon reflexes**
- **Ventilatory failure**

Important Phone Numbers:

General CDC 1-800-232-4636
National Botulism Surveillance 1-404-639-2206
Infant Botulism 1-510-231-7600
Consult with CDC National Center for Environmental Health and Agency for Toxic Substances and Disease Registry. 24/7 1-770-488-7100
BCL 1-334-260-3400

BRUCELLOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ unknown ☐ weeks ☐ years

Did the patient die from this illness? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐ No ☐ Unknown ☐ Yes Is this patient a food handler? ☐ No ☐ Unknown ☐ Yes

Is this case part of an outbreak? ☐ No ☐ Unknown ☐ Yes If yes, outbreak name:_____

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐ Yes ☐ No

IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

SIGNS AND SYMPTOMS

Onset type: ☐ Acute ☐ Insidious ☐ Not Stated

Fever: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Chills: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Weight Loss: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Sweating: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Body Ache: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Weakness: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Headache: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Malaise: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Anorexia: ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Abscess (Bone, Joint, Muscle): ☐ No ☐ Unknown ☐ Yes Duration / Severity: _____

Other Symptoms: _____

OTHER CLINICAL

Was *Brucella* species isolated from a clinical specimen? ☐ No ☐ Unknown ☐ Yes

What species was identified? _____

ANIMAL CONTACT

Did patient come in contact with an animal? ☐ No ☐ Unknown ☐ Yes Applicable incubation period for this illness is : **7 – 21 days**

If yes, select type of animal: ☐ Cat ☐ Cattle ☐ Chicken ☐ Dog ☐ Goats ☐ Lizard ☐ Rodent ☐ Sheep ☐ Turkey ☐ Turtle ☐ Domestic pig ☐ Wild boar/feral pig ☐ Unknown ☐ Other, specify: _____

Did the patient acquire a pet prior to onset of illness? ☐ No ☐ Unknown ☐ Yes

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐ CSF leak
☐ Alcohol abuse
☐ Burns
☐ Cirrhosis/liver failure
☐ Deaf/profound hearing loss
☐ Gastric surgery (type): _____
☐ Immunodeficiency (type): _____
☐ Leukemia
☐ None
☐ Other malignancy (type): _____
☐ Peptic ulcer
☐ Splenectomy/asplenia
☐ Hodgkin's disease
☐ Asthma
☐ Cerebral vascular accident (CVA) stroke
☐ Cochlear implant
☐ Diabetes mellitus (insulin): ☐ No ☐ Unk ☐ Yes
☐ Heart failure
☐ Immunoglobulin deficiency
☐ Multiple myeloma
☐ Organ transplant (organ): _____
☐ Other prior illness (type): _____
☐ Renal failure/dialysis
☐ Systemic lupus erythematosus (SLE)
☐ IVDU
☐ Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐ Chronic GI illness/diarrhea
☐ Current smoker
☐ Emphysema/COPD
☐ Hematologic disease (type): _____
☐ Immunosuppressive therapy (steroids, chemotherapy)
☐ Nephrotic Syndrome
☐ Other liver disease (type): _____
☐ Other renal disease (type): _____
☐ Sickle cell anemia
☐ Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐ No ☐ Unknown ☐ Yes

If Yes, did the health department collect contact information about other similarly ill persons and investigate further?
☐ No ☐ Unknown ☐ Yes

Are there other cases related to this one? ☐ No ☐ Unknown ☐ Yes

Is patient epidemiologically linked to a confirmed human or animal case of Brucellosis? ☐ No ☐ Unknown ☐ Yes

CASE CLASSIFICATION

1	Did the patient acute or insidious onset of fever and one of the following: night sweats, arthralgia, headache, fatigue, anorexia, myalgia, weight loss, arthritis/spondylitis, meningitis, or focal organ involvement (endocarditis, orchitis/epididymitis, hepatomegaly, splenomegaly)?	☐ No ☐ Unknown ☐ Yes
2	Was *Brucella* species isolated from a clinical specimen?	☐ No ☐ Unknown ☐ Yes
3	Was there a fourfold rise in agglutination titer against *Brucella* between acute and convalescent samples?	☐ No ☐ Unknown ☐ Yes
4	Was Brucella DNA detected in a clinical specimen by PCR assay?	☐ No ☐ Unknown ☐ Yes
5	Was a single agglutination titer greater than or equal to 160 by standard tube agglutination test (SAT) or *Brucella* microagglutination test (BMAT) in one or more serum specimens obtained after onset of symptoms?	☐ No ☐ Unknown ☐ Yes
6	Is patient epidemiologically linked to a confirmed human or animal case of *Brucellosis*?	☐ No ☐ Unknown ☐ Yes
Confirmed: 1 & 2 or 1 & 3	**Probable: 1 & 4 or 1 & 5 or 1 & 6**	

CAMPYLOBACTERIOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____
Earliest Date Reported to County: __ __ / __ __ /__ __ __ __

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

SIGNS AND SYMPTOMS

Diarrhea: ☐No ☐Unknown ☐Yes

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

DAY CARE

Attend a day care center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes

Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____

What type of day care facility: ☐Adult day health care ☐Adult day social care ☐Alzheimer's specific day care
☐Child care center ☐Child care provided by friend, relative, neighbor ☐In-home care giver

Is food prepared at this facility? ☐No ☐Unknown ☐Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? ☐No ☐Unknown ☐Yes

What was the last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __

Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is: **1 – 10 days**

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated? ☐Both filtered and disinfected ☐Disinfected ☐Filtered
☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated? ☐Both filtered and disinfected ☐Disinfected ☐Filtered
☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the **10 days** prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **10 days** prior to illness? ☐No ☐Unknown ☐Yes

What was the recreational water exposure type? (select all that apply)

☐Hot Spring ☐Hot Tub-Whirlpool-Jacuzzi-Spa ☐Interactive Fountain ☐Lake-Pond-River-Stream
☐Ocean ☐Other _____ ☐Recreational Water Park ☐Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐Camp Pool ☐Hospital/Therapy Pool ☐Hotel/Motel/Resort Vacation Pool
☐Kiddie/Wading Pool ☐Municipal/Community Pool ☐Neighborhood/subdivision/Apartment/Condo Pool
☐Other, specify_____ ☐Private Club/Membership Pool ☐Private Home Pool, not a kiddie/wading pool
☐School/College/University Pool ☐Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **10 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select type of animal: ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard ☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown ☐Other, specify: _____

Name or location of animal contact: _____

Did a patient come into contact with animal food/feed(s) in the **10 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select associated animal food/feed(s): ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard ☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown ☐Other, specify: _____

If applicable, please list food brand(s): _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐CSF leak
☐Alcohol abuse
☐Burns
☐Cirrhosis/liver failure
☐Deaf/profound hearing loss
☐Gastric surgery (type): _____
☐Immunodeficiency (type): _____
☐Leukemia
☐None
☐Other malignancy (type): _____
☐Peptic ulcer
☐Splenectomy/asplenia
☐Hodgkin's disease
☐Asthma
☐Cerebral vascular accident (CVA) stroke
☐Cochlear implant
☐Diabetes mellitus (insulin):☐No ☐Unk ☐Yes
☐Heart failure
☐Immunoglobulin deficiency
☐Multiple myeloma
☐Organ transplant (organ): _____
☐Other prior illness (type): _____
☐Renal failure/dialysis
☐Systemic lupus erythematosus (SLE)
☐IVDU
☐Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐Chronic GI illness/diarrhea
☐Current smoker
☐Emphysema/COPD
☐Hematologic disease (type): _____
☐Immunosuppressive therapy (steroids, chemotherapy)
☐Nephrotic Syndrome
☐Other liver disease (type): _____
☐Other renal disease (type): _____
☐Sickle cell anemia
☐Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐No ☐Unknown ☐Yes

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the NEDSS Investigation.

OTHER CLINICAL DATA

Was the isolate identified as *Campylobacter*? ☐No ☐Not Tested ☐Unknown ☐Yes

What was the EIA result at clinical (i.e., non-public health) laboratory? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

What was the PCR result at clinical (i.e., non-public health) laboratory? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

What was the species result at clinical laboratory (e.g., *Campylobacter jejuni*)? _____

What was the EIA result at State Public Health Laboratory (SPHL)? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

What was the PCR result at State Public Health Laboratory (SPHL)? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

What was the species result at State Public Health Laboratory (SPHL) (e.g., *C. jejuni*)? _____

What was the PCR result at Centers for Disease Control & Prevention (CDC)? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

PATIENT'S NAME: | **TEL.:** Home | Work

ADDRESS:

PHYSICIAN'S NAME: | **TEL.:**

– PATIENT IDENTIFIERS NOT TRANSMITTED TO CDC

Reset Form

SEND COMPLETED REPORT TO STATE INFECTION CONTROL

State will forward to: Centers for Disease Control and Prevention
Enteric Diseases Epidemiology Branch
1600 Clifton Road, MS C09
Atlanta, GA 30333 | Fax 404-639-2205

CENTERS FOR DISEASE CONTROL AND PREVENTION

CHOLERA AND OTHER VIBRIO ILLNESS SURVEILLANCE REPORT

OMB 0920- 0728 Exp. Date 1/31/2017

I. DEMOGRAPHIC AND ISOLATE INFORMATION

REPORTING HEALTH DEPARTMENT

1. First three letters of patient's last name: ☐☐☐

State: ☐☐ | City: | County/Parish:

State Epi No.: | State Lab Isolate ID: | CDC USE ONLY ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ | FDA No.

2. Date of birth: Mo. ☐☐ Day ☐☐ Yr. ☐☐☐☐

3. Age: Years ☐☐ Mos. ☐☐

4. Sex: ☐ M (1) ☐ F (2) ☐ Unk. (9)

5. Ethnicity: Hispanic or Latino Origin? ☐ Yes (1) ☐ No (2) ☐ Unk. (9) Reset #5

6. Race: Reset #6
☐ American Indian/ Alaska Native (5)
☐ Asian (4)
☐ Black or African American (2)
☐ Native Hawaiian or other Pacific Islander (6)
☐ White (1) ☐ Unk. (9)

7. Occupation: _____

8. Vibrio species isolated (check one or more): Reset #4

Species	Source of specimen(s) collected from patient: Stool	Blood	Wound	Other	Date specimen collected (If more than one specify earliest date) Mo. Day Yr.	If wound or other, specify site :
☐ *V. alginolyticus*	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. cholerae* O1	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. cholerae* O139	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. cholerae* non -O1, non -O139	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. cincinnatiensis*	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *Photobacterium damselae* subsp.*damselae* (formerly *V. damsela*)	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. fluvialis*	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. furnissii*	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *Grimontia hollisae* (formerly *V. hollisae*)	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. metschnikovii*	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. mimicus*	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. parahaemolyticus*	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *V. vulnificus*	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ *Vibrio* species -not identified	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	
☐ Other (specify): _____	☐	☐	☐	☐	☐☐ ☐☐ ☐☐	

9. Were other organisms isolated from the same specimen that yielded *Vibrio*? Reset #9
☐ Yes (1) ☐ No (2) ☐ Unk. (9)
Other (specify): _____

10. Was the identification of the species of *Vibrio* (e.g., *vulnificus, fluvialis*) confirmed at the State Public Health Laboratory? Reset #10
☐ Yes (1) ☐ No (2) ☐ Unk. (9)

11. Complete the following information if the isolate is *Vibrio cholerae* O1 or O139:

Serotype (check one)
☐ Inaba (1) ☐ Ogawa (2) ☐ Hikojima (3) ☐ Not Done (4) ☐ Unk. (9)

Biotype (check one)
☐ El Tor (1) ☐ Classical (2) ☐ Not Done (3) ☐ Unk. (9)

Toxigenic? (check one)
☐ Yes (1) ☐ No (2) ☐ Unk. (9)

If YES, toxin positive by: (check all, that apply)
☐ ELISA
☐ Latex agglutination
☐ Other (specify): _____

Save Form | Next Page

Previous Page

Name of Hospital: _____

Address: _____

State: ☐☐ Age: ☐☐ Sex: ☐

II. CLINICAL INFORMATION

Vibrio species: _____

1. Date and time of onset of first symptoms:

Mo. ☐☐ Day ☐☐ Yr. ☐☐

Hour ☐☐ Min. ☐☐ ☐ am (1) ☐ pm (2)

2. Symptoms and signs:

Fever ..... max. temp. ☐☐☐.☐ ☐ F (1) ☐ C (2)

Reset #2

	Yes (1)	No (2)	(9)
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Diarrhea (max. no. stools/24 hours: _____)	☐	☐	☐
Visible blood in stools	☐	☐	☐
Abdominal cramps	☐	☐	☐

	Yes (1)	No (2)	Unk. (9)	
Headache	☐	☐	☐	
Muscle pain	☐	☐	☐	
Cellulitis	☐	☐	☐	Site: _____
Bullae	☐	☐	☐	Site: _____
Shock (systolic BP <90)	☐	☐	☐	
Other	☐	☐	☐	(specify): _____

3. Total duration of illness: _____ (days)

4. Admitted to a hospital for this illness?

☐ Yes (1) ☐ No (2) ☐ Unk. (9)

Admission date: Mo. ☐☐ Day ☐☐ Yr. ☐☐

Discharge date: Mo. ☐☐ Day ☐☐ Yr. ☐☐

5. Any sequelae? (e.g., amputation, skin graft)

☐ Yes (1) _____

☐ No (2)

☐ Unk. (9)

6. Did patient die?

Reset #6

☐ Yes (1) ☐ No (2) ☐ Unk. (9)

If YES, date of death: Mo. ☐☐ Day ☐☐ Yr. ☐☐

7. Did patient take an antibiotic as treatment for this illness? (643)

Yes (1) ☐ No (2) ☐ Unk. (9) ☐

Reset #4 Reset #5

If YES, name(s) of antibiotic(s):

1. _____
2. _____
3. _____

	Date began antibiotic: Mo. ☐☐ Day ☐☐ Yr. ☐☐	Date ended antibiotic: Mo. ☐☐ Day ☐☐ Yr. ☐☐
1.		
2.		
3.		

Reset #7

8. Pre-existing conditions?

Reset #8

	Yes (1)	No (2)	Unk. (9)	
Alcoholism	☐	☐	☐	
Diabetes	☐	☐	☐	on insulin? ☐ ☐ ☐
Peptic ulcer	☐	☐	☐	
Gastric surgery	☐	☐	☐	type: _____
Heart disease	☐	☐	☐	Heart failure? ☐ ☐ ☐
Hematologic disease	☐	☐	☐	type: _____
Immunodeficiency	☐	☐	☐	type: _____
Liver disease	☐	☐	☐	type: _____
Malignancy	☐	☐	☐	type: _____
Renal disease	☐	☐	☐	type: _____
Other	☐	☐	☐	specify: _____

9. Was the patient receiving any of the following treatments or taking any of the following medications in the 30 days before this *Vibrio* illness began?

Reset #9

	Yes (1)	No (2)	Unk. (9)	If YES, specify treatment and dates:
Antibiotics	☐	☐	☐	
Chemotherapy	☐	☐	☐	
Radiotherapy	☐	☐	☐	
Systemic steroids	☐	☐	☐	
Immunosuppressants	☐	☐	☐	
Antacids	☐	☐	☐	
H_2-Blocker or other ulcer medication (e.g., Tagamet, Zantac, Omeprazole)	☐	☐	☐	

III. EPIDEMIOLOGIC INFORMATION

1. Did this case occur as part of an outbreak? (Two or more cases of *Vibrio* infection)

Yes (1) ☐ No (2) ☐ Unk. (9) ☐

Reset #1

If YES, describe: _____

2. Did the patient travel outside his/her home state in the 7 days before illness began?

Patient home state: ☐☐

Reset #2

Yes (1) ☐ No (2) ☐ Unk. (9) ☐

If YES, list destination(s) and dates:

	City/State/Country	Date Entered Mo. ☐☐ Day ☐☐ Yr. ☐☐	Date Left Mo. ☐☐ Day ☐☐ Yr. ☐☐
1.			
2.			
3.			

3. Please specify which of the following seafoods were eaten by the patient in the 7 days before illness began: (If multiple times, most recent meal)

Reset #3

Type of seafood	Yes (1)	No (2)	Unk. (9)	Mo. ☐☐ Day ☐☐ Yr. ☐☐	Any eaten raw? Yes (1)	No (2)	Unk. (9)
Clams	☐	☐	☐		☐	☐	☐
Crab	☐	☐	☐		☐	☐	☐
Lobster	☐	☐	☐		☐	☐	☐
Mussels	☐	☐	☐		☐	☐	☐
Oysters	☐	☐	☐		☐	☐	☐

Type of seafood	Yes (1)	No (2)	Unk. (9)	Mo. ☐☐ Day ☐☐ Yr. ☐☐	Any eaten raw? Yes (1)	No (2)	Unk. (9)
Shrimp	☐	☐	☐		☐	☐	☐
Crawfish	☐	☐	☐		☐	☐	☐
Other shellfish	☐	☐	☐		☐	☐	☐
(specify): _____							
Fish	☐	☐	☐		☐	☐	☐
(specify): _____							

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State: Age: Sex:

III. EPIDEMIOLOGIC INFORMATION (CONT.)

Vibrio species: _____

4. In the 7 days before illness began, was patient's skin exposed to any of the following? Reset #4

	Yes (1)	No (2)	Unk. (9)
A body of water (fresh, salt, or brackish water)			
Drippings from raw or live seafood			
Other contact with marine or freshwater life			

If YES, specify body of water location: _____

Date of exposure: Mo. Day Yr.

Time of exposure: Hour Min. am (1) pm (2)

If YES, to any of the above, answer each:

	Yes (1)	No (2)	Unk. (9)
Handling/cleaning seafood			
Swimming/diving/wading			
Walking on beach/shore/ fell on rocks/shells			
Boating/skiing/surfing			
Construction/repairs			
Bitten/stung			
Other: (specify)			

- If skin was exposed to water, indicate type:
  Salt (1) Brackish (3) Unk. (9)
  Fresh (2) Other(specify): (8) _____

Additional comments: _____

- If skin was exposed, did the patient sustain a wound during this exposure, or have a pre-existing wound? (choose one):
  YES, sustained a wound. (1) YES, had a pre-existing wound. (2) YES, uncertain if wound new or old. (3) NO (4) Unk. (9)

If YES, describe how wound occurred and site on body :
(Note: Skin bullae that appear as part of the acute illness should be recorded in section II, Clinical Information, only).

_____

If isolate is *Vibrio cholerae* O1 or O139, please answer questions 5 - 8.

5. If patient was infected with *V. cholerae* O1 or O139, to which of the following risks was the patient exposed in the 4 days before illness began:

	Yes (1)	No (2)	Unk. (9)
Raw seafood			
Cooked seafood			
Foreign travel			
Other person(s) with cholera or cholera-like illness			
Street-vended food			
Other			

(specify): _____

6. If answered "yes" to foreign travel (question III. 5), had the patient been educated in cholera prevention measures before travel? Yes (1) No (2) Unk. (9)

If YES, check all source(s) of information received:

- Pre-travel clinic
- Airport (departure gate)
- Newspaper
- Friends
- Private physician
- Health department
- Travel agency
- CDC travelers' hotline
- Other (specify): _____

7. If answered "yes" to foreign travel (question III. 5), what was the patient's reason for travel? (check all that apply)

- To visit relatives/friends (1401)
- Business
- Tourism
- Military
- Other (specify): _____
- Unk.

8. Has patient ever received a cholera vaccine? Yes (1) No (2) Unk. (9)

(If YES, specify type most recently received):

Oral Parenteral

Most recent date: Mo. Day Yr.

If domestically acquired illness due to <u>any</u> *Vibrio* species is suspected to be related to seafood consumption, please complete section IV (Seafood Investigation).

ADDITIONAL INFORMATION or COMMENTS

CDC Use Only Source:

Comment: _____

Syndrome:

CDC Isolate No. _____

Person completing section I - III: _____ Date: Mo. Day Yr.

Title/Agency: _____ Tel.: _____

Print

Save Form Next Page

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State: Age: Sex:

IV. SEAFOOD INVESTIGATION SECTION

Vibrio species: _____

For each seafood ingestion investigated, please complete as many of the following questions as possible. (Include additional pages section IV if more than one seafood type was ingested and investigated.)

1. Type of seafood (e.g., clams): _____

Date consumed: Mo. Day Yr.

Time consumed: Hour Min. am (1) pm (2)

Amount consumed:

Reset #1

If patient ate multiple seafoods in the 7 days before onset of illness, please note why this seafood was investigated (e.g.,consumed raw, implicated in outbreak investigation): _____

2. How was this fish or seafood prepared? Reset #2

Raw (1) Baked (2) Boiled (3) Broiled (4) Fried (5) Steamed (6) Unk. (9) Other (8) (specify): _____

Reset #3

3. Was seafood imported from another country? Yes (1) No (2) Unk. (9)

If YES, specify exporting country if known: _____

4. Was this fish or shellfish harvested by the patient or a friend of the patient? Yes (1) No (2) Unk. (9) (If YES, go to question 12.)

Reset #4

5. Where was this seafood obtained? (Check one)

Oyster bar or restaurant (1)
Truck or roadside vendor (2)
Food store (3)
Seafood market (4)
Other (8) (specify): _____

6. Name of restaurant, oyster bar, or food store: Tel:

Address:

7. If oysters, clams, or mussels were eaten, how were they distributed to the retail outlet? (1591)

Shellstock (sold in the shell) (1) Shucked (2) Unk. (9) Other (8) (specify): _____

8. Date restaurant or food outlet received seafood: Mo. Day Yr.

9. Was this restaurant or food outlet inspected as part of this investigation? Yes (1) No (2) Unk. (9)

10. Are shipping tags available from the suspect lot? Yes (1) No (2) Unk. (9)

(Attach copies if available)

11. Shippers who handled suspected seafood: (please include certification numbers if on tags)

12. Source(s) of seafood:

13. Harvest site: _____

Date: Mo. Day Yr.

Status:

Approved (1) Conditional (3)
Prohibited (2) Other (8) (specify): _____

Approved (1) Conditional (3)
Prohibited (2) Other (8) (specify): _____

Reset #13

14. Physical characteristics of harvest area as close as possible to harvest date:

Reset #14

	Result		Date Measured (Mo. Day Yr.)
Maximum ambient temp.		F (1) C (2)	
Surface water temp.		F (1) C (2)	
Salinity (ppt)			
Total rainfall (inches in prev. 5 days)			
Fecal coliform count			

(Attach copy of coliform data)

15. Was there evidence of improper storage, cross-contamination, or holding temperature at any point? Yes (1) No (2) Unk. (9) If YES, specify deficiencies:

Reset #15

Person completing section IV: _____ Date: Mo. Day Yr.

Title/Agency: _____ Tel.: _____

Save Form Print

CRYPTOSPORIDIOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

SIGNS AND SYMPTOMS

Diarrhea: ☐No ☐Unknown ☐Yes Duration of diarrhea is/was greater than 72 hours: ☐No ☐Unknown ☐Yes

Vomiting: ☐No ☐Unknown ☐Yes Anorexia (significant weight loss): ☐No ☐Unknown ☐Yes

Abdominal cramping: ☐No ☐Unknown ☐Yes

DAY CARE

Attend a day care center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes

Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____

What type of day care facility: ☐Adult day health care ☐Adult day social care ☐Alzheimer's specific day care ☐Child care center ☐Child care provided by friend, relative, neighbor ☐In-home care giver

Is food prepared at this facility? ☐No ☐Unknown ☐Yes Does this facility care for diapered persons? ☐No ☐Unknown ☐Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? ☐No ☐Unknown ☐Yes

What was the last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __

Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is: **1 – 12 days**

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _ _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated?

☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated?

☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the **12 days** prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **12 days** prior to illness? ☐No ☐Unknown ☐Yes

What was the recreational water exposure type? (select all that apply)

☐Hot Spring ☐Hot Tub-Whirlpool-Jacuzzi-Spa ☐Interactive Fountain ☐Lake-Pond-River-Stream
☐Ocean ☐Other _____ ☐Recreational Water Park ☐Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐Camp Pool ☐Hospital/Therapy Pool ☐Hotel/Motel/Resort Vacation Pool
☐Kiddie/Wading Pool ☐Municipal/Community Pool ☐Neighborhood/subdivision/Apartment/Condo Pool
☐Other, specify_____ ☐Private Club/Membership Pool ☐Private Home Pool, not a kiddie/wading pool
☐School/College/University Pool ☐Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **12 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select type of animal: ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard
☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown
☐Other, specify: _____

Name or location of animal contact: _____

Did the patient come into contact with animal food/feed(s) in the **12 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select associated animal food/feed(s): ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard
☐Poultry ☐Sheep ☐Rodent ☐Swine ☐Turtle ☐Unknown
☐Other, specify: _____

If applicable, please list food brand(s): _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐CSF leak
☐Alcohol abuse
☐Burns
☐Cirrhosis/liver failure
☐Deaf/profound hearing loss
☐Gastric surgery (type): _____
☐Immunodeficiency (type): _____
☐Leukemia
☐None
☐Other malignancy (type): _____
☐Peptic ulcer
☐Splenectomy/asplenia
☐Hodgkin's disease
☐Asthma
☐Cerebral vascular accident (CVA) stroke
☐Cochlear implant
☐Diabetes mellitus (insulin):☐No ☐Unk ☐Yes
☐Heart failure
☐Immunoglobulin deficiency
☐Multiple myeloma
☐Organ transplant (organ): _____
☐Other prior illness (type): _____
☐Renal failure/dialysis
☐Systemic lupus erythematosus (SLE)
☐IVDU
☐Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐Chronic GI illness/diarrhea
☐Current smoker
☐Emphysema/COPD
☐Hematologic disease (type): _____
☐Immunosuppressive therapy (steroids, chemotherapy)
☐Nephrotic Syndrome
☐Other liver disease (type): _____
☐Other renal disease (type): _____
☐Sickle cell anemia
☐Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐No ☐Unknown ☐Yes

Is this case epidemiologically linked to a confirmed case? ☐No ☐Unknown ☐Yes

If yes, enter the associated NBS investigation ID (s).

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

Note: Please enter name and Case ID of epi-linked case(s) in the ALNBS General Comments section.

DENGUE FEVER INVESTIGATION FORM

Comments:_____

_____

_____

Basic Demographic Data

Last Name: _____ First Name:_____
Middle Name:_____ Suffix: _____
DOB: __ __ / __ __ /__ __ __ __ Current Sex**:** □Female □Male □Unknown

Is the patient deceased? □ No □Unknown □Yes Deceased Date: __ __ / __ __ /__ __ __ __

Marital Status: (Circle) S / M / D / W/ Annulled/ Cohabitating/ Legally Separated/ Polygamous/Unknown

SSN: __ __ __ / __ __ /__ __ __ __
Identification Information: Type _____ Assigning Authority_____ ID Value:_____

Street Address 1: _____
Street Address 2: _____
City: _____ State:_____
Zip Code*:* __ __ __ __ __- __ __ __ __ County:_____ Country:_____
Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race : □ Unknown □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Investigation Summary

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: □Open □Closed
Investigator:_____ Date assigned: __ __ / __ __ /__ __ __ __

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __
Reporting Source: _____
Earliest Date Reported to: County: __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __
Reporter's Name: _____

Clinical

Physician's Name: _____
Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Street Address: _____
City: _____ State:_____
Zip Code*:* __ __ __ __ __- __ __ __ __ County:_____ Country:_____

Hospital

Was patient hospitalized for this illness? □ No □Unknown □Yes
If yes: Hospital Name: _____
Admission Date__ __ / __ __ /__ __ __ __ Discharge Date __ __ / __ __ /__ __ __ __
Total Duration of Stay Within Hospital _____days

Condition

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __
Illness End Date: __ __ / __ __ /__ __ __ __ Illness Duration: _____ Circle: days/hrs./minutes/months/unknown/weeks/years
Age at Onset: _____ Circle: days/hrs./minutes/months/unknown/weeks/years

Is the patient pregnant? □ No □Unknown □Yes

Did the patient die from this illness? □ No □Unknown □Yes

Epidemiologic

Is this patient associated with a day care facility?	□ No	□ Unknown	□Yes
Is this patient a food handler?	□ No	□ Unknown	□Yes
Is this case part of an outbreak?	□ No	□ Unknown	□Yes
If yes, outbreak name:	□ No	□ Unknown	□Yes

Where was the disease acquired?

☐ Indigenous, within jurisdiction	☐ Out of Country	☐ Out of jurisdiction, from another jurisdiction
☐ Out of state	☐Unknown	

Where was the disease acquired if *NOT* indigenous, within jurisdiction?	
Imported Country:	Imported State:
Imported City:	Imported County:

Transmission Mode

☐ Airborne	☐ Bloodborne	☐ Dermal	☐ Foodborne	☐ Indeterminate	☐ Mechanical
☐ Nosocomial	☐ Sexually Transmitted	☐ Vectorborne	☐ Waterborne	☐ Zoonotic	☐ Other

Detection Method

☐ Patient Self-referral	☐ Prenatal Testing	☐ Prison Entry Screening	☐ Provider Reported	☐ Routine Physical	☐ Other

Confimation Method

☐ Active Surveillance	☐ Case Outbreak Investigation	☐ Clinical Diagnosis	☐Epidemiologically Linked
☐ Laboratory Confirmed	☐ Laboratory Report	☐ Local/State Specified	☐ Medical Record Review
☐ No information given	☐ Occupational Disease Surveillance	☐ Provider Certified	☐Other

Confirmation Date: __ __ / __ __ /__ __ __ __

CASE STATUS: (Required for Notification) ☐Confirmed ☐ Not a Case ☐ Probable ☐Suspect ☐ Unknown

MMWR Week _____ MMWR Year _____

Custom Fields

Date Due __ __ / __ __ /__ __ __ __

Investigation Ready for Supervisor Review:_____

Date Investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Condition Specific Custom Fields

Clinical Data

Does the patient have:	*No*	*Unk*	*Yes*		*No*	*Unk*	*Yes*
Fever :				Headache:			
Eye pain:				Body pain:			
Joint pain :				Rash:			
Nausea or vomit:				Diarrhea:			
Chills:				Cough:			
Petechiae:				Bruises:			
Blood in vomit:				Blood in stool:			
Blood in urine:				Nose bleed:			
Bleeding gums:							

Epidemiologic Data

Have you had dengue before (with fever, body pains and rash)?	☐ No ☐Unknown ☐Yes
If Yes, when did you have dengue before? (Month/Year)	__ __ / __ __ __ __
How long have you lived in this location? _____ Circle: days / weeks / months / years	
During the 10 days before onset of illness have you traveled to other locations?	☐ No ☐Unknown ☐Yes
If yes, where did you travel?	_____
Have you been vaccinated against Yellow Fever?	☐ No ☐Unknown ☐Yes

Comments:_____

_____

_____

If pregnant, how many months pregnant? _____

Clinical criteria for case classification

Does the patient have?	***No***	***Unk***	***Yes***		***No***	***Unk***	***Yes***
Fever	☐	☐	☐	Frontal Headache	☐	☐	☐
Retro-ocular pain	☐	☐	☐	Muscle & Joint Pain	☐	☐	☐
Rash	☐	☐	☐				

Laboratory criteria for case classification

Isolation of dengue virus :	☐No ☐Not Tested ☐Unknown ☐Yes
A greater than or equal to 4 fold rise in IgG or IgM antibody titers against dengue virus antigens :	☐No ☐Not Tested ☐Unknown ☐Yes
Demonstration of dengue virus antigen in autopsy tissue or serum samples by immunohistochemistry (IHC) or by viral nucleic acid detection (PCR) :	☐No ☐Not Tested ☐Unknown ☐Yes

DIPHTHERIA INVESTIGATION FORM

Comments:_____
_____
_____

Basic Demographic Data

Last Name: _____ First Name:_____

Middle Name:_____ Suffix: _____

DOB: __ __ / __ __ /__ __ __ __ Current Sex*:* ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Deceased Date: __ __ / __ __ /__ __ __ __

Marital Status: (Circle) S / M / D / W/ Annulled/ Cohabitating/ Legally Separated/ Polygamous/Unknown

SSN: __ __ __ / __ __ /__ __ __ __

Street Address 1: _____

Street Address 2: _____

City: _____ State:_____

Zip Code*:* __ __ __ __ - __ __ __ __ County:_____Country:_____

Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __ __

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race : ☐Unknown ☐ American Indian or Alaska Native ☐Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __

Reporting Source:_____

Earliest Date Reported to: County : __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __

Reporter's Name:_____

Clinical

Physician's Name: _____

Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Physician's Address: _____

City:_____ State:_____

Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country_____

Hospital

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes

If yes: Hospital Name: _____

Admission Date__ __ / __ __ /__ __ __ __ Discharge Date __ __ / __ __ /__ __ __ __

Total Duration of stay within hospital _____days

Condition

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __

Illness End Date: __ __ / __ __ /__ __ __ __

Illness Duration: _____ Circle: days/hrs./minutes/months/unknown/weeks/years

Age at Onset: _____ Circle: days/hrs./minutes/months/unknown/weeks/years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes

Epidemiologic

Is this patient associated with a day care facility?	☐No ☐Unknown ☐Yes	Is this patient a food handler?	☐No ☐Unknown ☐Yes
Is this case part of an outbreak?	☐No ☐Unknown ☐Yes	If yes, outbreak name:	

Where was the disease acquired?

☐ Indigenous within jurisdiction	☐ Out of Country	☐ Out of jurisdiction, from another jurisdiction
☐ Out of state	☐Unknown	

If the answer is out of Country, Jurisdiction, or State					
Imported Country:			Imported State:		
Imported City:			Imported County:		
Transmission Mode					
☐ Airborne	☐ Bloodborne	☐ Dermal	☐ Foodborne	☐ Indeterminate	☐ Mechanical
☐ Nosocomial	☐ Sexually Transmitted	☐ Vectorborne	☐ Waterborne	☐ Zoonotic	☐ Other
Detection Method					
☐ Patient Self-referral	☐ Prenatal Testing	☐ Prison Entry Screening	☐ Provider Reported	☐ Routine Physical	☐ Other
Confimation Method					
☐ Active Surveillance	☐ Case Outbreak Investigation	☐ Clinical Diagnosis	☐ Epidemiologically Linked		
☐ Laboratory Confirmed	☐ Laboratory Report	☐ Local/State Specified	☐ Medical Record Review		
☐ No information given	☐ Occupational Disease Surveillance	☐ Provider Certified	☐ Other		
Confirmation Date: : __ __ / __ __ /__ __ __ __					
CASE STATUS: (Required for Notification) ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week _____ MMWR Year _____					
Custom Fields					
Date Due __ __ / __ __ /__ __ __ __ Investigation Ready for Supervisor Review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete) ☐ Reviewed (Not a case) ☐ Yes Date Investigation ready for supervisor review: __ __ / __ __ /__ __ __ __					
Based on the person's age and current recommendations, has the case received the recommended doses of vaccine for the disease under investigation? ☐ No ☐ Yes					
Birth Information:					
Birth Country (required field):			If Foreign Born, Number of Years in US _____		
If yes, to associated with a school or daycare? Answer questions below:					
Name of school or daycare: City of school or daycare: County of school or daycare:					
What grades attend the school (ie: K-12, K-6, 7-12, 7-8, 5-8, 9-12)			What grade is the case in at the school?		
Are there other cases in the classroom or other cases in the school building, or both? Explain:					
Condition Specific Custom Fields					
Clinical criteria for case classification					
Does the patient have: sore throat, low grade fever, and an adherent membrane of the tonsils, pharynx, and/or nose. (Cutaneous diphtheria should not be reported) :	☐ No ☐ Unknown ☐ Yes				
Epidemiologically linked to a laboratory confirmed case :	☐ No ☐ Unknown ☐ Yes				
Laboratory criteria for case classification					
Isolation of Corynebacterium diphtheriae from a clinical specimen :	☐ No ☐ Not Tested ☐ Unknown ☐ Yes				
Histopathologic diagnosis of diphtheria :	☐ No ☐ Not Tested ☐ Unknown ☐ Yes				

EHRLICHIOSIS/ANAPLASMOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

LABORATORY INFORMATION

Did the patient have:

Anemia (low RBCs)?	☐No ☐Unknown ☐Yes
Leukopenia (low WBCs)?	☐No ☐Unknown ☐Yes
Thrombocytopenia (low platelets)?	☐No ☐Unknown ☐Yes

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

SIGNS AND SYMPTOMS

Clinical Evidence:

Any reported fever: ☐No ☐Unknown ☐Yes Headache: ☐No ☐Unknown ☐Yes Myalgia: ☐No ☐Unknown ☐Yes

Anemia: ☐No ☐Unknown ☐Yes Leukopenia: ☐No ☐Unknown ☐Yes Thrombocytopenia: ☐No ☐Unknown ☐Yes

Any hepatic transaminase elevation: ☐No ☐Unknown ☐Yes

GIARDIASIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

SIGNS AND SYMPTOMS

Diarrhea: ☐No ☐Unknown ☐Yes Bloating: ☐No ☐Unknown ☐Yes Weight Loss: ☐No ☐Unknown ☐Yes

Abdominal cramps: ☐No ☐Unknown ☐Yes Malabsorption: ☐No ☐Unknown ☐Yes

DAY CARE

Attend a day care center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes

Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____

What type of day care facility: ☐Adult day health care ☐Adult day social care ☐Alzheimer's specific day care
☐Child care center ☐Child care provided by friend, relative, neighbor ☐In-home care giver

Is food prepared at this facility? ☐No ☐Unknown ☐Yes Does this facility care for diapered persons? ☐No ☐Unknown ☐Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? ☐No ☐Unknown ☐Yes

What was the last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __

Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is: **3-25 days**

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____
Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____
Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____
Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated?

☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated?

☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the **3-25 days** prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **3-25 days** prior to illness? ☐No ☐Unknown ☐Yes

What was the recreational water exposure type? (select all that apply)

☐Hot Spring ☐Hot Tub-Whirlpool-Jacuzzi-Spa ☐Interactive Fountain ☐Lake-Pond-River-Stream
☐Ocean ☐Other _____ ☐Recreational Water Park ☐Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐Camp Pool ☐Hospital/Therapy Pool ☐Hotel/Motel/Resort Vacation Pool
☐Kiddie/Wading Pool ☐Municipal/Community Pool ☐Neighborhood/subdivision/Apartment/Condo Pool
☐Other, specify_____ ☐Private Club/Membership Pool ☐Private Home Pool, not a kiddie/wading pool
☐School/College/University Pool ☐Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **3-25 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select type of animal: ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard
☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown
☐Other, specify: _____

Name or location of animal contact: _____

Did a patient come into contact with animal food/feed(s) in the **3-25 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select associated animal food/feed(s): ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard
☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown
☐Other, specify: _____

If applicable, please list food brand(s): _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐CSF leak
☐Alcohol abuse
☐Burns
☐Cirrhosis/liver failure
☐Deaf/profound hearing loss
☐Gastric surgery (type): _____
☐Immunodeficiency (type): _____
☐Leukemia
☐None
☐Other malignancy (type): _____
☐Peptic ulcer
☐Splenectomy/asplenia
☐Hodgkin's disease
☐Asthma
☐Cerebral vascular accident (CVA) stroke
☐Cochlear implant
☐Diabetes mellitus (insulin):☐No ☐Unk ☐Yes
☐Heart failure
☐Immunoglobulin deficiency
☐Multiple myeloma
☐Organ transplant (organ): _____
☐Other prior illness (type): _____
☐Renal failure/dialysis
☐Systemic lupus erythematosus (SLE)
☐IVDU
☐Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐Chronic GI illness/diarrhea
☐Current smoker
☐Emphysema/COPD
☐Hematologic disease (type): _____
☐Immunosuppressive therapy (steroids, chemotherapy)
☐Nephrotic Syndrome
☐Other liver disease (type): _____
☐Other renal disease (type): _____
☐Sickle cell anemia
☐Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐No ☐Unknown ☐Yes

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

Note: Please enter name and Case ID of epi-linked case(s) in the General Comments section of the NEDSS Investigation.

HAEMOPHILUS INFLUENAE (HIB) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed Investigator:_____

OTHER PATIENT INFORMATION

Type of Insurance:

☐ Indian Health Service (IHS) ☐ Medicaid/State assistance program ☐ Medicare ☐ Military/VA
☐ No health care coverage ☐ Other, specify: _____ ☐ Private/HMO/PPO/Managed care plan ☐ Unknown

Weight: _____lbs _____oz OR _____kg OR ☐ Unknown Height: _____ft _____in OR _____cm OR ☐ Unknown

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Hospital

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Condition

Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Types of infection caused by organism:

☐ Abscess (not skin) ☐ Bacteremia without focus ☐ Cellulitis ☐ Chorioamnionitis
☐ Conjunctivitis ☐ Empyema ☐ Endocarditis ☐ Endometriosis
☐ Epiglottitis ☐ Hemolytic uremic Syndrome (HUS) ☐ Meningitis ☐ Necrotizing fasciitis
☐ Osteomylitis ☐ Other, specify: _____ ☐ Otitis media ☐ Pericarditis
☐ Peritonitis ☐ Pneumonia ☐ Puerperal sepsis ☐ Septic abortion
☐ Septic arthritis ☐ Streptococcal toxic-shock syndrome (STSS) ☐ Unknown

Bacterial species isolated from any normally sterile site:

☐ Bacterial meningitis, other ☐ Group A Streptococcus, invasive ☐ Group B Streptococcus, invasive
☐ Haemophilus influenzae, invasive ☐ Listeria monocytogenes ☐ Neisseria meningitides, invasive
☐ Strep. pneumoniae, drug-res. invasive ☐ Streptococcal disease, invasive, other ☐ Streptococcal toxic-shock syndrome
☐ Streptococcus pneumoniae, invasive ☐ Streptococcus pneumoniae, invasive disease (IPD)

Date first positive culture obtained: __ __ / __ __ /__ __ __ __

Sterile sites from which organism isolated:

☐ Amniotic fluid (pre-birth) ☐ Blood ☐ Bone ☐ CSF ☐ Internal body site ☐ Joint
☐ Muscle ☐ Other, specify: _____ ☐ Pericardial fluid ☐ Peritoneal fluid ☐ Placenta (pre-birth) ☐ Pleural fluid

Nonsterile sites from which organism isolated:

☐ Amniotic fluid (delivery/post-birth) ☐ Middle ear ☐ Placenta (delivery/post-birth) ☐ Sinus ☐ Wound ☐ Other, specify: _____

Did the patient have any underlying conditions? ☐ No ☐ Unknown ☐ Yes

If yes, underlying conditions:

- ☐ AIDS
- ☐ Atherosclerotic Cardiovascular Disease (CAD)
- ☐ Cirrhosis/Liver failure
- ☐ CSF Leak (2° trauma/surgery)
- ☐ Diabetes Mellitus
- ☐ HIV
- ☐ Immunosuppressive Therapy
- ☐ Multiple Myeloma
- ☐ Obesity
- ☐ Other prior illness, specify: _____
- ☐ Splenectomy/Asplenia
- ☐ Alcohol abuse
- ☐ Burns
- ☐ Cochlear implant
- ☐ Current smoker
- ☐ Emphysema/COPD
- ☐ Hodgkin's disease
- ☐ IVDU
- ☐ Nephrotic Syndrome
- ☐ Organ transplant, specify:
- ☐ Renal Failure/Dialysis
- ☐ Systemic Lupus Erythematosus (SLE)
- ☐ Asthma
- ☐ Cerebral Vascular Accident (CVA)/Stroke
- ☐ Complement deficiency
- ☐ Deaf/Profound hearing loss
- ☐ Heart Failure/CHF
- ☐ Immunoglobulin Deficiency
- ☐ Leukemia
- ☐ None
- ☐ Other malignancy, specify: _____
- ☐ Sickle Cell Anemia
- ☐ Unknown

Other Prior Illness: _____ Other Prior Illness 2: _____ Other Prior Illness 3: _____

Did the patient die from this illness or did IPD contribute to death? ☐ No ☐ Unknown ☐ Yes

What was the serotype: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ Non-B ☐ Not Tested ☐ Not Typeable ☐ Unknown ☐ Other

Was the patient a< 15 years of age at the time of first positive culture? ☐ No ☐ Unknown ☐ Yes

EPIDEMIOLOGIC

If < 6 years of age, is the patient in daycare (supervised group of ≥ 2 unrelated children for > 4 hours/week)? ☐ No ☐ Unknown ☐ Yes

If yes, Day Care Facility: _____

Was the patient a resident of a nursing home or other chronic care facility at the time of first positive culture? ☐ No ☐ Unknown ☐ Yes

If yes, Chronic Care Facility: _____

Is this case part of an outbreak? ☐ No ☐ Unknown ☐ Yes If yes, outbreak name:_____

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

CUSTOM FIELDS

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐ Yes ☐ No

CONDITION SPECIFIC CUTOM FIELDS

Vaccine History

Did the patient receive *Haemophilus* b vaccine? ☐ No ☐ Unknown ☐ Yes

Cross reference ImmPRINT and enter relevant vaccine information using MANAGE VACCINATIONS page.

CASE CLASSIFICATION		
1	Did the patient experience meningitis, bacteremia, epiglottitis, or pneumonia?	☐ No ☐ Unknown ☐ Yes
2	Isolation of *Haemophius influenzae* from a normally sterile body site†? *†blood, cerebrospinal fluid (CSF), synovial/joint fluid, pleural fluid, or pericardial fluid*	☐ No ☐ Unknown ☐ Yes
3	Detection of *H. influenza* type b antigen in CSF?	☐ No ☐ Unknown ☐ Yes
Confirmed: 1 & 2		**Probable: 1 & 3**

Instructions for Completing the Hansen's Disease *(Leprosy)* Surveillance Form

The Hansen's Disease or Leprosy Surveillance Form *(LSF)* is the document used to report leprosy cases to the U.S. National Hansen's Disease Registry. These data are used for epidemiological, clinical, and basic research studies throughout the National Hansen's Disease Program *(NHDP),* and are the official source for information on leprosy cases in the U.S.

The information requested on the LSF is used by many clinicians and researchers, and collection of all information is highly desirable. However, the fields that are **boldfaced** on the form and in the instructions below are considered to be the minimal information needed to register a patient. Failure to provide this information will result in the form being returned which creates additional work and may cause delays in obtaining program services for the patient.

1. **Reporting State:** Use the abbreviation of the state from which the report is being sent. This is usually the state of the clinician's office and not necessarily the patient's resident state.
2. **Date of Report:** This is date of the initial LSF completion. If patient was previously reported and has relapsed, write the word "RELAPSE" next to the date.
3. Social Security Number: Optional; self-explanatory.
4. **Patient Name:** Self-explanatory.
5. **Present Address:** Please include the county and zip code which are used to geographically cluster patients.
6. **Place of Birth:** Include state and city, if born in the U.S., or the country, if foreign born.
7. **Date of Birth/Sex:** Self-explanatory.
8. **Race/Ethnicity:** This information should be voluntarily provided by the patient. If the patient refuses or indicates a race/ethnicity category not listed, check the "Not Specified" box.
9. **Date Entered the U.S.:** For patients who have immigrated to the U.S., provide the month and year of entry.
10. Date of Onset of Symptoms: This information is usually the patient's recollection of when classic leprosy symptoms *(rash, nodule formation, paresthesia, decreased peripheral sensation, etc.)* were first noticed.
11. **Date Leprosy First Diagnosed:** Provide the month and year a diagnosis was made. This usually coincides with a biopsy date if one was performed.
12. **How many doctors have you seen for this problem?** This will be based primarily on the patient's recollection. Include the physician reporting the case.
13. **Initial Diagnosis:** Was the patient diagnosed in the U.S. or outside the U.S.
14. **Type of Leprosy:** Classify the diagnosis based on one of the ICD-9-CM diagnosis codes. (NHDP Clinic physicians: Please circle specific classification, if possible)

    030.0 Lepromatous Leprosy *(macular, diffuse, infiltrated, nodular, neuritic – includes Ridley-Jopling [RJ], Lepromatous [LL] and Borderline lepromatous [BL]*): A form marked by erythematous macules, generalized papular and nodular lesions, and variously by upper respiratory infiltration, nodules on conjunctiva or sclera, and motor loss.

    030.1 Tuberculoid Leprosy *(macular, maculoanesthetic, major, minor, neuritic – includes RJTuberculoid [TT] and Borderline tuberculoid [BT])*: A form marked by usually one lesion with well-defined margins with scaly surface and local tender cutaneous or peripheral nerves.

    030.2 Indeterminate *(uncharacteristic, macular, neuritic)*: A form marked by one or more macular lesions, which may have slight erythema.

    030.3 Borderline *(dimorphous, infiltrated, neuritic – includes RJ Borderline [BB] or true mid disease only)*: A form marked by early nerve involvement and lesions of varying stages.

    030.8 Other Specified Leprosy: Use this code when the diagnosis is specified as "leprosy" but is not listed above *(030.0-030.3)*, including 'pure neural' disease.

    030.9 Leprosy, Inactive: Use this code when the diagnosis is identified as "leprosy" but inactive.
15. Diagnosis of Disease: Reaction=Y if steroids required. Enter INITIAL biopsy and skin smear dates and results.
16. **Residence *(Pre-diagnosis)*:** List all cities, counties, and states in the U.S. and all foreign countries a patient resided in BEFORE leprosy was diagnosed. This information is used to map all places where U.S. leprosy cases have resided.
17. **Disability: Eye, Hand & Foot.** For each eye, hand and foot check Yes or No. [Normal always = No]

    Loss of any sensation in hands or feet; for Eyes, is blinking abnormal (very infrequent?). Normal = No

    Visible deformity (muscle wasting, clawing of fingers or toes, ulcers or other abnormality of the hands or feet. For Eyes, lagophthalmos or reduced vision (e.g. cataract). Normal = No
18. Current Household Contacts: Self-explanatory.
19. Current Treatment for Leprosy: Date that treatment started and indicate all drugs used for initial treatment.

HANSEN'S DISEASE *(LEPROSY)* SURVEILLANCE FORM

NATIONAL HANSEN'S DISEASE PROGRAMS
1770 PHYSICIANS PARK DRIVE
BATON ROUGE, LA 70816
1-800-642-2477

FOR NHDP USE ONLY

1 Reporting State: ☐☐

2 Date of Report: Mo. ☐☐ Day ☐☐ Yr. ☐☐

3 Social Security Number *(optional)*: ☐☐☐ - ☐☐ - ☐☐☐☐

4 Patient Name: *(Last)* *(First)* *(Middle)*

5 Present Address: Street _____ City _____

County _____ State _____ Zip _____

6 Place of Birth:
State _____ City _____
Country _____

7 Date of Birth: Mo. ☐☐ Day ☐☐ Yr. ☐☐

Sex: ☐ Male ☐ Female

8 Race/Ethnicity:
☐ White, Not Hispanic ☐ White, Hispanic ☐ American Indian, Alaska Native ☐ Indian, Middle Easterner
☐ Black, Not Hispanic ☐ Black, Hispanic ☐ Asian ☐ Native Pacific Islander ☐ Not Specified

9 Date Entered U.S.: Mo. ☐☐ Yr. ☐☐

10 Date of Onset of Symptoms: Mo. ☐☐ Yr. ☐☐

11 Date Leprosy First Diagnosed: Mo. ☐☐ Yr. ☐☐

12 How many doctors have you seen for this problem? ☐

13 Initial Diagnosis: ☐ In U.S. ☐ Outside U.S.

14 Type of Leprosy: *(ICD-9-CM Code)* **(NHDP Clinic physicians: Please circle specific classification, if possible)**
☐ Lepromatous *(030.0 - LL, BL)* ☐ Indeterminate *(030.2 - IN)* ☐ Other Specified Leprosy *(030.8)*
☐ Tuberculoid *(030.1 - TT, BT)* ☐ Borderline *(030.3 - BB)* ☐ Leprosy, Unspecified *(030.9)*

15 Diagnosis of Disease:
Leprosy reaction at diagnosis? ☐ Yes ☐ No
Was biopsy performed in U.S.? ☐ Yes ☐ No
Date ____ / ____ / ____
Result _____
Skin Smear? Yes No ____ / ____ / ____ Date
BI: Positive ____ Negative ____

16 List all places in the U.S.A. and all foreign countries a PATIENT resided *(Including Military Service)* BEFORE leprosy was diagnosed:

TOWN	COUNTY	STATE	COUNTRY	INCLUSIVE DATES From Mo./Yr.	INCLUSIVE DATES To Mo./Yr.

17 Disability:

	Hands				Feet					Eyes			
	Right		Left		Right		Left			Right		Left	
	Yes	No	Yes	No	Yes	No	Yes	No		Yes	No	Yes	No
Loss of Sensation?	☐	☐	☐	☐	☐	☐	☐	☐	Blink abnormal?	☐	☐	☐	☐
Visible deformity?	☐	☐	☐	☐	☐	☐	☐	☐	Lagophthalmos?	☐	☐	☐	☐

18 Current Household Contacts: Name/Relationship
1 _____
2 _____
3 _____
4 _____

19 Current Treatment for Leprosy: *(check all that apply)*
Date Treatment Started: ____ / ____ Mo. Yr.
☐ Dapsone ☐ Rifampin ☐ Clofazimine
☐ Other *(list)* _____

20 Name and Address of Physician: _____

Investigator:

This form may be FAXED to NHDP at (225) 756-3706
A copy of this form should be sent to your local or state health department.

NHDP JUNE 2014

Fax to Alabama Department of Public Health at 334-206-3734

HEMOLYTIC UREMIC SYNDROME (HUS) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CLINICAL INFORMATION

Physician diagnosed with HUS or TTP? ☐No ☐Unknown ☐Yes

Did patient experience acute diarrhea within the **3 weeks** preceding HUS/TTP diagnosis? ☐No ☐Unknown ☐Yes

Anemia with microangiopathic changes? ☐No ☐Unknown ☐Yes

Renal injury (acute onset) evidenced by either hematuria, proteinuria, or elevated creatinine level? ☐No ☐Unknown ☐Yes

ASSOCIATED DISEASE

Enter Investigation ID for patient's associated investigation (e.g., STEC): _____

HEPATITIS A INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Place of Birth (Country): _____

Reason for Testing (Select all that apply):

☐Blood/Organ donor screening ☐Evaluation of elevated liver enzymes ☐Follow-up testing (prior viral hepatitis marker)
☐Other (specify) _____ ☐Prenatal screening ☐Screening of asymptomatic patient with risk factors
☐Symptoms of acute hepatitis ☐Unknown ☐Screening of asymptomatic patient without risk factors

Was the patient pregnant? ☐No ☐Unknown ☐Yes Due Date: __ __ / __ __ /__ __ __ __

Diagnosis Date: __ __ / __ __ /__ __ __ __

Is patient symptomatic? ☐No ☐Unknown ☐Yes Onset Date: __ __ / __ __ /__ __ __ __ Was patient jaundiced? ☐No ☐Unknown ☐Yes

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Liver enzyme levels at time of diagnosis:

ALT (SGPT) Result: _____ Upper Limit Normal: _____ Date of ALT Result: __ __ / __ __ /__ __ __ __

AST (SGOT) Result: _____ Upper Limit Normal: _____ Date of AST Result: __ __ / __ __ /__ __ __ __

Diagnostic Tests:

Total Ab† to hepatitis A virus (tot Ab-HAV):	☐Neg ☐Pos ☐Unk	Ab to hepatitis C virus (Ab-HCV):	☐Neg ☐Pos ☐Unk
IgM Ab to hepatitis A virus (IgM Ab-HAV):	☐Neg ☐Pos ☐Unk	Ab-HCV signal to cut-off ratio:	_____
Hepatitis B surface Ag‡ (HBsAg):	☐Neg ☐Pos ☐Unk	Supplemental Ab-HCV assay (e.g., RIBA):	☐Neg ☐Pos ☐Unk
Hepatitis B "e" Ag (HBeAg):	☐Neg ☐Pos ☐Unk	Hepatitis C virus RNA (e.g., PCR):	☐Neg ☐Pos ☐Unk
Total Ab to hepatitis B core antigen (tot Ab-HBc):	☐Neg ☐Pos ☐Unk	Ab to hepatitis D virus (Ab-HDV):	☐Neg ☐Pos ☐Unk
IgM Ab to hepatitis B core antigen (IgM Ab-HBc):	☐Neg ☐Pos ☐Unk	Ab to hepatitis E virus (Abi-HEV):	☐Neg ☐Pos ☐Unk
Hepatitis B virus DNA:	☐Neg ☐Pos ☐Unk		

†*Ab=Antibody, ‡Ag = Antigen*

Epi-Link: If this case has a diagnosis of hepatitis A without lab confirmation, is there an epi-link to a lab-confirmed case? ☐No ☐Unknown ☐Yes

EPIDEMIOLOGIC

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

Diagnosis: ☐Hepatitis A, acute ☐Hepatitis B viral infection, perinatal ☐Hepatitis B virus infection, chronic
☐Hepatitis B, acute ☐Hepatitis C Virus infection, chronic or resolved ☐Hepatitis C, acute
☐Hepatitis Delta co- or super-infection, acute ☐Hepatitis E, acute ☐Hepatitis non-ABC, acute

Number of hepatitis A contacts given post-exposure prophylaxis (PEP): _____

If no PEP administered, why? (e.g., ≥ 6 years with no daycare, contacts identified > 2 weeks after last exposure): _____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

SIGNS & SYMPTOMS

Fever:	☐No ☐Unknown ☐Yes	Highest Temp: _____°F	Nausea:	☐No ☐Unknown ☐Yes
Headache:	☐No ☐Unknown ☐Yes		Vomiting:	☐No ☐Unknown ☐Yes
Malaise (unexplained tiredness):	☐No ☐Unknown ☐Yes		Diarrhea:	☐No ☐Unknown ☐Yes
Anorexia (loss of appetite):	☐No ☐Unknown ☐Yes		Abdominal Pain:	☐No ☐Unknown ☐Yes

MEDICAL HISTORY

During the 2 to 6 WEEKS prior to onset of symptoms, was the patient:

A contact of a person with confirmed or suspected hepatitis A virus infection? ☐No ☐Unknown ☐Yes

If yes, type of contact (Select all that apply):

☐Babysitter of this patient ☐Child cared for by this patient ☐Household member (non-sexual)
☐Other (specify) _____ ☐Playmate ☐Sex partner ☐Unknown

During the 2 to 6 WEEKS prior to onset of symptoms, was the patient:

A child or employee in a daycare center, nursery, or preschool? ☐No ☐Unknown ☐Yes

A household contact of a child or employee in a daycare center, nursery, or preschool? ☐No ☐Unknown ☐Yes

If yes for either, was there an identified hepatitis A case in the child care facility? ☐No ☐Unknown ☐Yes

INVESTIGATOR: *ASK BOTH OF THE FOLLOWING QUESTIONS REGARDLESS OF THE PATIENT'S GENDER*

In the 2 to 6 WEEKS before symptom onset, how many:

Male sex partners did the patient have: ☐0 ☐1 ☐2-5 ☐>5 ☐Unknown

Female sex partners did the patient have: ☐0 ☐1 ☐2-5 ☐>5 ☐Unknown

In the 2 to 6 WEEKS before symptom onset, did the patient:

Inject drugs no prescribed by a doctor? ☐No ☐Unknown ☐Yes

Use street drugs, but not inject? ☐No ☐Unknown ☐Yes

Travel outside the U.S.A. or Canada? ☐No ☐Unknown ☐Yes If yes, where did they travel? _____

In the 3 MONTHS (2 incubation periods) prior to symptom onset:

Did anyone in the patient's household travel outside the U.S.A. or Canada? ☐No ☐Unknown ☐Yes

If yes, where did they travel? _____

Outbreak Related:

Is the patient suspected of being part of a common source outbreak? ☐No ☐Unknown ☐Yes

If yes, select type of outbreak: ☐Foodborne – associated with an infected food handler
☐Foodborne – NOT associated with an infected food handler (Specify food item: _____)
☐Source not identified
☐Waterborne

Food Handler Information:

Was the patient employed as a food handler during the **2 WEEKS** prior to onset of symptoms or while ill? ☐No ☐Unknown ☐Yes

Vaccine Information:

Has the patient ever received hepatitis A vaccine? ☐No ☐Unknown ☐Yes If yes, number of doses? ☐1 ☐2 ☐≥ 3 Year last shot: _____

Has the patient ever received immune globulin? ☐No ☐Unknown ☐Yes If yes, date of last dose: __ __ / __ __ /__ __ __ __

Vaccine Information: ***Must be added via the Events Tab, add new Vaccinations feature after investigation is submitted.***

Vaccination 1 Record: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination 1: _____ ☐years ☐months

Vaccine 1 Administered (*Select*): ☐Hep A – adult ☐Hep A, NOS ☐Hep A, ped/adol, 2 dose
☐Hep A, ped/adol, 2 dose ☐Hep A, pediatric, NOS ☐Hep A-Hep B

Vaccination 2 Record: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination 2: _____ ☐years ☐months

Vaccine 2 Administered (*Select*): ☐Hep A – adult ☐Hep A, NOS ☐Hep A, ped/adol, 2 dose
☐Hep A, ped/adol, 2 dose ☐Hep A, pediatric, NOS ☐Hep A-Hep B

During the 6 WEEKS to 6 MONTHS prior to illness (N/A to hepatitis A infection):

PHEP - GENERAL:

Date of presumptive diagnosis: __ __ / __ __ /__ __ __ __

Method of initial report to Public Health: ☐ELR ☐Email ☐Fax ☐Mail ☐Online REPORT card ☐Phone

Which reporter type (or designee) provided initial report to Public Health?: ☐Day care director ☐Dentist ☐Physician ☐Hospital administrator
☐Lab director ☐Medical examiner ☐Nurse ☐Nursing home administrator ☐Other state health department or CDC
☐Patient/family ☐School principal

PHEP PROJECT – CONTROL MEASURES IMPLEMENTED (Answer all):

Date first control measures initiated: __ __ / __ __ /__ __ __ __ Other measures: _____

Education case/contacts:	☐No	☐Unk	☐Yes	☐N/A	Exclusions from foodhandling:	☐No	☐Unk	☐Yes	☐N/A
Exclusions from healthcare:	☐No	☐Unk	☐Yes	☐N/A	Exclusions from daycare/school:	☐No	☐Unk	☐Yes	☐N/A
Immunization:	☐No	☐Unk	☐Yes	☐N/A	Prophylaxis:	☐No	☐Unk	☐Yes	☐N/A
Identification of exposed individuals:	☐No	☐Unk	☐Yes	☐N/A	Identification of additional cases:	☐No	☐Unk	☐Yes	☐N/A
Identification of likely source of infection:	☐No	☐Unk	☐Yes	☐N/A	Collection of food:	☐No	☐Unk	☐Yes	☐N/A

Notify state/federal partner agencies/organizations: ☐No ☐Unknown ☐Yes ☐N/A

HEPATITIS B INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Place of Birth (Country): _____

Reason for Testing (Select all that apply):

☐Blood/Organ donor screening ☐Evaluation of elevated liver enzymes ☐Follow-up testing (prior viral hepatitis marker)
☐Other (specify) _____ ☐Prenatal screening ☐Screening of asymptomatic patient with risk factors
☐Symptoms of acute hepatitis ☐Unknown ☐Screening of asymptomatic patient without risk factors

Was the patient pregnant? ☐No ☐Unknown ☐Yes Due Date: __ __ / __ __ /__ __ __ __

Diagnosis Date: __ __ / __ __ /__ __ __ __

Is the patient symptomatic? ☐No ☐Unknown ☐Yes Symptom Onset Date: __ __ / __ __ /__ __ __ __

Was the patient jaundiced? ☐No ☐Unknown ☐Yes

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Liver enzyme levels at time of diagnosis:

ALT (SGPT) Result: _____ Upper Limit Normal: _____ Date of ALT Result: __ __ / __ __ /__ __ __ __

AST (SGOT) Result: _____ Upper Limit Normal: _____ Date of AST Result: __ __ / __ __ /__ __ __ __

Diagnostic Tests:

Total Ab† to hepatitis A virus (tot Ab-HAV):	☐Neg ☐Pos ☐Unk	Ab to hepatitis C virus (Ab-HCV):	☐Neg ☐Pos ☐Unk
IgM Ab to hepatitis A virus (IgM Ab-HAV):	☐Neg ☐Pos ☐Unk	Ab-HCV signal to cut-off ratio:	_____
Hepatitis B surface Ag‡ (HBsAg):	☐Neg ☐Pos ☐Unk	Supplemental Ab-HCV assay (e.g., RIBA):	☐Neg ☐Pos ☐Unk
Hepatitis B "e" Ag (HBeAg):	☐Neg ☐Pos ☐Unk	Hepatitis C virus RNA (e.g., PCR):	☐Neg ☐Pos ☐Unk
Total Ab to hepatitis B core antigen (tot Ab-HBc):	☐Neg ☐Pos ☐Unk	Ab to hepatitis D virus (Ab-HDV):	☐Neg ☐Pos ☐Unk
IgM Ab to hepatitis B core antigen (IgM Ab-HBc):	☐Neg ☐Pos ☐Unk	Ab to hepatitis E virus (Abi-HEV):	☐Neg ☐Pos ☐Unk
Hepatitis B virus DNA:	☐Neg ☐Pos ☐Unk		

†*Ab=Antibody,* ‡*Ag = Antigen*

EPIDEMIOLOGIC

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

Diagnosis: ☐Hepatitis A, acute ☐Hepatitis B viral infection, perinatal ☐Hepatitis B virus infection, chronic
☐Hepatitis B, acute ☐Hepatitis C Virus infection, chronic or resolved ☐Hepatitis C, acute
☐Hepatitis Delta co- or super-infection, acute ☐Hepatitis E, acute ☐Hepatitis non-ABC, acute

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

IF NO CLINICAL INFORMATION AVAILABLE OR CHRONIC CASE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

SIGNS & SYMPTOMS

Fever:	☐No ☐Unknown ☐Yes Highest Temp: _____°F	Nausea:	☐No ☐Unknown ☐Yes
Headache:	☐No ☐Unknown ☐Yes	Vomiting:	☐No ☐Unknown ☐Yes
Malaise (unexplained tiredness):	☐No ☐Unknown ☐Yes	Diarrhea:	☐No ☐Unknown ☐Yes
Anorexia (loss of appetite):	☐No ☐Unknown ☐Yes	Abdominal Pain:	☐No ☐Unknown ☐Yes

MEDICAL HISTORY

During the 6 WEEKS to 6 MONTHS prior to onset of symptoms, was the patient:

A contact of a person with confirmed or suspected acute of chronic hepatitis B virus infection? ☐No ☐Unknown ☐Yes

If yes, type of contact (Select all that apply):

☐Babysitter of this patient ☐Child cared for by this patient ☐Household member (non-sexual)
☐Other (specify) _____ ☐Playmate ☐Sex partner ☐Unknown

During the 6 WEEKS to 6 MONTHS prior to onset of symptoms, did the patient:

Undergo hemodialysis? ☐No ☐Unknown ☐Yes

Have an accidental stick or puncture with a needle or other object contaminated with blood? ☐No ☐Unknown ☐Yes

Receive blood or blood products (transfusion)? ☐No ☐Unknown ☐Yes

If yes, date of transfusion: __ __ / __ __ /__ __ __ __

Receive any IV infusions and/or injections in the outpatient setting? ☐No ☐Unknown ☐Yes

Have other exposure to someone else's blood? ☐No ☐Unknown ☐Yes

If yes, specify other blood exposure: _____

During the 6 WEEKS to 6 MONTHS prior to onset of symptoms:

Was the patient employed in a medical or dental field involving direct contact with human blood? ☐No ☐Unknown ☐Yes

If yes, frequency of direct blood contact? ☐Frequent (several times a week) ☐Infrequent

Was the patient employed as a public safety worker (fire fighter, law enforcement, correctional officer) in direct contact with human blood? ☐No ☐Unknown ☐Yes

If yes, frequency of direct blood contact? ☐Frequent (several times a week) ☐Infrequent

Did the patient receive a tattoo? ☐No ☐Unknown ☐Yes

If yes, where was the tattooing performed (select all that apply)?

☐Commercial parlor/shop ☐Correctional facility ☐Other (specify)_____ ☐Unknown

Did the patient have any part of their body pierced (other than ear)? ☐No ☐Unknown ☐Yes

If yes, where was the piercing performed (select all that apply)?

☐Commercial parlor/shop ☐Correctional facility ☐Other (specify)_____ ☐Unknown

Did the patient have dental work or oral surgery? ☐No ☐Unknown ☐Yes

Did the patient have surgery (other than oral surgery)? ☐No ☐Unknown ☐Yes

Was the patient hospitalized? ☐No ☐Unknown ☐Yes

Was the patient a resident of a long term care facility? ☐No ☐Unknown ☐Yes

Was the patient incarcerated for more than 24 hours? ☐No ☐Unknown ☐Yes Type of facility (select all): ☐Jail ☐Juvenile facility ☐Prison

During the 6 WEEKS to 6 MONTHS prior to onset of symptoms, did the patient:

Inject drugs no prescribed by a doctor? ☐No ☐Unknown ☐Yes Use street drugs, but not inject? ☐No ☐Unknown ☐Yes

In the 6 MONTHS before symptom onset, how may: *(ASK BOTH OF THE FOLLOWING QUESTIONS REGARDLESS OF THE PATIENT'S GENDER)*

Male sex partners did the patient have? ☐0 ☐1 ☐2-5 ☐>5 ☐Unknown

Female sex partners did the patient have? ☐0 ☐1 ☐2-5 ☐>5 ☐Unknown

During his or her lifetime, was the patient EVER:

Treated for a sexually-transmitted disease? ☐No ☐Unknown ☐Yes If yes, year of most recent treatment: _____

Was the patient incarcerated for longer than 6 months? ☐No ☐Unknown ☐Yes

If yes, year of most recent incarceration: _____ If yes, length of most recent incarceration: _____

Vaccine Information

Has the patient ever received hepatitis B vaccine? ☐No ☐Unknown ☐Yes If yes, number of doses? ☐1 ☐2 ☐≥ 3 Year last shot: _____

Was the patient tested for antibody to HBsAg (anti-HBs) within 1 – 2 months after last dose? ☐No ☐Unknown ☐Yes

If yes, was the serum anti-HBs ≥ 10 mIU/mL (answer "yes" if HBsAb lab result reported was positive or reactive)? ☐No ☐Unknown ☐Yes

Vaccine Information: ***Must be added via the Events Tab, add new Vaccinations feature after investigation is submitted.***

Vaccination 1 Record: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination 1: _____ ☐years ☐months

Vaccine 1 Administered (*Select*):

☐DTaP-Hep B-IPV	☐DTap –IPV-Hep B	☐DTaP-IPV-Hib-Hep B, historical
☐DTap-Hib-Hep B	☐HBIG (Hepatitis B immune globulin)	☐Hep A-Hep B
☐Hep B, adolescent or pediatric	☐Hep B, adolescent/high risk infant	☐Hep B, adult
☐Hep B, dialysis	☐Hep B, NOS	☐Hib-Hep B

Vaccination 2 Record: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination 2: _____ ☐years ☐months

Vaccine 2 Administered (*Select*):

☐DTaP-Hep B-IPV	☐DTap –IPV-Hep B	☐DTaP-IPV-Hib-Hep B, historical
☐DTap-Hib-Hep B	☐HBIG (Hepatitis B immune globulin)	☐Hep A-Hep B
☐Hep B, adolescent or pediatric	☐Hep B, adolescent/high risk infant	☐Hep B, adult
☐Hep B, dialysis	☐Hep B, NOS	☐Hib-Hep B

Vaccination 3 Record: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination 2: _____ ☐years ☐months

Vaccine 3 Administered (*Select*):

☐DTaP-Hep B-IPV	☐DTap –IPV-Hep B	☐DTaP-IPV-Hib-Hep B, historical
☐DTap-Hib-Hep B	☐HBIG (Hepatitis B immune globulin)	☐Hep A-Hep B
☐Hep B, adolescent or pediatric	☐Hep B, adolescent/high risk infant	☐Hep B, adult
☐Hep B, dialysis	☐Hep B, NOS	☐Hib-Hep B

During the 6 WEEKS to 6 MONTHS prior to illness:

If yes to dental work or oral surgery, name of dentist or oral surgeon: _____

Address: _____ City: _____ Phone: (__ __ __) - __ __ __ - __ __ __ __

HEPATITIS C INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Place of Birth (Country): _____

Reason for Testing (Select all that apply):

☐Blood/Organ donor screening ☐Evaluation of elevated liver enzymes ☐Follow-up testing (prior viral hepatitis marker)
☐Other (specify) _____ ☐Prenatal screening ☐Screening of asymptomatic patient with risk factors
☐Symptoms of acute hepatitis ☐Unknown ☐Screening of asymptomatic patient without risk factors

Was the patient pregnant? ☐No ☐Unknown ☐Yes Due Date: __ __ / __ __ /__ __ __ __

Diagnosis Date: __ __ / __ __ /__ __ __ __

Is the patient symptomatic? ☐No ☐Unknown ☐Yes Symptom Onset Date: __ __ / __ __ /__ __ __ __

Was the patient jaundiced? ☐No ☐Unknown ☐Yes

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Liver enzyme levels at time of diagnosis:

ALT (SGPT) Result: _____ Upper Limit Normal: _____ Date of ALT Result: __ __ / __ __ /__ __ __ __

AST (SGOT) Result: _____ Upper Limit Normal: _____ Date of AST Result: __ __ / __ __ /__ __ __ __

Diagnostic Tests:

Total Ab† to hepatitis A virus (tot Ab-HAV):	☐Neg ☐Pos ☐Unk	Ab to hepatitis C virus (Ab-HCV):	☐Neg ☐Pos ☐Unk
IgM Ab to hepatitis A virus (IgM Ab-HAV):	☐Neg ☐Pos ☐Unk	Ab-HCV signal to cut-off ratio:	_____
Hepatitis B surface Ag‡ (HBsAg):	☐Neg ☐Pos ☐Unk	Supplemental Ab-HCV assay (e.g., RIBA):	☐Neg ☐Pos ☐Unk
Hepatitis B "e" Ag (HBeAg):	☐Neg ☐Pos ☐Unk	Hepatitis C virus RNA (e.g., PCR):	☐Neg ☐Pos ☐Unk
Total Ab to hepatitis B core antigen (tot Ab-HBc):	☐Neg ☐Pos ☐Unk	Ab to hepatitis D virus (Ab-HDV):	☐Neg ☐Pos ☐Unk
IgM Ab to hepatitis B core antigen (IgM Ab-HBc):	☐Neg ☐Pos ☐Unk	Ab to hepatitis E virus (Abi-HEV):	☐Neg ☐Pos ☐Unk
Hepatitis B virus DNA:	☐Neg ☐Pos ☐Unk		

†*Ab=Antibody,* ‡*Ag = Antigen*

EPIDEMIOLOGIC

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

Diagnosis: ☐Hepatitis A, acute ☐Hepatitis B, acute ☐Hepatitis Delta co- or super-infection, acute ☐Hepatitis B viral infection, perinatal ☐Hepatitis C Virus infection, chronic or resolved ☐Hepatitis E, acute ☐Hepatitis B virus infection, chronic ☐Hepatitis C, acute ☐Hepatitis non-ABC, acute

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

IF NO CLINICAL INFORMATION AVAILABLE OR CHRONIC CASE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

SIGNS & SYMPTOMS

Fever:	☐No ☐Unknown ☐Yes	Highest Temp: _____°F	Nausea:	☐No ☐Unknown ☐Yes
Headache:	☐No ☐Unknown ☐Yes		Vomiting:	☐No ☐Unknown ☐Yes
Malaise (unexplained tiredness):	☐No ☐Unknown ☐Yes		Diarrhea:	☐No ☐Unknown ☐Yes
Anorexia (loss of appetite):	☐No ☐Unknown ☐Yes		Abdominal Pain:	☐No ☐Unknown ☐Yes

MEDICAL HISTORY

During the 2 WEEKS to 6 MONTHS prior to onset of symptoms, was the patient:

A contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection? ☐No ☐Unknown ☐Yes

If yes, type of contact (Select all that apply):

☐Babysitter of this patient ☐Child cared for by this patient ☐Household member (non-sexual)
☐Other (specify) _____ ☐Playmate ☐Sex partner ☐Unknown

During the 2 WEEKS to 6 MONTHS prior to onset of symptoms, did the patient:

Undergo hemodialysis? ☐No ☐Unknown ☐Yes

Have an accidental stick or puncture with a needle or other object contaminated with blood? ☐No ☐Unknown ☐Yes

Receive blood or blood products (transfusion)? ☐No ☐Unknown ☐Yes

If yes, date of transfusion: __ __ / __ __ /__ __ __ __

Receive any IV infusions and/or injections in the outpatient setting? ☐No ☐Unknown ☐Yes

Have other exposure to someone else's blood? ☐No ☐Unknown ☐Yes

If yes, specify other blood exposure: _____

During the 2 WEEKS to 6 MONTHS prior to onset of symptoms:

Was the patient employed in a medical or dental field involving direct contact with human blood? ☐No ☐Unknown ☐Yes

If yes, frequency of direct blood contact? ☐Frequent (several times a week) ☐Infrequent

Was the patient employed as a public safety worker (fire fighter, law enforcement, correctional officer) in direct contact with human blood? ☐No ☐Unknown ☐Yes

If yes, frequency of direct blood contact? ☐Frequent (several times a week) ☐Infrequent

Did the patient receive a tattoo? ☐No ☐Unknown ☐Yes

If yes, where was the tattooing performed (select all that apply)?

☐Commercial parlor/shop ☐Correctional facility ☐Other (specify)_____ ☐Unknown

Did the patient have any part of their body pierced (other than ear)? ☐No ☐Unknown ☐Yes

If yes, where was the piercing performed (select all that apply)?

☐Commercial parlor/shop ☐Correctional facility ☐Other (specify)_____ ☐Unknown

Did the patient have dental work or oral surgery? ☐No ☐Unknown ☐Yes

Did the patient have surgery (other than oral surgery)? ☐No ☐Unknown ☐Yes

Was the patient hospitalized? ☐No ☐Unknown ☐Yes

Was the patient a resident of a long term care facility? ☐No ☐Unknown ☐Yes

Was the patient incarcerated for more than 24 hours? ☐No ☐Unknown ☐Yes Type of facility (select all): ☐Jail ☐Juvenile facility ☐Prison

During the 2 WEEKS to 6 MONTHS prior to onset of symptoms, did the patient:

Inject drugs no prescribed by a doctor? ☐No ☐Unknown ☐Yes Use street drugs, but not inject? ☐No ☐Unknown ☐Yes

INVESTIGATOR: *ASK BOTH OF THE FOLLOWING QUESTIONS REGARDLESS OF THE PATIENT'S GENDER*

In the 6 MONTHS before symptom onset, how may:

Male sex partners did the patient have: ☐0 ☐1 ☐2-5 ☐>5 ☐Unknown

Female sex partners did the patient have: ☐0 ☐1 ☐2-5 ☐>5 ☐Unknown

During his or her lifetime, was the patient EVER:

Treated for a sexually-transmitted disease? ☐No ☐Unknown ☐Yes If yes, year of most recent treatment: _____

Was the patient incarcerated for longer than 6 months? ☐No ☐Unknown ☐Yes

If yes, year of most recent incarceration: _____ If yes, length of most recent incarceration: _____

During the 2 WEEKS to 6 MONTHS prior to illness:

If yes to dental work or oral surgery, name of dentist or oral surgeon: _____

Address: _____ City: _____ Phone: (__ __ __) - __ __ __ - __ __ __ __

HEPATITIS E INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Place of Birth (Country): _____

Reason for Testing (Select all that apply):

☐ Blood/Organ donor screening
☐ Other (specify) _____
☐ Symptoms of acute hepatitis
☐ Evaluation of elevated liver enzymes
☐ Prenatal screening
☐ Unknown
☐ Follow-up testing (prior viral hepatitis marker)
☐ Screening of asymptomatic patient with risk factors
☐ Screening of asymptomatic patient without risk factors

Was the patient pregnant? ☐ No ☐ Unknown ☐ Yes Due Date: __ __ / __ __ /__ __ __ __

Diagnosis Date: __ __ / __ __ /__ __ __ __

Is the patient symptomatic? ☐ No ☐ Unknown ☐ Yes Symptom Onset Date: __ __ / __ __ /__ __ __ __

Was the patient jaundiced? ☐ No ☐ Unknown ☐ Yes

Did the patient die from this illness? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Liver enzyme levels at time of diagnosis:

ALT (SGPT) Result: _____ Upper Limit Normal: _____ Date of ALT Result: __ __ / __ __ /__ __ __ __

AST (SGOT) Result: _____ Upper Limit Normal: _____ Date of AST Result: __ __ / __ __ /__ __ __ __

Diagnostic Tests:

Total Ab† to hepatitis A virus (tot Ab-HAV):	☐ Neg ☐ Pos ☐ Unk	Ab to hepatitis C virus (Ab-HCV):	☐ Neg ☐ Pos ☐ Unk
IgM Ab to hepatitis A virus (IgM Ab-HAV):	☐ Neg ☐ Pos ☐ Unk	Ab-HCV signal to cut-off ratio:	_____
Hepatitis B surface Ag‡ (HBsAg):	☐ Neg ☐ Pos ☐ Unk	Supplemental Ab-HCV assay (e.g., RIBA):	☐ Neg ☐ Pos ☐ Unk
Hepatitis B "e" Ag (HBeAg):	☐ Neg ☐ Pos ☐ Unk	Hepatitis C virus RNA (e.g., PCR):	☐ Neg ☐ Pos ☐ Unk
Total Ab to hepatitis B core antigen (tot Ab-HBc):	☐ Neg ☐ Pos ☐ Unk	Ab to hepatitis D virus (Ab-HDV):	☐ Neg ☐ Pos ☐ Unk
IgM Ab to hepatitis B core antigen (IgM Ab-HBc):	☐ Neg ☐ Pos ☐ Unk	Ab to hepatitis E virus (Abi-HEV):	☐ Neg ☐ Pos ☐ Unk
Hepatitis B virus DNA:	☐ Neg ☐ Pos ☐ Unk		

†*Ab=Antibody, ‡Ag = Antigen*

EPIDEMIOLOGIC

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week: _____ MMWR Year:_____

Diagnosis: ☐ Hepatitis A, acute ☐ Hepatitis B viral infection, perinatal ☐ Hepatitis B virus infection, chronic
☐ Hepatitis B, acute ☐ Hepatitis C Virus infection, chronic or resolved ☐ Hepatitis C, acute
☐ Hepatitis Delta co- or super-infection, acute ☐ Hepatitis E, acute ☐ Hepatitis non-ABC, acute

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐ Yes ☐ No

IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

SYMPTOMS

Jaundice:	☐ No ☐ Unknown ☐ Yes	Loss of appetite:	☐ No ☐ Unknown ☐ Yes
Dark urine:	☐ No ☐ Unknown ☐ Yes	Nausea:	☐ No ☐ Unknown ☐ Yes
Fatigue:	☐ No ☐ Unknown ☐ Yes	Vomiting:	☐ No ☐ Unknown ☐ Yes
Abdominal pain:	☐ No ☐ Unknown ☐ Yes	Diarrhea:	☐ No ☐ Unknown ☐ Yes

EXPOSURE HISTORY

During the 60 DAYS prior to onset of symptoms, did the patient: Travel outside the U.S.A. or Canada? ☐ No ☐ Unknown ☐ Yes

During the 2 WEEKS prior to onset of symptoms through 2 WEEKS after symptoms began, was the patient:

A child or employee in a daycare center, nursery, or preschool? ☐ No ☐ Unknown ☐ Yes If yes, where: _____

A household contact of a child or employee in a daycare center, nursery, or preschool? ☐ No ☐ Unknown ☐ Yes If yes, where: _____

A household contact of a pregnant woman? ☐ No ☐ Unknown ☐ Yes If yes, who: _____

Employed as a food handler while symptomatic with diarrhea? ☐ No ☐ Unknown ☐ Yes

Receive any IV infusions and/or injections in the outpatient setting? ☐ No ☐ Unknown ☐ Yes

Outbreak Related: Is the patient aware of others with similar illness? ☐ No ☐ Unknown ☐ Yes If yes, who: _____

CASE CLASSIFICATION

1	Did the patient have a discrete onset of any sign or symptom consistent with acute viral hepatitis (for example)? ☐ Anorexia ☐ Abdominal pain ☐ Dark (tea colored) urine ☐ Fatique ☐ Jaundice ☐ Nausea ☐ Vomiting	☐ No ☐ Unknown ☐ Yes
2	Was antibody to hepatitis E virus (anti-HEV) positive?	☐ No ☐ Unknown ☐ Yes

Confirmed: 1 & 2

Influenza-Associated Pediatric Mortality Case Report Form

Form Approved
OMB No. 0920-0004

STATE USE ONLY – DO NOT SEND INFORMATION *IN THIS SECTION* TO CDC

Last Name: _____ First Name: _____ County: _____

Address: City: State, Zip:

Patient Demographics

1. State:	2. County:	3. State ID:	4. CDC ID:
5. Age: _____ O Days O Months O Years	6. Date of birth: _____/ _____/ _____ MM DD YYYY	7a. Is sex known? ☐ Yes ☐ No 7b. Sex: O Male O Female	

8a. Is ethnicity known? ☐ Yes ☐ No

8b. Ethnicity: O Hispanic or Latino O Not Hispanic or Latino

9a. Is race known? ☐ Yes ☐ No

9b. Race: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

Death Information

10. Date of illness onset: _____/ _____/ _____ MM DD YYYY	11. Date of death: _____/ _____/ _____ MM DD YYYY	12. Was an autopsy performed? O Yes O No O Unknown

13 a. Did cardiac/respiratory arrest occur outside the hospital? O Yes O No O Unknown

13 b. Location of death: O Outside the Hospital (e.g. home or in transit to hospital) O Emergency Dept (ED) O Inpatient ward O ICU
O Other (specify): _____

13 c. If the death occurred in the hospital, what was the date of admission? _____/ _____/ _____ MM DD YYYY

CDC Laboratory Specimens

14 a. Were pathology specimens sent to CDC's Infectious Diseases Pathology Branch? O Yes O No O Unknown
Please provide the lab ID No. if known_____

14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division? O Yes O No O Unknown
Please provide the lab ID No. if known_____

Influenza Testing (check all that were used)

Test Type	Result	Specimen Collection Date
15. ☐ Commercial rapid diagnostic test	O Influenza A O Influenza B O Negative O Influenza A/B (Not Distinguished) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ Viral culture	O Influenza A (Subtyping Not Done) O 2009 Influenza A (H1N1) O Influenza A (H3) O Influenza A (H3N2v) O Influenza A (Unable To Subtype) O Influenza B (Lineage Not Determined) O Influenza B/Victoria lineage O Influenza B/Yamagata lineage O Influenza virus co-infection (specify)_____ O Negative	_____/ _____/ _____
☐ Fluorescent antibody (IFA or DFA)	O Influenza A (Subtyping Not Done) O Influenza B O Negative O Influenza A (Unable To Subtype) O Influenza A (H3) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ Enzyme immunoassay (EIA)	O Influenza A (Subtyping Not Done) O Influenza B O Negative O Influenza A (Unable To Subtype) O Influenza A (H3) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ RT-PCR	O Influenza A (Subtyping Not Done) O 2009 Influenza A (H1N1) O Influenza A (H3) O Influenza A (H1) O Influenza A (H3N2v) O Influenza A (Unable To Subtype) O Influenza B (Lineage Not Determined) O Influenza B/Victoria lineage O Influenza B/Yamagata lineage O Influenza virus co-infection (specify)_____ O Negative	_____/ _____/ _____
☐ Immunohistochemistry (IHC)	O Influenza A O Influenza B O Negative O Influenza virus co-infection (specify)_____	_____/ _____/ _____

Culture confirmation of bacterial pathogens from STERILE (Invasive) SITES

16 a. Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid? **Specimens collected greater than 24 hours after death are not sterile.** O Yes O No O Unknown

16 b. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

Specimen Type	Collection Date	Result
☐ Blood	Date __/__/__	O Positive O Negative O Unknown
☐ Pleural fluid	Date __/__/__	O Positive O Negative O Unknown
☐ CSF	Date __/__/__	O Positive O Negative O Unknown
☐ Lung Tissue	Date __/__/__	O Positive O Negative O Unknown
☐ Other _____	Date __/__/__	O Positive O Negative O Unknown
☐ Unknown		

16 c. If positive, please check the organism cultured.

☐ *Streptococcus pneumoniae*

☐ Group A *Streptococcus*

☐ Other bacteria: _____
(If reporting another viral co-infection please do so in section 18 Clinical Diagnosis and Complications)

☐ *Staphylococcus aureus,* methicillin **sensitive (MSSA)**

☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**

☐ *Staphylococcus aureus,* **sensitivity not done**

☐ *Haemophilus influenzae* not-type b

☐ *Haemophilus influenzae* type b

☐ *Pseudomonas aeruginosa*

Culture confirmation of bacterial pathogens from NON-STERILE SITES

16 d. Were other **respiratory** specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? O Yes O No O Unknown

16 e. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

Specimen Type	Collection Date	Result
☐ Sputum	Date __/__/__	O Positive O Negative O Unknown
☐ ET tube	Date __/__/__	O Positive O Negative O Unknown
☐ Other _____	Date __/__/__	O Positive O Negative O Unknown
☐ Unknown		

16 f. If positive, please check the organism cultured.

☐ *Streptococcus pneumoniae*	☐ *Staphylococcus aureus,* methicillin **sensitive (MSSA)**	☐ *Haemophilus influenzae* not-type b
☐ Group A *Streptococcus*	☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**	☐ *Haemophilus influenzae* type b
☐ Other bacteria:	☐ *Staphylococcus aureus,* **sensitivity not done**	☐ *Pseudomonas aeruginosa*

_____

(If reporting another viral co-infection please do so in section 18 Clinical Diagnosis and Complications)

Pathology confirmation of bacterial pathogens

16 g. Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist? *(If pathology results are available from CDC it is not necessary to input those results here, however please make sure to complete section 14 "CDC Laboratory Specimens")* O Yes O No O Unknown

If yes please indicate the results of these tests in the comments section at the end of the form.

Medical Care

17. Was the patient placed on mechanical ventilation? O Yes O No O Unknown

Clinical Diagnoses and Complications

18 a. Did complications occur during the acute illness? O Yes O No O Unknown

18 b. **If yes,** check all complications that occurred during the acute illness:

☐ Pneumonia (Chest X-Ray confirmed) ☐ Acute Respiratory Disease Syndrome (ARDS) ☐ Croup ☐ Seizures

☐ Bronchiolitis ☐ Encephalopathy/encephalitis ☐ Reye syndrome ☐ Shock

☐ Sepsis ☐ Hemorrhagic pneumonia/pneumonitis ☐ Cardiomyopathy/myocarditis

☐ Another viral co-infection: _____ ☐ Other: _____

19 a. Did the child have any medical conditions that existed before the start of the acute illness? O Yes O No O Unknown

19 b. **If yes,** check all medical conditions that existed before the start of the acute illness:

☐ Moderate to severe developmental delay ☐ Hemoglobinopathy (e.g. sickle cell disease) ☐ Asthma/ reactive airway disease

☐ Diabetes mellitus ☐ History of febrile seizures ☐ Seizure disorder ☐ Cystic fibrosis

☐ Cardiac disease/congenital heart disease (specify) _____ ☐ Renal disease (specify) _____ ☐ Skin or soft tissue infection (SSTI)

☐ Chromosomal Abnormality/Genetic Syndrome (specify) _____ ☐ Mitochondrial Disorder (specify) _____

☐ Chronic pulmonary disease (specify) _____ ☐ Immunosuppressive condition (specify) _____

☐ Cancer (diagnosis and/or treatment began in previous 12 months) (specify)_____ ☐ Endocrine disorder (specify) _____ ☐ Obesity ☐ Cerebral Palsy ☐ Premature at birth (specify gestational age) ____ weeks

☐ Neuromuscular disorder (e.g. muscular dystrophy) (specify) _____ ☐ Other Neurological disorder (specify) _____

☐ Pregnant (specify gestational age) _____ weeks ☐ Other (specify) _____

Medication and Therapy History

20 a. Was the patient receiving any of the following therapies ***prior*** to illness onset?
(if yes, check all that apply)

☐ Yes ☐ No ☐ Unknown

☐Antiviral Prophylaxis ☐ Chronic aspirin therapy ☐ Chemotherapy or radiation therapy ☐ Steroids by mouth or injection

☐ Other immunosuppressive therapy:_____

20 b. Did the patient receive any of the following ***after*** illness onset? **(if yes, check all that apply)**

☐ Yes ☐ No ☐ Unknown

☐ Antibiotic therapy specify_____ ☐ Antiviral therapy specify_____

Influenza Vaccine History

21. Did the patient receive any influenza vaccine during the current season (before illness) O Yes O No O Unknown

22. **If YES*,** please specify the influenza vaccine received before illness onset:
- ☐ Inactivated influenza vaccine (IIV3) *[injected]*
- ☐ Quadrivalent inactivated influenza vaccine (IIV4) *[injected]*
- ☐ Live-attenuated influenza vaccine (LAIV4) *[nasal spray]*
- ☐ Unknown

23. **If YES***, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

O 1 dose **ONLY**	☐ <14 days prior to illness onset ☐ ≥14 days prior to illness onset	Date dose given:_____/ _____/ _____ MM DD YYYY	
O 2 doses	☐ 2nd dose given <14 days prior to onset ☐ 2nd dose given ≥14 days prior to onset	Date of 1st dose: _____/ _____/_____ MM DD YYYY	Date of 2nd dose: _____/ _____/ _____ MM DD YYYY

23b. IF the patient received two doses of influenza vaccine during the current season, please specify the SECOND influenza vaccine received before illness onset:
- ☐ Inactivated influenza vaccine (IIV3) *[injected]*
- ☐ Quadrivalent inactivated influenza vaccine (IIV4) *[injected]*
- ☐ Live-attenuated influenza vaccine (LAIV4) *[nasal spray]*
- ☐ Unknown

24 . Did the patient receive any influenza vaccine in previous seasons? O Yes O No O Unknown

24 a. **If YES**, and patient was **≤8 years of age** at the time of death, did they receive 2 doses of vaccine during a previous season? O Yes O No O Unknown

Submitted By: _____ Date: _____/ _____/ _____
MM DD YYYY
Phone No.: (_____) _____ - _____
E-mail Address: _____

Case Investigation Closed: ☐ Yes ☐ No

INVASIVE PNEUMOCOCCAL DISEASE (IPD)
(*STREPTOCOCCUS PNEUMONIAE, INVASIVE DISEASE*) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

OTHER PATIENT INFORMATION

Type of Insurance:

☐Indian Health Service (IHS) ☐Medicaid/State assistance program ☐Medicare ☐Military/VA
☐No health care coverage ☐Other, specify: _____ ☐Private/HMO/PPO/Managed care plan ☐Unknown

Weight: _____lbs _____oz OR _____kg OR ☐Unknown Height: _____ft _____in OR _____cm OR ☐Unknown

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Hospital

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Condition

Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Types of infection caused by organism:

☐Abscess (not skin) ☐Bacteremia without focus ☐Cellulitis ☐Chorioamnionitis
☐Conjunctivitis ☐Empyema ☐Endocarditis ☐Endometriosis
☐Epiglottitis ☐Hemolytic uremic Syndrome (HUS) ☐Meningitis ☐Necrotizing fasciitis
☐Osteomylitis ☐Other, specify: _____ ☐Otitis media ☐Pericarditis
☐Peritonitis ☐Pneumonia ☐Puerperal sepsis ☐Septic abortion
☐Septic arthritis ☐Streptococcal toxic-shock syndrome (STSS) ☐Unknown

Bacterial species isolated from any normally sterile site:

☐Bacterial meningitis, other ☐Group A Streptococcus, invasive ☐Group B Streptococcus, invasive
☐Haemophilus influenzae, invasive ☐Listeria monocytogenes ☐Neisseria meningitides, invasive
☐Strep. pneumoniae, drug-res. invasive ☐Streptococcal disease, invasive, other ☐Streptococcal toxic-shock syndrome
☐Streptococcus pneumoniae, invasive ☐Streptococcus pneumoniae, invasive disease (IPD)

Date first positive culture obtained: __ __ / __ __ /__ __ __ __

Sterile sites from which organism isolated:

☐Amniotic fluid (pre-birth) ☐Blood ☐Bone ☐CSF ☐Internal body site ☐Joint
☐Muscle ☐Other, specify: _____ ☐Pericardial fluid ☐Peritoneal fluid ☐Placenta (pre-birth) ☐Pleural fluid

Nonsterile sites from which organism isolated:

☐Amniotic fluid (delivery/post-birth) ☐Middle ear ☐Placenta (delivery/post-birth) ☐Sinus ☐Wound ☐Other, specify: _____

Did the patient have any underlying conditions? ☐No ☐Unknown ☐Yes

If yes, underlying conditions:

☐AIDS	☐Alcohol abuse	☐Asthma
☐Atherosclerotic Cardiovascular Disease (CAD)	☐Burns	☐Cerebral Vascular Accident (CVA)/Stroke
☐Cirrhosis/Liver failure	☐Cochlear implant	☐Complement deficiency
☐CSF Leak (2° trauma/surgery)	☐Current smoker	☐Deaf/Profound hearing loss
☐Diabetes Mellitus	☐Emphysema/COPD	☐Heart Failure/CHF
☐HIV	☐Hodgkin's disease	☐Immunoglobulin Deficiency
☐Immunosuppressive Therapy	☐IVDU	☐Leukemia
☐Multiple Myeloma	☐Nephrotic Syndrome	☐None
☐Obesity	☐Organ transplant, specify:	☐Other malignancy, specify: _____
☐Other prior illness, specify: _____	☐Renal Failure/Dialysis	☐Sickle Cell Anemia
☐Splenectomy/Asplenia	☐Systemic Lupus Erythematosus (SLE)	☐Unknown

Did the patient die from this illness? ☐No ☐Unknown ☐Yes

Resistance Testing Results (Obtain from Laboratory)

Oxacillin Zone Size: _____mm Interpretation: ☐Not Tested ☐R <20mm (possibly resistant) ☐S>20mm (susceptible) ☐Unknown

Antimicrobial Agent: _____ Susceptibility Method: ☐AGAR ☐Broth ☐Disk (KB) ☐Strip

S/I/R/U Result: ☐Intermediate ☐Not Tested ☐Resistant ☐Susceptible ☐Unknown

Sign: ☐< ☐≤ ☐= ☐≥ ☐> MIC Value: _____

Does the patient have persistent disease as defined by positive sterile site cultures 2-7 days after the first positive culture? ☐No ☐Unknown ☐Yes

VACCINE INFORMATION

Has patient received 23-valent pneumococcal POLYSACCHARIDE vaccine (i.e., Pneumovax 23)? ☐No ☐Unknown ☐Yes

If < 15 years of age, did the patient receive pneumococcal CONJUGATE vaccine? ☐No ☐Unknown ☐Yes

If yes for either, please enter dosage data in the Vaccination Record

VACCINATION RECORD

Must be added via the Events Tab, add new Vaccinations feature after investigation is submitted.

Vaccination Record 1: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination: _____ ☐years ☐months

Vaccine Administered (*Select*): ☐Pneumococcal conjugate vaccine, 13 valent ☐Pneumococcal conjugate vaccine, polyvalent (PCV7,
☐Pneumococcal vaccine, NOS ☐Pneumococcal polysaccharide vaccine (PPV23, Pneum

Vaccination Record 2: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination: _____ ☐years ☐months

Vaccine Administered (*Select*): ☐Pneumococcal conjugate vaccine, 13 valent ☐Pneumococcal conjugate vaccine, polyvalent (PCV7,
☐Pneumococcal vaccine, NOS ☐Pneumococcal polysaccharide vaccine (PPV23, Pneum

Vaccination Record 3: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination: _____ ☐years ☐months

Vaccine Administered (*Select*): ☐Pneumococcal conjugate vaccine, 13 valent ☐Pneumococcal conjugate vaccine, polyvalent (PCV7,
☐Pneumococcal vaccine, NOS ☐Pneumococcal polysaccharide vaccine (PPV23, Pneum

Vaccination Record 4: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination: _____ ☐years ☐months

Vaccine Administered (*Select*): ☐Pneumococcal conjugate vaccine, 13 valent ☐Pneumococcal conjugate vaccine, polyvalent (PCV7,
☐Pneumococcal vaccine, NOS ☐Pneumococcal polysaccharide vaccine (PPV23, Pneum

Record additional pneumococcal vaccinations at end of investigation and enter into ALNBS.

EPIDEMIOLOGIC

If < 6 years of age, is the patient in daycare (supervised group of ≥ 2 unrelated children for > 4 hours/week)? ☐No ☐Unknown ☐Yes

If yes, Day Care Facility: _____

Was the patient a resident of a nursing home or other chronic care facility at the time of first positive culture? ☐No ☐Unknown ☐Yes

If yes, Chronic Care Facility: _____

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name: _____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General Comments:_____

_____

_____

CUSTOM FIELDS

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

Reset Patient ID Info

Patient's Name: _____ Telephone Number: _____ Hospital: _____
LAST / FIRST / MI

Address: _____ _____ Patient Chart No.: _____
NUMBER / STREET / APT NO / CITY / STATE ZIP CODE

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC

Form Approved OMB No. 0920-0728

CDC • National Center for Immunization and Respiratory Diseases

LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY *LEGIONELLA* SPECIES)

Reset Form

Department of Health & Human Services
Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, 30329-4027
http://www.cdc.gov/legionella/index.htm

Case No.: ☐☐☐☐☐☐ (CDC use only)

1. State Health Dept. Case No.:	2. Reporting State: ☐☐	3. County of Residence:	4. State of Residence: ☐☐	5. Occupation:

6a. Date of Birth: ☐☐ ☐☐ ☐☐☐☐ (Mo. Day Year)

6b. Age: ☐☐☐ 1 ☐ Days 2 ☐ Mos. 3 ☐ Years

7. Sex: 1 ☐ Male 2 ☐ Female

8. Ethnicity: 1 ☐ Hispanic/Latino 2 ☐ Not Hispanic/Latino 9 ☐ Unknown

9. Race: (check all that apply) 1 ☐ American Indian/ Alaska Native 1 ☐ Asian 1 ☐ Black or African American 1 ☐ Native Hawaiian or Other Pacific Islander 1 ☐ White 1 ☐ Unknown

10. Diagnosis: (check one)
- 1 ☐ Legionnaires' Disease (pneumonia, clinical or X-ray diagnosed)
- 2 ☐ Pontiac Fever (fever and myalgia without pneumonia)
- 8 ☐ Other (e.g., endocarditis, wound infection): _____

11. Date of symptom onset of legionellosis: ☐☐ ☐☐ ☐☐☐☐ (Mo. Day Year)

12. Date of first report to public health at any level: ☐☐ ☐☐ ☐☐☐☐ (Mo. Day Year)

13. Was the patient hospitalized during treatment for legionellosis? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If yes, date of admission: ☐☐ ☐☐ ☐☐☐☐ (Mo. Day Year)
Hospital name: _____
City, State: _____

14. Outcome of illness: 1 ☐ Survived 2 ☐ Died 3 ☐ Still ill 9 ☐ Unknown

15. In the 10 days before onset, did the patient spend any nights away from home (excluding healthcare settings)?
(check one) 1 ☒ Yes* 2 ☐ No 9 ☐ Unknown *If yes, please complete the following table.*

ACCOMMODATION NAME	ADDRESS	CITY	STATE	ZIP	COUNTRY	ROOM NUMBER	DATES OF STAY	
							ARRIVAL	DEPARTURE

*If yes, was this case reported to CDC at **travellegionella@cdc.gov**? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

16. In the 10 days before onset, did the patient get in or spend time near a whirlpool spa (i.e., hot tub)?
(check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown *If yes, describe where:* _____ *If yes, list dates:* _____

17. In the 10 days before onset, did the patient use a nebulizer, CPAP, BiPAP or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma or for any other reason?
(check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown *If yes, does this device use a humidifier?* 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If yes, what type of water is used in the device? (check all that apply) 1 ☐ Sterile 1 ☐ Distilled 1 ☐ Bottled 1 ☐ Tap 1 ☐ Other 1 ☐ Unknown

18. In the 10 days before onset, did the patient visit or stay in a healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)?
(check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown *If yes, please complete the following table.*

TYPE OF HEALTHCARE SETTING / FACILITY (CHECK ONE)	TYPE OF EXPOSURE (CHECK ONE)	NAME OF FACILITY	IS THIS FACILITY ALSO A TRANSPLANT CENTER?	REASON FOR VISIT	CITY	STATE	DATE OF VISIT / ADMISSION	
							START DATE	END DATE
1 ☐ Hospital 2 ☐ Long term care 3 ☐ Clinic 8 ☐ Other:_____	1 ☐ Inpatient 2 ☐ Outpatient 3 ☐ Visitor or volunteer 4 ☐ Employee		1 ☐ Yes 2 ☐ No 9 ☐ Unknown					
1 ☐ Hospital 2 ☐ Long term care 3 ☐ Clinic 8 ☐ Other:_____	1 ☐ Inpatient 2 ☐ Outpatient 3 ☐ Visitor or volunteer 4 ☐ Employee		1 ☐ Yes 2 ☐ No 9 ☐ Unknown					

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

Save Form Next Page

Previous Page

State Health Dept. Case No.: _____

19. Was this case associated with a healthcare exposure: (check one)

1 ☐ **Definitely:** Patient was hospitalized or a resident of a long term care facility for the entire 10 days prior to onset

2 ☐ **No:** No exposure to a healthcare facility in the 10 days prior to onset

3 ☐ **Possibly:** Patient had exposure to a healthcare facility for a portion of the 10 days prior to onset

8 ☐ **Other (specify)** _____

9 ☐ **Unknown**

20. **In the 10 days before onset,** did the patient visit or stay in an assisted living facility or senior living facility? (check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

TYPE OF FACILITY	TYPE OF EXPOSURE	NAME OF FACILITY	CITY	STATE	DATE OF VISIT	
					START DATE	END DATE
1 ☐ Assisted Living	1 ☐ Resident 2 ☐ Visitor or Volunteer 3 ☐ Employee					
2 ☐ Senior Living (Includes retirement homes without skilled nursing or personal care)	1 ☐ Resident 2 ☐ Visitor or Volunteer 3 ☐ Employee					

21. Was this case associated with a known outbreak or possible cluster? (check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If yes, specify name of facility, city, and state of outbreak: _____

PLEASE CHECK ALL METHODS OF DIAGNOSIS WHICH APPLY:

1 ☐ CONFIRMED CASE

1 ☐ **Urine Antigen Positive:** *If yes,*

Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

2 ☐ **Culture Positive:** *If yes,*

Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid 4 ☐ blood 8 ☐ other (specify) _____

Species: _____ Serogroup: _____

3 ☐ **Fourfold rise in antibody titer to *Legionella pneumophila* serogroup 1:** *If yes,*

Initial (acute) titer: _____ Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

Convalescent titer: _____ Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

2 ☐ SUSPECT CASE

4 ☐ **Fourfold rise in antibody titer OTHER THAN *Legionella pneumophila* serogroup 1 or to multiple species or serogroups of *Legionella* using pooled antigen:** *If yes,*

Initial (acute) titer: _____ Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

Convalescent titer: _____ Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

Species: _____ Serogroup: _____

5 ☐ **Direct Fluorescent Antibody (DFA) or Immunohistochemistry (IHC) Positive:** *If yes,*

Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid 4 ☐ blood 8 ☐ other (specify) _____

Species: _____ Serogroup: _____

6 ☐ **Nucleic Acid Assay (e.g., PCR):** *If yes,*

Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid 4 ☐ blood 8 ☐ other (specify) _____

Species: _____ Serogroup: _____

Interviewer's Name:	State Health Dept. Official who reviewed this report:
Affiliation:	Title:
Telephone No.:	Telephone No.:

REPORTING INSTRUCTIONS

Local Health Dept. Please submit this document to:

State/DHD/SSS via your CD clerk

State Health Dept. Return completed form to:

Respiratory Diseases Branch, Mailstop C25
Office of Infectious Diseases
Centers for Disease Control and Prevention
1600 Clifton Rd. NE, Atlanta, GA 30329

_____

_____

_____

LEPTOSPIROSIS INVESTIGATION FORM

Comments:_____
_____
_____

Basic Demographic Data

Last Name: _____ First Name:_____
Middle Name:_____ Suffix: _____

DOB: __ __ / __ __ /__ __ __ __ Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Deceased Date: __ __ / __ __ /__ __ __ __
Marital Status: (Circle) S / M / D / W/ Annulled/ Cohabitating/ Legally Separated/ Polygamous/Unknown
SSN: __ __ __ / __ __ /__ __ __ __
Identification Information: Type:_____ Assigning Authority_____ ID Value_____
Street Address 1: _____
Street Address 2: _____
City: _____ State:_____
Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____
Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race : ☐Unknown ☐ American Indian or Alaska Native ☐Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __
Reporting Source:_____
Earliest Date Reported to: County : __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __
Reporter's Name:_____

Clinical

Physician's Name: _____
Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Physician's Address: _____
City:_____ State:_____
Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country

Hospital

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes
If yes: Hospital Name: _____
Admission Date__ __ / __ __ /__ __ __ __ Discharge Date __ __ / __ __ /__ __ __ __
Total Duration of stay within hospital _____days

Condition

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __
Illness End Date: __ __ / __ __ /__ __ __ __
Illness Duration: _____ Circle: days/hrs./minutes/months/unknown/weeks/years
Age at Onset: _____ Circle: days/hrs./minutes/months/unknown/weeks/years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes

Epidemiologic

Is this patient associated with a day care facility?	☐No ☐Unknown ☐Yes	Is this patient a food handler?	☐No ☐Unknown ☐Yes
Is this case part of an outbreak?	☐No ☐Unknown ☐Yes	If yes, outbreak name:	

Where was the disease acquired?

☐ Indigenous within jurisdiction	☐ Out of Country	☐ Out of jurisdiction, from another jurisdiction
☐ Out of state	☐ Unknown	

If the answer is out of Country, Jurisdiction, or State

Imported Country:	Imported State:
Imported City:	Imported County:

Transmission Mode

☐ Airborne	☐ Bloodborne	☐ Dermal	☐ Foodborne	☐ Indeterminate	☐ Mechanical
☐ Nosocomial	☐ Sexually Transmitted	☐ Vectorborne	☐ Waterborne	☐ Zoonotic	☐ Other

Detection Method

☐ Patient Self-referral	☐ Prenatal Testing	☐ Prison Entry Screening	☐ Provider Reported	☐ Routine Physical	☐ Other

Confimation Method

☐ Active Surveillance	☐ Case Outbreak Investigation	☐ Clinical Diagnosis	☐ Epidemiologically Linked
☐ Laboratory Confirmed	☐ Laboratory Report	☐ Local/State Specified	☐ Medical Record Review
☐ No information given	☐ Occupational Disease Surveillance	☐ Provider Certified	☐ Other

Confirmation Date: : __ __ / __ __ /__ __ __ __

CASE STATUS: (Required for Notification) ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown

MMWR Week _____ MMWR Year _____

Custom Fields

Date Due __ __ / __ __ /__ __ __ __

Investigation Ready for Supervisor Review:

☐ Reviewed (Complete) ☐ Reviewed (Incomplete) ☐ Reviewed (Not a case) ☐ Yes

Date Investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Condition Specific Custom Fields	
Clinical Data	
Autopsy :	☐ No ☐ Unknown ☐ Yes
Initial clinical impression	
Leptospirosis:	☐ No ☐ Unknown ☐ Yes
Unknown (initial clinical impression):	☐ No ☐ Unknown ☐ Yes
Other, specify (initial clinical impression):	
Presumptive serotype:	
Signs and Symptoms	
Renal involvement	
anuria or oliguria:	☐ No ☐ Unknown ☐ Yes
elevated BUN (over 20 mg.%):	☐ No ☐ Unknown ☐ Yes
hematuria:	☐ No ☐ Unknown ☐ Yes
albuminuria (over "2+"):	☐ No ☐ Unknown ☐ Yes
Liver involvement	
jaundice:	☐ No ☐ Unknown ☐ Yes

Central nervous system involvement	
stiff neck:	☐No ☐Unknown ☐Yes
elevated CSF protein (over 50 mg.%):	☐No ☐Unknown ☐Yes
elevated CSF cell count (over 5 cells per ml):	☐No ☐Unknown ☐Yes
Manifestations	
Other Manifestations	☐No ☐Unknown ☐Yes
Animal / Water Contact	
Recent contact with animals:	☐No ☐Unknown ☐Yes

If yes, select animal type:

☐ Alpaca	☐ Bat	☐ Bovidae	☐ Bovine	☐ Burro/Donkey	☐ Cat
☐ Chipmunk	☐ Cow	☐ Coyote	☐ Dog	☐ Equine	☐ Ferret
☐ Fox, fennec	☐ Fox, grey	☐ Fox, red	☐ Fox, unknown	☐ Gerbil	☐ Goat
☐ Groundhog	☐ Guinea pig	☐ Hamster	☐ Llama	☐ Mink	☐ Mole
☐ Mouse	☐ Muskrat	☐ Opossum	☐ Other / Unknown	☐ Ovine	☐ Prairie dog
☐ Rabbit	☐ Raccoon	☐ Rat	☐ Shrew	☐ Skunk, other	☐ Squirrel,flying
☐ Squirrel, fox	☐ Squirrel, other	☐ Weasel	☐ Wolf/Hybrid	☐ Chicken	☐ lizard
☐ turkey	☐ turtle				

Water, Recent history of contact in potentially contaminated water (i.e., sewage, streams, ponds, floods, etc.):	☐No ☐Unknown ☐Yes
Clinical criteria for case classification	
Does the patient have: fever, headache, chills, myalgia, conjunctival suffusion :	☐No ☐Unknown ☐Yes
Less frequently seen: meningitis, rash, jaundice, or renal insufficiency :	☐No ☐Unknown ☐Yes
Laboratory criteria for case classification	
Isolation of Leptospira :	☐No ☐Not tested ☐Unknown ☐Yes
A greater than or equal to 4 fold rise in Leptospira agglutination titer	☐No ☐Not tested ☐Unknown ☐Yes
Demonstration of Leptospira by IFA :	☐No ☐Not tested ☐Unknown ☐Yes

***LISTERIA* CASE FORM** Completed by _____ Date completed _____

Form Approved
OMB No. 0920-0004

BOX 1: CASE-PATIENT INFORMATION

Case-patients = adults and children >1 month of age. For fetal or neonatal infections, the MOTHER is the case-patient.

Patient's name: _____ **Surrogate's name:** _____
Patient's street address: _____
City: _____ **State:** _____ **Zip:** _____
Phone numbers: (h) _____ **(w)** _____ **(m)** _____
Hospital name(s): _____ **Hospital contact name(s):** _____
_____ _____
Hospital contact numbers: _____ _____ _____
----------*detach here to remove personal identifiers if necessary*

Sex: ☐ M ☐ F
State of residence: ___ ___
Age: _____
DOB: ____/____/_____

Ethnicity (*check one*):
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Unknown

Race (*check all that apply*):
☐ African American/Black
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Native American/Alaska Native
☐ White
☐ Unknown

State or local epi case ID: _____
CDC outbreak (EFORS) ID: _____

BOX 2: IS *LISTERIA* CASE ASSOCIATED WITH PREGNANCY? (Illness in pregnant woman, fetus, or neonate ≤1 month)

☐ Yes ***If yes, skip to Box 4.***
☐ No ***If no, continue with Box 3.***
☐ Unknown ***If unknown, continue with Box 3.***

BOX 3: CASES NOT ASSOCIATED WITH PREGNANCY (Illness in non-pregnant adults and children > 1 month of age)

Type(s) of specimen(s) that grew *Listeria* (*check all that apply*)	**Specimen collection date**	**Submitting Lab (state, city, county)**	**State Public Health Lab Isolate ID Number (*important: must have at least one*)**
☐ Blood	____/____/____		
☐ CSF	____/____/____		
☐ Stool	____/____/____		
☐ Other _____	____/____/____		
☐ Other _____	____/____/____		

Type(s) of illness (*check all that apply*)	**Was patient hospitalized for listeriosis?**	**Patient's outcome**
☐ Bacteremia/sepsis	☐ Yes ***If yes:***	☐ Survived
☐ Meningitis	Admit date: ____/____/____	☐ Died
☐ Febrile gastroenteritis	Discharge date: ____/____/____	☐ Unknown
☐ Other _____	☐ Still hospitalized	
☐ Unknown	☐ No	
	☐ Unknown	

Please send completed forms to: Enteric Diseases Epidemiology Branch, Centers for Disease Control and Prevention, Mailstop A-38, Atlanta, GA 30333. Fax (404) 639-2205.

BOX 4: CASES ASSOCIATED WITH PREGNANCY (Illness in pregnant woman, fetus, or neonate ≤1 month of age)			
Type(s) of specimen(s) that grew *Listeria* (*check all that apply*)	**Specimen collection date**	**Submitting Lab (state, city, county)**	**State Public Health Lab Isolate ID Number (*important: must have at least one*)**
☐ Blood from mother	____/____/____		
☐ Blood from neonate	____/____/____		
☐ CSF from mother	____/____/____		
☐ CSF from neonate	____/____/____		
☐ Stool from mother	____/____/____		
☐ Placenta	____/____/____		
☐ Amniotic fluid	____/____/____		
☐ Other _____	____/____/____		
☐ Other _____	____/____/____		

BOX 4 (CONTINUED): CASES ASSOCIATED WITH PREGNANCY					
Outcome of pregnancy (single gestation or twin 1) (*check one*)	**Weeks of gestation**	**Date**	**Outcome of pregnancy (twin 2) (*check one*)**	**Weeks of gestation**	**Date**
☐ Still pregnant		____/____/____	☐ Still pregnant as of: __/__/__		____/____/____
☐ Fetal death (miscarriage or stillbirth)		____/____/____	☐ Fetal death (miscarriage or stillbirth)		____/____/____
☐ Induced abortion		____/____/____	☐ Induced abortion		____/____/____
☐ Delivery (live birth)		____/____/____	☐ Delivery (live birth)		____/____/____
☐ Other _____		____/____/____	☐ Other _____		____/____/____

Type(s) of illness in mother (*check all that apply*)	**Type(s) of illness in neonate (twin 1) (*check all that apply*)**	**Type(s) of illness in neonate 2 (twin 2) (*check all that apply*)**
☐ Bacteremia/sepsis	☐ Bacteremia/sepsis	☐ Bacteremia/sepsis
☐ Meningitis	☐ Meningitis	☐ Meningitis
☐ Febrile gastroenteritis	☐ Pneumonia	☐ Pneumonia
☐ Amnionitis	☐ Granulomatosis infantisepticum	☐ Granulomatosis infantisepticum
☐ Non-specific "flu-like" illness	☐ None	☐ None
☐ None	☐ Other _____	☐ Other _____
☐ Other _____	☐ Unknown	☐ Unknown
☐ Unknown		

Was mother hospitalized for listeriosis?	**Was neonate (twin 1) hospitalized for listeriosis?**	**Was neonate 2 (twin 2) hospitalized for listeriosis?**
☐ Yes ***If yes:***	☐ Yes ***If yes:***	☐ Yes ***If yes:***
Admit date: ____/____/____	Admit date: ____/____/____	Admit date: ____/____/____
Discharge date: ____/____/____	Discharge date: ____/____/____	Discharge date: ____/____/____
☐ Still hospitalized	☐ Still hospitalized	☐ Still hospitalized
☐ No	☐ No	☐ No
☐ Unknown	☐ Unknown	☐ Unknown

Mother's outcome	**Neonate's (twin 1's) outcome**	**Neonate 2's (twin 2's) outcome**
☐ Survived	☐ Survived	☐ Survived
☐ Died	☐ Died	☐ Died
☐ Unknown	☐ Unknown	☐ Unknown

CASE-PATIENT INTERVIEW

Date of interview(mm/dd/yyyy): ___/___/_____ Initials of interviewer: _____
Interviewee: ☐ Case-patient ☐ Surrogate ☐ Unknown
If surrogate, relationship to patient: ☐ Parent ☐ Child ☐ Sibling ☐ Spouse ☐ Other, Specify _____

When did your illness begin? (Onset of illness) (mm/dd/yyyy): ___/___/_____ ☐ Not applicable (e.g. pregnant woman without clinical illness)
During the 4 weeks before your illness (*delivery date*), were you admitted to a hospital (≥overnight)? ☐Yes ☐No ☐Don't know
During the 4 weeks before your illness (*delivery date)*, were you a resident in a nursing home or other long term care facility? ☐Yes ☐No ☐Don't know
If yes, Date of admission (mm/dd/yyyy) ___/___/___
Date of discharge (mm/dd/yyyy) ___/___/___ or ☐ Still hospitalized or residing in facility
During the 4 weeks before your illness (*delivery date*), did you travel to a state outside your state of residence? ☐Yes ☐No ☐Don't know
If yes, please list states visited: _____

During the 4 weeks before your illness (*delivery date*), did you travel outside the U.S.? ☐Yes ☐No ☐Don't know
If yes, name of country visited _____
If yes, Date of departure from U.S. (mm/dd/yyyy) ___/___/___
Date of return to U. S. (mm/dd/yyyy) ___/___/___

Which of the following symptoms were associated with illness? ***(read each)***

Fever	☐ Yes	☐ No	☐ Don't know	Diarrhea (≥3 loose stools/day)	☐ Yes	☐ No	☐ Don't know
Chills	☐ Yes	☐ No	☐ Don't know	Vomiting	☐ Yes	☐ No	☐ Don't know
Headache	☐ Yes	☐ No	☐ Don't know	Preterm labor	☐ Yes	☐ No	☐ Don't know
Muscle Aches	☐ Yes	☐ No	☐ Don't know	Other _____	☐ Yes	☐ No	☐ Don't know
Stiff Neck	☐ Yes	☐ No	☐ Don't know	Other _____	☐ Yes	☐ No	☐ Don't know

FOOD HISTORY

INSTRUCTIONS FOR INTERVIEWER: Ask case-patient about the food he/she consumed during the 4 weeks before his/her Listeria SPECIMEN COLLECTION DATE. Please list venues and food exposures form U.S. locations only. In the event of a fetal death or neonatal infection (<1 month of age), the MOTHER is the case-patient, and she should be asked about her food history during the 4 weeks before DELIVERY. Please refer to patient as "you" if interviewing the case-patient directly; if interviewing a surrogate, please use "he" or "she."

INSTRUCTIONS TO READ TO CASE-PATIENT (OR SURROGATE):

I am interested in the foods you ate during the 4 weeks before your illness *(delivery*). I see that you had a positive test for listeriosis *(delivered)* on ____/____/____. For most of the interview, I will be asking you questions about the 4 weeks before this date, that is, from ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date). *(Have patient get calendar for reference if possible.)* First I'd like to ask you about where the foods you ate were purchased. I am going to read you a list of places where food can be purchased. For each, please tell me if you ate food purchased from that type of place in the four week time period. I know that it can be difficult to remember that far back, but please do the best you can. If you're not sure, please tell me whether it's likely or unlikely that you ate food purchased from that location.

I. FOOD PURCHASE HISTORY

A. Grocery stores: Did you eat food purchased from any grocery stores during the 4 week time period? *(Please read all options.)*
☐ Yes ☐ It's likely ☐ It's unlikely ☐ No ***If yes or likely,***

Store Name	Street Address	City	County	State
1.				
2.				
3.				
4.				
5.				
6.				
7.				

B. Delis, small markets, farmers' markets: Did you eat food purchased from any delicatessens, small local markets, other small shops, or farmers' markets during the 4 week period? ☐ Yes ☐ It's likely ☐ It's unlikely ☐ No ***If yes or likely,***

Store Name	Street Address	City	County	State
1.				
2.				
3.				
4.				
5.				
6.				
7.				

C. Restaurants: Did you eat food from any restaurants, including sit-down, fast-food, and take-out restaurants during the 4 week period?
☐ Yes ☐ It's likely ☐ It's unlikely ☐ No ***If yes or likely,***

Restaurant Name	Street Address	City	County	State	Dining dates (mm/dd/yyy)
1.					___/___/___
2.					___/___/___
3.					___/___/___
4.					___/___/___
5.					___/___/___
6.					___/___/___
7.					___/___/___
					___/___/___

D. Other venues: cafeterias, concession stands, institutions: Did you eat food purchased or obtained from any other venues, such as school cafeterias, concession stands, street vendors, institutions (e.g. hospital food), local farms, or private vendors during the 4 week period?
☐ Yes ☐ It's likely ☐ It's unlikely ☐ No ***If yes or likely,***

Name	Street Address	City	County	State	Dining dates (mm/dd/yyy)
1.					___/___/___

2.					___/___/___
3.					___/___/___
4.					___/___/___
5.					___/___/___
6.					___/___/___
7.					___/___/___

II. FOOD CONSUMPTION HISTORY

INSTRUCTIONS FOR INTERVIEWER: Please read all options to case-patient in each category. For the names of purchase sites, it is preferable to use codes from Section I above, e.g. A1 for first grocery store, A3 for third grocery store, C5 for fifth restaurant. A DELI COUNTER serves portions or helpings of salads, cheeses, and meats sliced ON-SITE at a specified counter within a grocery store, food market, or delicatessen. Foods sliced and packaged AT the FACTORY and sold as pre-packaged containers in self-serve refrigerated display cases are NOT considered to be from a deli counter

INSTRUCTIONS TO READ TO CASE-PATIENT (OR SURROGATE):

Now I'd like to ask you about the foods that you ate between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date). For each food item, please give me your best guess as to whether you ATE the food, you're not sure but you LIKELY ATE the food, you're not sure but you LIKELY DID NOT EAT the food, or you DID NOT EAT the food.

MEATS: In the 4 week period, did you eat any of the following COLD CUT, DELI MEAT, OR LUNCHEON MEAT items?

	Ate (=1)	**Likely Ate (=2)**	**Likely did NOT eat (=3)**	**Did NOT eat (=4)**	***If ate or likely ate,* How often?**	***If ate or likely ate,* Where was it purchased? *(choose all types that apply)***	**Name(s) of store/restaurant/venue: *(all names that apply)***	**Types or brands: *(all that apply)***
Ham	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Bologna	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Turkey breast	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Other turkey deli meat (e.g. turkey ham)	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____

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	Ate (=1)	**Likely Ate (=2)**	**Likely did NOT eat (=3)**	**Did NOT eat (=4)**	***If ate or likely ate,* How often?**	***If ate or likely ate,* Where was it purchased? *(choose all types that apply)***	**Name(s) of store/restaurant/venue: *(all names that apply)***	**Types or brands: *(all that apply)***
Chicken deli meat (*NOT fresh chicken or rotisserie chicken*)	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Pastrami/ Corned beef	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Other deli/ luncheon meat (*specify)*_____	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Patè or meat spread that was not canned	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Hot dogs	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____

If Yes, were the hot dogs: ☐ Heated before consumption
☐ Not heated before consumption (eaten directly out of package)

CHEESES: In the 4 weeks between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date), did you eat any of the following CHEESES?

	Ate (=1)	**Likely Ate (=2)**	**Likely did NOT eat (=3)**	**Did NOT eat (=4)**	***If ate or likely ate,* How often?**	***If ate or likely ate,* Where was it purchased? *(choose all types that apply)***	**Name(s) of store/restaurant/venue: *(all names that apply)***	**Types or brands: *(all that apply)***
Brie	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Feta	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Camembert	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Goat	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Blue or gorgonzola	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____

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	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	*If ate or likely ate,* How often?	*If ate or likely ate,* Where was it purchased? *(choose all types that apply)*	Name(s) of store/restaurant/venue: *(all names that apply)*	Types or brands: *(all that apply)*
Mexican-style cheese (Queso fresco, queso blanco)	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Farmer's cheese	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Raw (Unpast-eurized milk) cheese	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Other soft white cheese (*not cream, cottage, or ricotta – specify)*____ _____	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____

READY-TO-EAT SALADS: In the 4 week period, did you eat any of the following ready-to-eat, deli-style salads (that were NOT PREPARED AT HOME)?

	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	*If ate or likely ate,* How often?	*If ate or likely ate,* Where was it purchased? *(choose all types that apply)*	Name(s) of store/restaurant/venue: *(all names that apply)*	Types or brands: *(all that apply)*
Potato salad	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Pasta salad	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Tuna salad	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Bean salad	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Hummus	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____

	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	*If ate or likely ate,* How often?	*If ate or likely ate,* Where was it purchased? *(choose all types that apply)* Name(s) of store/restaurant/venue: *(all names that apply)* Types or brands: *(all that apply)*
Cole slaw	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store _____ _____ ☐ Deli/small market _____ _____ ☐ Restaurant _____ _____ ☐ Other venue _____ _____ ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know
Seafood salad	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store _____ _____ ☐ Deli/small market _____ _____ ☐ Restaurant _____ _____ ☐ Other venue _____ _____ ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know
Fruit salad (*including pre-cut cubes of a single fruit)*	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store _____ _____ ☐ Deli/small market _____ _____ ☐ Restaurant _____ _____ ☐ Other venue _____ _____ ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know
Sprouts (*Specify, e.g., alfalfa, clover, bean* ….) _____ _____	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store _____ _____ ☐ Deli/small market _____ _____ ☐ Restaurant _____ _____ ☐ Other venue _____ _____ ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know
Other ready-to-eat meat, vegetable or fruit salad not made at home (*Specify*) _____	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store _____ _____ ☐ Deli/small market _____ _____ ☐ Restaurant _____ _____ ☐ Other venue _____ _____ ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know

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SEAFOOD: In the 4 weeks between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date), did you eat any of the following ready-to-eat fish or seafood items or fruit items?

	Ate (=1)	**Likely Ate (=2)**	**Likely did NOT eat (=3)**	**Did NOT eat (=4)**	***If ate or likely ate,* How often?**	***If ate or likely ate,* Where was it purchased? *(choose all types that apply)***	**Name(s) of store/restaurant/venue: *(all names that apply)***	**Types or brands: *(all that apply)***
Precooked shrimp	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Precooked crab (*including imitation crab meat)*	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Smoked or cured fish that was not from a can (e.g. smoked salmon or lox)	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____

Fruit: In the 4 weeks between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date), did you eat any of the following fruit items?			
Honeydew melon 1 2 3 4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store _____ _____ ☐ Deli/small market _____ _____ ☐ Restaurant _____ _____ ☐ Other venue _____ _____ ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know
Cantaloupe 1 2 3 4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store _____ _____ ☐ Deli/small market _____ _____ ☐ Restaurant _____ _____ ☐ Other venue _____ _____ ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know
Watermelon 1 2 3 4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store _____ _____ ☐ Deli/small market _____ _____ ☐ Restaurant _____ _____ ☐ Other venue _____ _____ ☐ Don't know **Was this item purchased from a deli counter at any of the sites?** ☐ Yes ☐ No ☐ Don't know

MILK: In the 4 weeks between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date), did you drink any of the following types of milk?

	Drank (=1)	**Likely drank (=2)**	**Likely did NOT drink (=3)**	**Did NOT drink (=4)**	***If ate or likely ate,* How often?**	***If ate or likely ate,* Where was it purchased? *(choose all types that apply)***	**Name(s) of store/restaurant/venue: *(all names that apply)***	**Types or brands: *(all that apply)***
Whole milk	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was any of this milk unpasteurized (raw)?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
2% milk	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was any of this milk unpasteurized (raw)?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
1% milk	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was any of this milk unpasteurized (raw)?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Skim milk	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was any of this milk unpasteurized (raw)?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Other milk – chocolate, buttermilk, etc. (*Specify)*___ _____	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know **Was any of this milk unpasteurized (raw)?** ☐ Yes ☐ No ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____

OTHER DAIRY: In the 4 week period, did you eat any of the following other dairy items?

	Ate (=1)	**Likely Ate (=2)**	**Likely did NOT eat (=3)**	**Did NOT eat (=4)**	***If ate or likely ate,* How often?**	***If ate or likely ate,* Where was it purchased? *(choose all types that apply)***	**Name(s) of store/restaurant/venue: *(all names that apply)***	**Types or brands: *(all that apply)***
Butter (*not margarine or other butter substitute*)	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Cream	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Ice cream	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Sour cream	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____
Yogurt	1	2	3	4	☐ ~ 1-2 x/month ☐ ~ 1x/week ☐ ~ 2-4x/week ☐ ~ 5-7x/week ☐ not sure	☐ Grocery store ☐ Deli/small market ☐ Restaurant ☐ Other venue ☐ Don't know	_____ _____ _____ _____	_____ _____ _____ _____

That is all. Thank you very much!

LYME DISEASE INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Where was the disease acquired? ☐Indigenous within jurisdiction ☐Out of Country ☐Out of jurisdiction, from another jurisdiction ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

SYMPTOMS AND SIGNS OF CURRENT EPISODE

Dermatologic

Erythema migrans (physician diagnosed EM at least 5 cm in diameter)? ☐No ☐Unknown ☐Yes

Rheumatologic

Arthritis characterized by brief attacks of joint swelling? ☐No ☐Unknown ☐Yes

Neurologic

Bell's palsy or other cranial neuritis? ☐No ☐Unknown ☐Yes

Radiculoneuropathy? ☐No ☐Unknown ☐Yes

Lymphocytic meningitis? ☐No ☐Unknown ☐Yes

Encephalitis/Encephalomyelitis? ☐No ☐Unknown ☐Yes

CSF tested for *B. burgdorferi* antibodies? ☐No ☐Unknown ☐Yes

CSF antibody greater than serum antibody? ☐No ☐Unknown ☐Yes

*Note: Encephalomyelitis **MUST** be confirmed by Ab in CSF **and** CSF Ab titer **MUST** be > serum Ab titer.*

Cardiologic

2nd or 3rd degree atrioventricular (A-V) block? ☐No ☐Unknown ☐Yes

*Note: For cardiovascular system late manifestation to be present, A-V block **MUST** be acute **and** resolve.*

Other Clinical

Was LD diagnosed by a physician? ☐No ☐Unknown ☐Yes

Other clinical comments: _____

EXPOSURE

Exposure to a potential tick habitat (wooded, brushy, or grassy area) within 30 DAYS of onset of EM? ☐No ☐Unknown ☐Yes

If yes, did this exposure occur in Alabama? ☐No ☐Unknown ☐Yes

What Alabama county:_____

If no, where did the exposure occur? _____

*Note: Exposure MUST occur in a county in which LD is endemic to be considered in case classification. To become endemic, a county must have **≥ 2 confirmed** cases of LD **acquired** in the county. Currently, LD is endemic to Mobile, Jefferson, Shelby & Chambers counties.*

MALARIA INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Where was the disease acquired? ☐Indigenous within jurisdiction ☐Out of Country ☐Out of jurisdiction, from another jurisdiction ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments: _____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

LABORATORY

Positive lab result (*select all that apply*): ☐Smear ☐PCR ☐RDT ☐No test done/unknown

Malaria Species (*select all that apply*): ☐*Falciparum* ☐*Malariae* ☐Not Determined ☐Other species: _____ ☐*Ovale* ☐*Vivax*

Parasitemia:_____%

Specimens sent to CDC: ☐No ☐Unknown ☐Yes If yes: ☐Smears ☐Whole Blood ☐Other: _____

TRAVEL HISTORY

Did the patient live or travel outside the United States (US) during the past 2 years? ☐No ☐Unknown ☐Yes

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

Did the patient reside in US prior to most recent travel? ☐No ☐Unknown ☐Yes

Principal reason for travel from/to US for most recent trip:

☐Airline/ship crew ☐Military ☐Peace Corps ☐Refugee/immigrant ☐Tourism ☐Visiting friends/relatives
☐Business ☐Missionary or dependent ☐Other:_____ ☐Student/teacher ☐Unknown

NON-TRAVEL RISK FACTORS

Has patient had Malaria in last 12 months prior to this report? ☐No ☐Unknown ☐Yes Date of previous illness: __ __ / __ __ /__ __ __ __

If yes, (*select all that apply*): ☐*Falciparum* ☐*Malariae* ☐Not Determined ☐Other species: _____ ☐*Ovale* ☐*Vivax*

Blood transfusion/organ transplant within last 12 months? ☐Yes ☐No ☐Unknown Transfusion/transplant date: __ __ / __ __ /__ __ __ __

MALARIA CHEMOPROPHYLAXIS

Height: _____ feet _____ inches Weight: _____ pounds Was malaria chemoprophylaxis taken? ☐No ☐Unknown ☐Yes

If yes, which drugs were taken?

☐Atovaquone/proguanil ☐Chloroquine ☐Doxycycline ☐Mefloquine ☐Other: _____ ☐Primaquine ☐Unknown

Was chemoprophylaxis taken as prescribed? ☐No (missed doses) ☐Unknown ☐Yes (no missed doses)

If doses where missed, what was the reason?

☐Didn't think needed ☐Had a side effect: _____ ☐Prematurely stopped taking once home ☐Was advised by others to stop
☐Forgot ☐Other: _____ ☐Unknown

CLINICAL COMPLICATIONS

Clinical Complications: ☐ARDS ☐Cerebral Malaria ☐None ☐Other: _____ ☐Renal failure ☐Severe anemia (Hb < 7)

Therapy for this attack (*select all that apply*):

☐Artesunate ☐Clindamyacin ☐Exchange transfusion ☐Primaquine ☐Tetracycline
☐Artemether/lumefantrine ☐Chloroquine ☐Mefloquine ☐Quinidine ☐Unknown
☐Atovaquone/proguanil ☐Doxycycline ☐Other: _____ ☐Quinine

FOLLOW UP (COMPLETE 4 WEEKS POST-TREATMENT)

List all prescription and over the counter medicines patient took during **2 weeks** before starting malaria treatment:

_____

List all prescription and over the counter medicines patient took during **4 weeks** after starting malaria treatment:

_____

Was malaria treatment taken as prescribed? ☐No (missed doses) ☐Unknown ☐Yes (no missed doses)

Did all signs and symptoms of malaria resolve within **7 days** of initiating malaria treatment? ☐Yes ☐No ☐Unknown

If yes, did patient experience recurrence of malaria signs or symptoms during **4 weeks** after starting malaria treatment? ☐Yes ☐No ☐Unknown

Did patient experience any adverse events within **4 weeks** after receiving malaria treatment? ☐Yes ☐No ☐Unknown

If yes, specify event:

Event 1: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? ☐Yes ☐No ☐Unknown Outcome: ☐Fatal ☐Life-threatening ☐Serious†

Event 2: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? ☐Yes ☐No ☐Unknown Outcome: ☐Fatal ☐Life-threatening ☐Serious†

Event 3: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? ☐Yes ☐No ☐Unknown Outcome: ☐Fatal ☐Life-threatening ☐Serious†

Event 4: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? ☐Yes ☐No ☐Unknown Outcome: ☐Fatal ☐Life-threatening ☐Serious†

Event 5: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? ☐Yes ☐No ☐Unknown Outcome: ☐Fatal ☐Life-threatening ☐Serious†

†Serious adverse event: *persistent or significant disability/incapacity, congenital anomaly/birth defect, medically significant (i.e., jeopardizes patient or may require medical/surgical intervention), or requires inpatient hospitalization.*

MEASLES (RUBEOLA) INVESTIGATION FORM

Comments:_____
_____

Basic Demographic Data

Last Name: _____ First Name:_____
Middle Name:_____ Suffix: _____
DOB: __ __ / __ __ /__ __ __ __ Current Sex: ☐Female ☐Male ☐Unknown
Is the patient deceased? ☐ No ☐Unknown ☐Yes Deceased Date: __ __ / __ __ /__ __ __ __
Marital Status: (Circle) S / M / D / W/ Annulled/ Cohabitating/ Legally Separated/ Polygamous/Unknown
SSN: __ __ __ / __ __ /__ __ __ __
Identification Information: Type:_____Assigning Authority_____
IDValue_____
Street Address : _____
City: _____ State:_____
Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____
Home Ph:(__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __Work Ph:(__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Ethnicity: ☐ Hispanic or Latino ☐Not Hispanic or Latino

Race : ☐Unknown ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Investigation Summary

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed
Investigator:_____Date assigned: __ __ / __ __ /__ __ __ __

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____
Earliest Date Reported to County : __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __
Reporter:_____

Clinical

Physician's Name:_____
Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Physician's Address: _____
City: _____ State:_____ Zip Code: __ __ __ __ __- __ __ __ __
County:_____ Country:_____

Hospital

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐Yes
If yes: Hospital Name:_____
Admission Date :__ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Total duration of hospital stay____days

Condition

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __
Illness End Date: __ __ / __ __ /__ __ __ __ Illness Duration: ____ **(Circle)**: minutes / hour(s) / day(s) / month(s) / year(s)

Did the patient have a rash? ☐No ☐Unk ☐Yes Rash Onset : __ __ / __ __ /__ __ __ __ If yes, Rash Duration_____days
Was the rash generalized? ☐No ☐Unk ☐Yes Did the patient have a fever? ☐No ☐Unk ☐Yes
Fever Onset: __ __ / __ __ /__ __ __ __ Highest Measured Temp___° C / F

Symptoms Did the patient have any of the following:?

Cough: ☐No ☐Unknown ☐Yes	Coryza (runny nose): ☐No ☐Unknown ☐Yes	Conjunctivitis: ☐No ☐Unknown ☐Yes

Complications

Croup: ☐No ☐Unknown ☐Yes	Otitis Media: ☐No ☐Unknown ☐Yes	Diarrhea: ☐No ☐Unknown ☐Yes
Pneumonia: ☐No ☐Unknown ☐Yes	Encephalitis: ☐No ☐Unknown ☐Yes	Thrombocytopenia: ☐No ☐Unknown ☐Yes
Other Complications ☐No ☐Unk ☐Yes	Specify Other:_____	Did the patient develop hepatitis? ☐No ☐Unk ☐Yes

Did the patient die from measles or complications (including a seconday infection) associated with measles? ☐No ☐Unknown ☐Yes

Laboratory

Was a lab test done for measles? ☐No ☐Unk ☐Yes	Was an IgM test performed? ☐No ☐Unk ☐Yes	Specimen Date?__ __ /__ __ /__ __ ____

Result of IgM Test: ☐Indeterminate ☐Negative ☐Not Done ☐Pending ☐Positive ☐Unknown
Was IgG acute/convalescent testing performed? ☐No ☐Unknown ☐Yes

Date IgG Acute Specimen Taken: __ __/ __ __/__ __ __ __	Date IgG Convalescent Specimen Taken: __ __/ __ __/__ __ __ __	Result of Acute/Convalescent IgG Tests: ☐Indeterminate ☐No significant rise in IgG ☐Not done ☐Pending ☐Significant rise in IgG ☐Unknown

Was other laboratory testing done? ☐No ☐Unknown ☐Yes	Specify Other Test: _____	Date of Other Test: __ __ / __ __ /__ __ __ __	Other Lab Test Results _____
Were specimens sent to CDC for genotyping?(molecular) ☐No ☐Unk ☐Yes		Date Sent for Genotyping: __ __ / __ __ /__ __ __ __	

Was the (Measles) virus genotype sequenced? ☐No ☐Unknown ☐Yes			If 'Yes' identify the Genotype:
☐ Measles genotype A	☐ Measles genotype B2	☐ Measles genotype B3	☐ Measles genotype C1
☐ Measles genotype C2	☐ Measles genotype D10	☐ Measles genotype D2	☐ Measles genotype D3
☐ Measles genotype D4	☐ Measles genotype D5	☐ Measles genotype D6	☐ Measles genotype D7
☐ Measles genotype D8	☐ Measles genotype D9	☐ Measles genotype G2	☐ Measles genotype G3
☐ Measles genotype H1	☐ Measles genotype H2	☐ Unknown	☐ Other
If "Other", specify other sequence: _____		Specimen Type: _____	

Vaccine Information

Did the patient receive a measles-containing vaccine? ☐No ☐Unknown ☐Yes	If no, reason: - _____
Number of doses received BEFORE first birthday: _____	Number of doses received ON or AFTER first birthday: _____
If vaccinated BEFORE first birthday, but no doses given ON or AFTER first birthday, **what is the reason?** _____	If patient received one dose ON or AFTER first birthday, but never received a second dose after the first birthday, **what is the reason?** _____

Epidemiologic

Does this patient reside in the USA?	☐No ☐Unknown ☐Yes
Is this case epi-linked to another confirmed or probable case?	☐No ☐Unknown ☐Yes
Transmission Setting:	
Were age and setting verified?	☐No ☐Unk ☐Yes
Is this case part of an outbreak of 3 or more cases?	☐No ☐Unk ☐Yes
Outbreak Name:	Source of Infection
Did rash onset occur within 18 days of entering the USA, following any travel or living outside the USA ?	☐No ☐Unk ☐Yes
Is this case traceable (linked) to an international import?	☐No ☐Unk ☐Yes

Where was the disease acquired?
☐Indigenous, within jurisdiction ☐Out of country ☐Out of jurisdiction, from another jurisdiction ☐Out of state ☐Unknown

Imported Country:	Imported State:
Imported City:	Imported County:
Case Status: (Required for Notification)	☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐ Unknown

Confirmation Method: ☐Clinical Diagnosis (non-laboratory confirmed) ☐Epidemiologically linked ☐Laboratory confirmed

(Required for Notification) MMWR Week _____ **MMWR Year** _____

Custom Fields Date Due __ __ / __ __ /__ __ __ __

Investigation Ready for Supervisor Review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete) ☐ Reviewed (Not a case) ☐Yes

Date Investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Detection of Measles by PCR

Was PCR testing performed?	☐No ☐Unk ☐Yes

Based on the person's age and current recommendations, has the case received the recommended doses of vaccine for the disease under investigation? ☐No ☐Yes

Birth Information:

Birth Country (required field):	If Foreign Born, Number of Years in US _____

If yes, to associated with a school or daycare? Answer questions below:

Name of school or daycare:

City of school or daycare:

County of school or daycare:

What grades attend the school (ie: K-12, K-6, 7-12, 7-8, 5-8, 9-12)	What grade is the case in at the school?

Are there other cases in the classroom or other cases in the school building, or both? Explain:

Source of Exposure For Current Case

☐ Enter State ID IF source was an in-state case _____ ☐ Enter Country IF out of US_____ ☐ Enter State IF out of State_____

Contact Information: (For statistical health department use)	Mother's Name:
Father's Name:	Contact phone number: (__ __ __)-__ __ __-__ __ __ __
Activity History for 18 Days Before Rash Onset	Continued Activity History For 18 Days Before Rash Onset

Clinical criteria for case classification

A generalized rash lasting greater than or equal to 3 days: ☐No ☐Unknown ☐Yes	
A temperature greater than or equal to 101.0 degrees F (greater than or equal to 38.3 degrees C):	☐No ☐Unk ☐Yes
Cough, coryza, or conjunctivitis: ☐No ☐Unk ☐Yes	Epidemiologically linked to a confirmed case: ☐No ☐Unk ☐Yes

Laboratory criteria for case classification

Positive serologic test for measles IgM antibody	☐no ☐not tested ☐unknown ☐yes
Significant rise in measles antibody level by any standard serologic assay:	☐no ☐not tested ☐unknown ☐yes
Isolation of measles virus from a clinical specimen:	☐no ☐not tested ☐unknown ☐yes

Vaccination Record (Use Manage Vaccinations button)

Date Administered: __ __ / __ __ /__ __ __ __	Age at Vaccination: **(Circle):** /days /hrs ./ minutes / months / unknown / weeks/ years

Vaccination Anatomical Site: ☐Left Arm ☐ Left Gluteus Maximus ☐Left Naris ☐Left Thigh ☐Oral Cavity ☐Right Arm ☐Right GluteusMaximus ☐Right Naris ☐Right Thigh ☐Other

Given By	Last Name:	First Name:	Provider ID:

Organization Name:	Organization ID:	Vaccine Administered:	
Manufacturer:	Organization ID	Lot Number:	Expiration Date: __ __ / __ __ /__ __ __ __

MUMPS INVESTIGATION FORM

Comments_____

_____

_____

Basic Demographic Data

Last Name: _____ First Name:_____
Middle Name:_____ Suffix: _____

DOB: __ __ / __ __ /__ __ __ __ Current Sex: Female □ Male □ Unknown □
Is the patient deceased? No □ Unknown □ Yes □ Deceased Date: __ __ / __ __ /__ __ __ __

Marital Status: (Circle) S / M / D / W Annulled/ Cohabitating/ Legally Separated/ Polygamous
SSN: __ __ __ / __ __ /__ __ __ __
Identification Information: Type _____ Assigning Authority_____ ID Value:_____
Street Address 1: _____
Street Address 2: _____

City: _____ State:_____
Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____

Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race : □ Unknown □ American Indian or Alaska Native □Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Investigation Summary

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: □ Open □ Closed
Investigator:_____Date assigned: __ __ / __ __ /__ __ __

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __
Reporting Source:_____
Earliest Date Reported to: County : __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __
Reporter:_____

Clinical

Physician's Name: _____
Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Physician's Address: _____
City:_____ State:_____
Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____

Was patient hospitalized for this illness? □ No □ Unknown □ Yes
If yes: Hospital Name:_____
Admission Date : __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __
Duration of Stay _____ days

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __
Illness End Date: __ __ / __ __ /__ __ __ __ Illness Duration: _____Circle:days/hrs./minutes/months/unknown/weeks/years
Age at Onset: _____ Circle: minutes / hour(s) / day(s) / month(s) / year(s)
Did the patient die from this illness? □ No □ Unknown □ Yes

Epidemiologic	**No**	**Unk**	**Yes**		**No**	**Unk**	**Yes**
Is this patient associated with a day care facility?	□	□	□	Is this patient a food handler?	□	□	□
Is this case part of an outbreak?	□	□	□	If yes, outbreak name:_____			

Where was the disease acquired?

□ Indigenous within jurisdiction	□ Out of Country	□ Out of jurisdiction, from another jurisdiction
□ Out of state	□ Unknown	

If the answer is out of Country, Jurisdiction, or State

Imported Country:	Imported State:
Imported City:	Imported County:

Transmission Mode

□ Airborne	□ Bloodborne	□ Dermal	□ Foodborne	□ Indeterminate	□ Mechanical
□ Nosocomial	□ Sexually Transmitted	□ Vectorborne	□ Waterborne	□ Zoonotic	□ Other

Detection Method

☐ Patient Self-referral	☐ Prenatal Testing	☐ Prison Entry Screening	☐ Provider Reported	☐ Routine Physical	☐ Other

Confirmation Method select all that apply

☐ Active Surveillance	☐ Case Outbreak Investigation	☐ Clinical Diagnosis	☐ Epidemiologically Linked
☐ Laboratory Confirmed	☐ Laboratory Report	☐ Local/State Specified	☐ Medical Record Review
☐ No information given	☐ Occupational Disease Surveillance	☐ Provider Certified	☐ Other

Confirmation Date: : __ __ / __ __ /__ __ __ __

CASE STATUS: (Required for Notification) ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown

MMWR Week:_____ MMWR Year_____

Custom Fields

Date Due: __ __ / __ __ /__ __ __ __ Investigation Ready for supervisor review: _____

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Based on the person's age and current recommendations, has the case received the recommended doses of vaccine for the disease under investigation? ☐ No ☐ Yes

If yes, to associated with a school or daycare?

Name of school or daycare:

City of school or daycare:

County of school or daycare:

What grades attend the school (ie: K-12, K-6, 7-12, 7-8, 5-8, 9-12)	What grade is the case in at the school?

Are there other cases in the classroom or other cases in the school building, or both? Explain:

Condition Specific Custom Fields	
Outcome (if patient died)	Date of death: : __ __ / __ __ /__ __ __ __

Postmortem examination results:

Death certificate diagnoses:

Symptoms

Did the patient have Parotitis?	No☐ Unknown☐ Yes☐	If yes, Duration of Parotitis (specify hours or days) :

Other glandular swelling such as submaxillar or sublingual glands:

Other symptoms and duration of symptoms:

Complications

Meningitis: No☐ Unknown☐ Yes☐	Deafness: No☐ Unknown☐ Yes☐	Orchitis: No☐ Unknown☐ Yes☐
Encephalitis: No☐ Unknown☐ Yes☐	Other Complications: No☐ Unknown☐ Yes☐	Specify Other Complication:
Oophoritis: No☐ Unknown☐ Yes☐	Mastitis: No☐ Unknown☐ Yes☐	

Recent travel history and dates of travel

International:

Domestic:

For college students include all interstate travel (e.g., sporting events, extracurricular events, and holidays/breaks):

Laboratory			
Was laboratory testing done for mumps? No□ Unknown□ Yes□		Was IgM testing performed? No□ Unknown□ Yes□	
Date IgM Specimen Taken: __ __ /__ __/__ __ __ __		Result of IgM Test: □ Indeterminate □ Negative □ Not Done □ Pending □ Positive □ Unknown	
Was IgG Acute/Convalescent testing performed? No□ Unknown□ Yes□ Date IgG Acute Specimen Taken: __ __ /__ __/__ __ __ __ Date IgG Convalescent Taken: __ __ /__ __/__ __ __ __ Result of Acute/Convalescent IgG Test: □ Indeterminate □ No significant rise in IgG □ Not done □ Pending □ Significant rise in IgG □ Unknown			
Was other laboratory testing done? No□ Unknown□ Yes□		Specify Other Test:	
Date of Other Test: __ __ /__ __/__ __ __ __		Other Laboratory Test Results:	
Were the clinical specimens sent to CDC for genotyping (molecular typing)? No□ Unknown□ Yes□		Date sent for genotyping: : __ __ /__ __/__ __ __ __	
Vaccine Information			
Did the patient receive mumps-containing vaccine?		No□ Unknown□ Yes□	
If No, Reason: □ Born outside of U.S.	□ Lab evidence of previous disease	□ MD diagnosis of previous disease	
□ Medical Contraindication	□ Never offered vaccine	□ Parent/Patient forgot to vaccinate	
□ Parent/Patient refusal	□ Parent/Patient report of disease	□ Philosophical objection	
□ Religious exemption	□ Under age for vaccination	□ Unknown	□ Other
Number of doses received ON or AFTER first birthday: _____			
Epidemiologic			
Length of time in the U.S.:____years:		Country of Birth:	
Transmission Setting:			
Were age and setting verified?		No□ Unknown□ Yes□	
Source of Infection (i.e. person ID, country,...):			
Did parotitis or other mumps-associated complication onset occur within 12-25 days of entering the USA, following any travel or living outside USA? (Import Status)		No□ Unknown□ Yes□	
If this is a U.S.-acquired case, how should the case be classified by source?		Endemic case □ Import-linked case □ Imported-virus case□ Unknown source case □	
Is this case epi-linked to another confirmed or probable case?		No□ Unknown□ Yes□	
Mumps Case Definition			
Clinical criteria for case classification			
Acute onset of unilateral or bilateral tender, self-limited swelling of the parotid or other salivary gland:		No□ Unknown□ Yes□	
Epidemiologically linked to a confirmed or probable case :		No□ Unknown□ Yes□	
Laboratory criteria for case classification			
Isolation of mumps virus :		No□ Not Tested□ Unknown□ Yes□	
Significant rise between acute- and convalescent-phase serum samples:		No□ Not Tested□ Unknown□ Yes□	
Positive serologic test for mumps IgM antibody:		No□ Unknown□ Yes□	
Was a PCR test performed? No□ Yes□ Result of PCR Test: □ Indeterminate □ Negative □ Not Done □ Pending □ Positive Date of PCR Test: __ __ /__ __/__ __ __ __		Was a Culture test performed? No□ Yes□ Result of Culture Test: □ Indeterminate □ Negative □ Not Done □ Pending □ Positive Date of culture Test: __ __ /__ __/__ __ __ __	

Vaccination Record **Use Manage Vaccination to Add Vaccination Record**			
Please note: Record ALL doses of EVERY vaccine given. Record all information that is known, even data on vaccine doses administered beyond the recommended guidelines			
1. Date Administered: __ __ / __ __ /__ __ __ __		Age at Vaccination:	
Vaccination Anatomical Site			
Given By			
Provider			
Organization			
Vaccine Administered			
Vaccine Manufacturer			
Lot Number		Expiration Date: __ __ / __ __ /__ __ __ __	
2. Date Administered: __ __ / __ __ /__ __ __ __		Age at Vaccination:	
Vaccination Anatomical Site			
Given By			
Provider			
Organization			
Vaccine Administered			
Vaccine Manufacturer			
Lot Number		Expiration Date: __ __ / __ __ /__ __ __ __	
3. Date Administered: __ __ / __ __ /__ __ __ __		Age at Vaccination:	
Vaccination Anatomical Site			
Given By			
Provider			
Organization			
Vaccine Administered			
Vaccine Manufacturer			
Lot Number		Expiration Date: __ __ / __ __ /__ __ __ __	
4. Date Administered: __ __ / __ __ /__ __ __ __		Age at Vaccination:	
Vaccination Anatomical Site			
Given By			
Provider			
Organization			
Vaccine Administered			
Vaccine Manufacturer			
Lot Number		Expiration Date: __ __ / __ __ /__ __ __ __	
5. Date Administered: __ __ / __ __ /__ __ __ __		Age at Vaccination:	
Vaccination Anatomical Site			
Given By			
Provider			
Organization			
Vaccine Administered			
Vaccine Manufacturer			
Lot Number		Expiration Date: __ __ / __ __ /__ __ __ __	

MENINGOCOCCAL DISEASE INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

OTHER PATIENT INFORMATION

Type of Insurance:

☐Indian Health Service (IHS) ☐Medicaid/State assistance program ☐Medicare ☐Military/VA
☐No health care coverage ☐Other, specify: _____ ☐Private/HMO/PPO/Managed care plan ☐Unknown

Weight: _____lbs _____oz OR _____kg OR ☐Unknown Height: _____ft _____in OR _____cm OR ☐Unknown

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Hospital

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Condition

Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Types of infection caused by organism:

☐Abscess (not skin) ☐Bacteremia without focus ☐Cellulitis ☐Chorioamnionitis
☐Conjunctivitis ☐Empyema ☐Endocarditis ☐Endometriosis
☐Epiglottitis ☐Hemolytic uremic Syndrome (HUS) ☐Meningitis ☐Necrotizing fasciitis
☐Osteomylitis ☐Other, specify: _____ ☐Otitis media ☐Pericarditis
☐Peritonitis ☐Pneumonia ☐Puerperal sepsis ☐Septic abortion
☐Septic arthritis ☐Streptococcal toxic-shock syndrome (STSS) ☐Unknown

Bacterial species isolated from any normally sterile site:

☐Bacterial meningitis, other ☐Group A Streptococcus, invasive ☐Group B Streptococcus, invasive
☐Haemophilus influenzae, invasive ☐Listeria monocytogenes ☐Neisseria meningitides, invasive
☐Strep. pneumoniae, drug-res. invasive ☐Streptococcal disease, invasive, other ☐Streptococcal toxic-shock syndrome
☐Streptococcus pneumoniae, invasive ☐Streptococcus pneumoniae, invasive disease (IPD)

Date first positive culture obtained: __ __ / __ __ /__ __ __ __

Sterile sites from which organism isolated:

☐Amniotic fluid (pre-birth) ☐Blood ☐Bone ☐CSF ☐Internal body site ☐Joint
☐Muscle ☐Other, specify: _____ ☐Pericardial fluid ☐Peritoneal fluid ☐Placenta (pre-birth) ☐Pleural fluid

Nonsterile sites from which organism isolated:

☐Amniotic fluid (delivery/post-birth) ☐Middle ear ☐Placenta (delivery/post-birth) ☐Sinus ☐Wound ☐Other, specify: _____

Did the patient have any underlying conditions? ☐No ☐Unknown ☐Yes

If yes, underlying conditions:

☐AIDS	☐Alcohol abuse	☐Asthma
☐Atherosclerotic Cardiovascular Disease (CAD)	☐Burns	☐Cerebral Vascular Accident (CVA)/Stroke
☐Cirrhosis/Liver failure	☐Cochlear implant	☐Complement deficiency
☐CSF Leak (2° trauma/surgery)	☐Current smoker	☐Deaf/Profound hearing loss
☐Diabetes Mellitus	☐Emphysema/COPD	☐Heart Failure/CHF
☐HIV	☐Hodgkin's disease	☐Immunoglobulin Deficiency
☐Immunosuppressive Therapy	☐IVDU	☐Leukemia
☐Multiple Myeloma	☐Nephrotic Syndrome	☐None
☐Obesity	☐Organ transplant, specify:	☐Other malignancy, specify: _____
☐Other prior illness, specify: _____	☐Renal Failure/Dialysis	☐Sickle Cell Anemia
☐Splenectomy/Asplenia	☐Systemic Lupus Erythematosus (SLE)	☐Unknown

Did the patient die from this illness or did IPD contribute to death? ☐No ☐Unknown ☐Yes

What was the serogroup?
☐A ☐B ☐C ☐H ☐I ☐K ☐L ☐W135 ☐X ☐Y ☐Z ☐Z(29E) ☐Not groupable ☐Unknown ☐Other (specify)

How was the case identified?
☐Clinical purpura fulminans ☐Culture from other sterile site (specify) ☐Gram negative diplococcic (sterile site) ☐Isolation of N. meningitidis from blood ☐Isolation of N. meningitidis from CSF ☐N.meningitidis antigen by IHC ☐N. meningitidis DNA by PCR ☐Other (specify) ☐Positive meningococcal antigen test in CSF

If case identified by non-culture method, date sample collected for diagnostic testing: __ __ / __ __ /__ __ __ __
Is this a secondary case? ☐No ☐Unknown ☐Yes
If *N. meningitidis* was isolated from blood or CSF, was it resistant to:
Sulfa: ☐No ☐Unknown ☐Yes
Rifampin: ☐No ☐Unknown ☐Yes
Is patient currently attending college? (15-24 years only) ☐No ☐Unknown ☐Yes

VACCINE INFORMATION

Has patient received the polysaccharide meningococcal vaccine? ☐No ☐Unknown ☐Yes
Has patient received the conjugate meningococcal vaccine? ☐No ☐Unknown ☐Yes
If yes for either, please enter dosage data in the Vaccination Record

VACCINE RECORD

Must be added via the Events Tab, add new Vaccinations feature after investigation is submitted.

Vaccination Record 1: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination: _____ ☐years ☐months
Vaccine Administered (*Select*): ☐meningococcal A, C, Y, W-135 diphtheria conjugate ☐Meningococcal C conjugate
☐Meningococcal conjugate, MCV4 (Menactra) ☐Meningococcal oligosaccharide, MCV40 (Menomune)
☐Meningococcal polysaccharide, MPSV4 ☐Meningococcal, NOS

Vaccination Record 2: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination: _____ ☐years ☐months
Vaccine Administered (*Select*): ☐meningococcal A, C, Y, W-135 diphtheria conjugate ☐Meningococcal C conjugate
☐Meningococcal conjugate, MCV4 (Menactra) ☐Meningococcal oligosaccharide, MCV40 (Menomune)
☐Meningococcal polysaccharide, MPSV4 ☐Meningococcal, NOS

Vaccination Record 3: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination: _____ ☐years ☐months
Vaccine Administered (*Select*): ☐meningococcal A, C, Y, W-135 diphtheria conjugate ☐Meningococcal C conjugate
☐Meningococcal conjugate, MCV4 (Menactra) ☐Meningococcal oligosaccharide, MCV40 (Menomune)
☐Meningococcal polysaccharide, MPSV4 ☐Meningococcal, NOS

Vaccination Record 4: Date Administered: __ __ / __ __ /__ __ __ __ Age at Vaccination: _____ ☐years ☐months
Vaccine Administered (*Select*): ☐meningococcal A, C, Y, W-135 diphtheria conjugate ☐Meningococcal C conjugate
☐Meningococcal conjugate, MCV4 (Menactra) ☐Meningococcal oligosaccharide, MCV40 (Menomune)
☐Meningococcal polysaccharide, MPSV4 ☐Meningococcal, NOS

Record additional pneumococcal vaccinations at end of investigation and enter into ALNBS.

EPIDEMIOLOGIC

If < 6 years of age, is the patient in daycare (supervised group of ≥ 2 unrelated children for > 4 hours/week)? ☐No ☐Unknown ☐Yes

If yes, Day Care Facility: _____

Was the patient a resident of a nursing home or other chronic care facility at the time of first positive culture? ☐No ☐Unknown ☐Yes

If yes, Chronic Care Facility: _____

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name: _____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General Comments: _____

_____

_____

CUSTOM FIELDS

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor): _____

Prophylaxed Contacts

Number of prophylaxed contacts: _____

CONDITION SPECIFIC CUSTOM FIELDS

Was patient diagnosed with purpura fulminations? ☐No ☐Unknown ☐Yes

Was isolate sent to the state laboratory for determination of serogrouping: ☐No ☐Unknown ☐Yes

Date sent: __ __ / __ __ /__ __ __ __

PHEP PROJECT - GENERAL

Date of presumptive diagnosis: __ __ / __ __ /__ __ __ __

Method of initial report to Public Health: ☐ELR ☐Email ☐Fax ☐Mail ☐Online REPORT card ☐Phone

Which reporter type (or designee) provided initial report to Public Health?: ☐Day care director ☐Dentist ☐Physician ☐Hospital administrator ☐Lab director ☐Medical examiner ☐Nurse ☐Nursing home administrator ☐Other state health department or CDC ☐Patient/family ☐School principal

PHEP PROJECT - CONTROL MEASURES IMPLEMENTED (Answer all)

Date first control measures initiated: __ __ / __ __ /__ __ __ __ Other measures: _____

Education case/contacts:	☐No	☐Unk	☐Yes	☐N/A	Exclusions from foodhandling:	☐No ☐Unk ☐Yes ☐N/A	
Exclusions from healthcare:	☐No	☐Unk	☐Yes	☐N/A	Exclusions from daycare/school:	☐No ☐Unk ☐Yes ☐N/A	
Immunization:	☐No	☐Unk	☐Yes	☐N/A	Prophylaxis:	☐No ☐Unk ☐Yes ☐N/A	
Identification of exposed individuals:	☐No	☐Unk	☐Yes	☐N/A	Identification of additional cases:	☐No ☐Unk ☐Yes ☐N/A	
Identification of likely source of infection:	☐No	☐Unk	☐Yes	☐N/A	Collection of food:	☐No ☐Unk ☐Yes ☐N/A	

Notify state/federal partner agencies/organizations: ☐No ☐Unknown ☐Yes ☐N/A

Human Infection with Novel Influenza A Virus Case Report Form

Form Approved
OMB No. 0920-0004

State: _____ Date reported to health department: ___/___/_____ (MM/DD/YYYY) Date interview completed: ___/___/_____ (MM/DD/YYYY)

State Epi ID:_____ State Lab ID: _____

Household ID (*CDC use only*):_____CDC ID (*CDC use only*):_____ Cluster ID (*CDC use only*):_____

1. At the time of this report, is the case
   ☐ Confirmed ☐ Probable ☐ Case under investigation (skip to Q.3) ☐ Not a case (skip to Q.3)
2. What is the subtype?
   ☐ Influenza A(H1N1) **variant** ☐ Influenza A(H1N2) **variant** ☐ Influenza A(H3N2) **variant** ☐ Influenza A(H5N1)
   ☐ Influenza A(H7N9) ☐ Other _____ ☐ Unknown

Demographic Information

3. Date of birth: _____/_____/_____ (MM/DD/YYYY)
4. Country of usual residence: _____ If usual resident of U.S., county of residence: _____
5. Race: (check all that apply) ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander
6. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
7. Sex: ☐ Male ☐ Female

Symptoms, Clinical Course, Treatment, Testing, and Outcome

8. What date did symptoms associated with this illness start? _____/_____/_____ (MM/DD/YYYY)
9. During this illness, did the patient experience any of the following?

Symptom	Symptom Present?	Symptom	Symptom Present?
Fever (highest temp _____ °F)	☐ Yes ☐ No ☐ Unk	Shortness of breath	☐ Yes ☐ No ☐ Unk
If fever present, date of onset ___/___/____ (MM/DD/YYYY)		Vomiting	☐ Yes ☐ No ☐ Unk
Felt feverish	☐ Yes ☐ No ☐ Unk	Diarrhea	☐ Yes ☐ No ☐ Unk
If felt feverish, date of onset ___/___/____ (MM/DD/YYYY)		Eye infection/redness	☐ Yes ☐ No ☐ Unk
Cough	☐ Yes ☐ No ☐ Unk	Rash	☐ Yes ☐ No ☐ Unk
Sore Throat	☐ Yes ☐ No ☐ Unk	Fatigue	☐ Yes ☐ No ☐ Unk
Muscle aches	☐ Yes ☐ No ☐ Unk	Seizures	☐ Yes ☐ No ☐ Unk
Headache	☐ Yes ☐ No ☐ Unk	Other, specify	☐ Yes ☐ No ☐ Unk

10. Does the patient still have symptoms?
    ☐ Yes (skip to Q.12) ☐ No ☐ Unknown (skip to Q.12)
11. When did the patient feel back to normal? _____/_____/_____ (MM/DD/YYYY)
12. Did the patient receive any medical care for the illness?
    ☐ Yes ☐ No (skip to Q.29) ☐ Unknown (skip to Q.29)
13. Where and on what date did the patient seek care (check all that apply)?
    ☐ Doctor's office **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Emergency room **date**:_____/_____/_____ (MM/DD/YYYY)
    ☐ Urgent care clinic **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Health department **date**:_____/_____/_____ (MM/DD/YYYY)
    ☐ Other _____ **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Unknown
14. Was the patient hospitalized for the illness?
    ☐ Yes ☐ No (skip to Q.23) ☐ Unknown (skip to Q.23)
15. Date(s) of hospital admission? **First admission date:**___/___/____ (MM/DD/YYYY) **Second admission date:**___/___/____ (MM/DD/YYYY)
16. Was the patient admitted to an intensive care unit (ICU)?
    ☐ Yes ☐ No (skip to Q.18) ☐ Unknown (skip to Q.18)
17. Date of **ICU admission:** _____/_____/_____ (MM/DD/YYYY) Date of **ICU discharge:** _____/_____/_____ (MM/DD/YYYY)
18. Did the patient receive mechanical ventilation / have a breathing tube?
    ☐ Yes ☐ No (skip to Q.20) ☐ Unknown (skip to Q.20)
19. For how many days did the patient receive mechanical ventilation or have a breathing tube? _____ days
20. Was the patient discharged?
    ☐ Yes ☐ No (skip to Q.23) ☐ Unknown (skip to Q.23)
21. Date(s) of hospital discharge? **First discharge date:**___/___/____ (MM/DD/YYYY) **Second discharge date:**___/___/____ (MM/DD/YYYY)
22. Where was the patient discharged?
    ☐ Home ☐ Nursing facility/rehab ☐ Hospice ☐ Other _____ ☐ Unknown
23. Did the patient have a new abnormality on chest x-ray or CAT scan?
    ☐ No, x-ray or scan was normal ☐ Yes, x-ray or scan detected new abnormality ☐ No, chest x-ray or CAT scan not performed ☐ Unknown

24. Did the patient receive a diagnosis of pneumonia?
☐ Yes ☐ No ☐ Unknown

25. Did the patient receive a diagnosis of ARDS?
☐ Yes ☐ No ☐ Unknown

26. Did the patient have leukopenia (white blood cell count <5000 leukocytes/mm^3) associated with this illness?
☐ Normal ☐ Abnormal ☐ Test not performed ☐ Unknown

27. Did the patient have lymphopenia (total lymphocytes <800/mm^3 or lymphocytes <15% of WBC) associated with this illness?
☐ Normal ☐ Abnormal ☐ Test not performed ☐ Unknown

28. Did the patient have thrombocytopenia (total platelets <150,000/mm^3) associated with this illness?
☐ Normal ☐ Abnormal ☐ Test not performed ☐ Unknown

29. Did the patient experience any other complications as a result of this illness? ☐ Yes (please describe below) ☐ No ☐ Unknown

_____

_____

30. Did the patient receive influenza antiviral medications prior to becoming ill (within 2 weeks) or after becoming ill?
☐ Yes, (please complete table below) ☐ No ☐ Unknown

Drug	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antivirals	Dosage (if known)
Oseltamivir (Tamiflu)				mg
Zanamivir (Relenza)				mg
Other influenza antiviral_____				mg

31. Did the patient die as a result of this illness?
☐ Yes, **Date of death**:_____/_____/_____ (MM/DD/YYYY) ☐ No ☐ Unknown

Influenza Testing

32. When was the specimen collected that indicated novel influenza A virus infection by Reverse Transcription-Polymerase Chain Reaction (RT-PCR)? _____/_____/_____ (MM/DD/YYYY)

33. Where was the specimen collected? ☐ Doctor's office ☐ Hospital ☐ Emergency room ☐ Urgent care clinic ☐ Health department
☐ Other _____ ☐ Unknown

34. Was a rapid influenza diagnostic test (RIDT) used on any respiratory specimens collected?
☐ Yes ☐ No (skip to Q.38) ☐ Unknown (skip to Q.38)

35. When was the RIDT specimen collected? _____/_____/_____ (MM/DD/YYYY)

36. What was the result? ☐ Influenza A ☐ Influenza B ☐ Influenza A/B (type not distinguished) ☐ Negative ☐ Other _____

37. What brand of RIDT was used? _____

Medical History -- Past Medical History and Vaccination Status

38. Does the patient have any of the following chronic medical conditions? Please specify **ALL** conditions that qualify.

a. Asthma/reactive airway disease ☐ Yes ☐ No ☐ Unknown
b. Other chronic lung disease ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
c. Chronic heart or circulatory disease ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
d. Diabetes mellitus ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
e. Kidney or renal disease ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
f. Non-cancer immunosuppressive condition ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
g. Cancer chemotherapy in past 12 months ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
h. Neurologic/neurodevelopmental disorder ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
i. Other chronic diseases ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____

39. Does the patient frequently use a stroller or wheelchair? If yes, please describe.
☐ Yes _____ ☐ No ☐ Unknown

40. Was patient pregnant or ≤6 weeks postpartum at illness onset?
☐ Yes, pregnant (weeks pregnant at onset)_____ ☐Yes, postpartum (delivery date) ___/___/____ (MM/DD/YYYY) ☐ No ☐ Unknown

41. Does the patient currently smoke?
☐ Yes ☐ No ☐ Unknown

42. Was the patient vaccinated against influenza in the past year?
☐ Yes ☐ No (skip to Q.45) ☐ Unknown (skip to Q.45)

43. Month and year of influenza vaccination? **Vaccination date 1:**____/_____ (MM/YYYY) **Vaccination date 2:**____/_____ (MM/YYYY)

44. Type of influenza vaccine (check all that apply): ☐ Inactivated (injection) ☐ Live attenuated (nasal spray) ☐ Unknown

Human Infection with Novel Influenza A Virus
Case Report Form

Epidemiologic Risk Factors

45. In the 7 days prior to illness onset, did the patient travel outside of his/her usual area? ☐ Yes ☐ No (skip to Q.48) ☐ Unknown (skip to Q.48)
46. When and where did the patient travel? **Please describe details of the patient's travel in the notes section at the end of the form.**
    Trip 1: Dates of travel: _____/_____/_____ to _____/_____/_____ Country _____ State _____ City/County_____
    Trip 2: Dates of travel: _____/_____/_____ to _____/_____/_____ Country _____ State _____ City/County_____
47. Did the patient travel in a group (check all that apply)?
    ☐ No, travelled alone ☐ Yes, with household members ☐ Yes, with non-household members ☐ Unknown

Risk Factors—Domestic and Agricultural Animals

48. In the 7 days before becoming ill, did the patient attend an agricultural fair/event or live animal market?
    ☐ Yes (specify name, if >1 fair, please describe in the notes section _____) ☐ No (skip to Q.50) ☐ Unknown (skip to Q.50)
49. In the 7 days before becoming ill, on what days did the patient attend an agricultural fair/event or live animal market (check all that apply)?
    ☐ on the day of illness onset ☐ 1 day before illness onset ☐ 2 days before illness onset ☐ 3 days before illness onset
    ☐ 4 days before illness onset ☐ 5 days before illness onset ☐ 6 days before illness onset ☐ 7 days before illness onset
50. In the 7 days before becoming ill, did the patient have **DIRECT** contact with (touch or handle) any livestock animals like poultry or pigs?
    ☐ Yes ☐ No (skip to Q.53) ☐ Unknown (skip to Q.53)
51. What type(s) of animals did the patient have direct contact with (check all that apply)?
    ☐ Horses ☐ Cows ☐ Poultry/wild birds ☐ Sheep ☐ Goats ☐ Pigs/hogs ☐ Other_____
52. Where did the direct contact occur (check all that apply)?
    ☐ Home ☐ Work ☐ Agricultural fair or event ☐ Live animal market ☐ Petting zoo ☐Other_____
53. In the 7 days before becoming ill, did the patient have **INDIRECT** contact with (walk through an area containing or come within 6 feet of) any livestock animals?
    ☐ Yes ☐ No (skip to Q.56) ☐ Unknown (skip to Q.56)
54. What type(s) of animals did the patient have indirect contact with (check all that apply)?
    ☐ Horses ☐ Cows ☐ Poultry/wild birds ☐ Sheep ☐ Goats ☐ Pigs/hogs ☐ Other_____
55. Where did the indirect contact occur (check all that apply)?
    ☐ Home ☐ Work ☐ Agricultural fair or event ☐ Live animal market ☐ Petting zoo ☐Other_____
56. In the 7 days before becoming ill, did the patient have direct or indirect contact with any animal exhibiting signs of illness?
    ☐ Yes (specify animal type and location _____) ☐ No ☐ Unknown

Please answer Q.57–58 if ANY contact (direct, indirect, or both) with pigs/hogs identified above. If no contact identified, please skip to Q.59.

57. In the 7 days before becoming ill, on what days did the patient have **ANY** contact (direct, indirect, or both) with pigs (check all that apply)?
    ☐ on the day of illness onset ☐ 1 day before illness onset ☐ 2 days before illness onset ☐ 3 days before illness onset
    ☐ 4 days before illness onset ☐ 5 days before illness onset ☐ 6 days before illness onset ☐ 7 days before illness onset
58. From Q. 57, what was the total number of different days the patient reported **ANY** pig contact (direct, indirect, or both)? _____ days
59. Does anyone else in the household own, keep or care for livestock animals?
    ☐ Yes ☐ No (skip to Q.61) ☐ Unknown (skip to Q.61)
60. What type(s) of animals are kept or cared for by household members (check all that apply)?
    ☐ Horses ☐ Cows ☐ Poultry/wild birds ☐ Sheep ☐ Goats ☐ Pigs/hogs ☐ Other_____

Risk Factors—Household, Occupational, Nosocomial, and Secondary Spread

61. Does the patient reside in an institutional or group setting (e.g. nursing home, boarding school, college dormitory)?
    ☐ Yes (skip to Q.63) ☐ No ☐ Unknown (skip to Q.63)
62. How many people resided in the patient's household(s) in the week before or after illness onset (excluding the patient)? _____
    A household member is anyone with at least one overnight stay +/- 7 days from patient's illness onset, and the patient may have resided in >1 household. Please complete the table below for each household member and continue in the notes section if more space is needed.

ID	Household (HH)	Relation to patient (e.g. parent, brother, friend)	Sex (M/F)	Age	Fever or any respiratory symptom +/– 7 days from case patient's onset?	Date of illness onset	If HH member **ILL**		If HH member **NOT ILL**
							Any pig/hog contact ≤7 days before his/her onset?	Attend agricultural fair ≤7 days before his/her onset?	Pig/hog contact or fair attendance ≤10 days before patient's onset?
1	☐A ☐B ☐C				☐Y ☐N ☐U		☐Y ☐N ☐U	☐Y ☐N ☐U	☐Y ☐N ☐U
2	☐A ☐B ☐C				☐Y ☐N ☐U		☐Y ☐N ☐U	☐Y ☐N ☐U	☐Y ☐N ☐U
3	☐A ☐B ☐C				☐Y ☐N ☐U		☐Y ☐N ☐U	☐Y ☐N ☐U	☐Y ☐N ☐U
4	☐A ☐B ☐C				☐Y ☐N ☐U		☐Y ☐N ☐U	☐Y ☐N ☐U	☐Y ☐N ☐U
5	☐A ☐B ☐C				☐Y ☐N ☐U		☐Y ☐N ☐U	☐Y ☐N ☐U	☐Y ☐N ☐U
6	☐A ☐B ☐C				☐Y ☐N ☐U		☐Y ☐N ☐U	☐Y ☐N ☐U	☐Y ☐N ☐U

63. In the 7 days before or after becoming ill, did the patient attend or work at a child care facility?
☐ Yes (before becoming ill) ☐ Yes (after becoming ill) ☐ No (skip to Q.65) ☐ Unknown (skip to Q.65)
64. Approximately how many children are in the patient's class or room at the child care facility? _____
65. In the 7 days before or after becoming ill, did the patient attend or work at a school?
☐ Yes (before becoming ill) ☐ Yes (after becoming ill) ☐ No (skip to Q.67) ☐ Unknown (skip to Q.67)
66. Approximately how many students are in the patient's class at the school? _____ children
67. In the 7 days before or after the patient became ill, did anyone else in the patient's household(s) work at or attend a child care facility or school?
☐ Yes ☐ No (skip to Q.69) ☐ Unknown (skip to Q.69)
68. List ID numbers from Q.62 (the table above) for household members working at or attending a child care facility or school:
_____
69. Does the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?
☐ Yes ☐ No ☐ Unknown
70. In the 7 days before or after becoming ill, did the patient work in or volunteer at a healthcare facility or setting?
☐ Yes ☐ No (skip to Q.73) ☐ Unknown (skip to Q.73)
71. Specify healthcare facility job/role:
☐ Physician ☐ Nurse ☐ Administration staff ☐ Housekeeping ☐ Patient transport ☐ Volunteer ☐ Other_____
72. Did the patient have direct patient contact while working or volunteering at a healthcare facility?
☐ Yes ☐ No ☐ Unknown
73. In the 7 days before becoming ill, was the patient in a hospital for any reason (i.e., visiting, working, or for treatment)?
☐ Yes ☐ No ☐ Unknown
If yes, what were the dates? ____/____/_____, ____/____/_____ City/Town _____
74. In the 7 days before becoming ill, was the patient in a clinic or a doctor's office for any reason?
☐ Yes ☐ No ☐ Unknown
If yes, what were the dates? ____/____/_____, ____/____/_____ City/Town _____
75. In the 7 days before becoming ill, did the patient have close contact (e.g. caring for, speaking with, or touching) with anyone **other than a household member** who routinely has contact with pigs/hogs?
☐ Yes ☐ No ☐ Unknown
76. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **in the 7 days BEFORE** the case patient's illness onset?
☐ Yes (**please list those ill before the case patient in the table below**) ☐ No ☐ Unknown

Relationship to patient	Sex (M/F)	Age	Date of illness onset	Any pig/hog contact or fair attendance ≤7 days before his/her onset?	Comments
				☐ Y ☐ N ☐ U	
				☐ Y ☐ N ☐ U	
				☐ Y ☐ N ☐ U	
				☐ Y ☐ N ☐ U	

77. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **beginning AFTER** the case patient's illness onset?
☐ Yes (**please list those ill after the case patient in the table below**) ☐ No ☐ Unknown

Relationship to patient	Sex (M/F)	Age	Date of illness onset	Any pig/hog contact or fair attendance ≤7 days before his/her onset?	Comments
				☐ Y ☐ N ☐ U	
				☐ Y ☐ N ☐ U	
				☐ Y ☐ N ☐ U	
				☐ Y ☐ N ☐ U	

78. Is the patient a contact of a confirmed or probable case of novel influenza A infection?
☐ Yes (**please list patient's confirmed or probable contacts in the table below**) ☐ No ☐ Unknown

Relationship to patient	State Epi ID	State Lab ID	Case status	Sex (M/F)	Age	Date of illness onset (MM/DD/YYYY)
			☐ Confirmed ☐ Probable			
			☐ Confirmed ☐ Probable			
			☐ Confirmed ☐ Probable			
			☐ Confirmed ☐ Probable			

79. Any additional comments or notes (e.g. travel details, names/dates of fairs attended by case patient, dates of household members fair attendance and location of fair, information about other ill contacts)?

This is the end of the case report form. Thank you very much for your time.
Please fax completed forms to 1.888.232.1322
If you have any questions please feel free to contact the Epidemiology and Prevention Branch at 404.639.3747.

Pertussis Surveillance Worksheet

NAME (Last, First) | Hospital Record No.

Address (Street and No.) | City | County | Zip | Phone

Reporting Physician/Nurse/Hospital/Clinic/LabPhone | Address | Phone

DETACH HERE and transmit only lower portion if sent to CDC

CDC NETSS id | **County** | **State** | **Zip**

Birth Date (Month, Day, Year)

Age (Unk= 999)

Age Type: 0 = 0-120 years; 1 = 0-11 months; 2 = 0-52 weeks; 3 = 0-28 days; 9 = Age Unknown

Race: N = Native Amer./Alaskan Native; A = Asian/Pacific Islander; B = African American; W = White; O = Other; U = Unknown

Ethnicity: H = Hispanic; N = Not Hispanic; U = Unknown

Sex: M = Male; F = Female; U = Unknown

Event Date (Month, Day, Year)

Event Type: 1 = Onset Date; 2 = Diagnosis Date; 3 = Lab Test Done; 4 = Reported to County; 5 = Reported to State or MMWR Report Date; 9 = Unknown

Outbreak Associated: 999 = Unknown

Reported (Month, Day, Year)

Report Status: 1 = Confirmed; 2 = Probable; 3 = Suspect; 9 = Unknown

CLINICAL DATA

Any Cough? (Y = Yes; N = No; U = Unknown) **Cough Onset** (Month, Day, Year)

Paroxysmal Cough? (Y = Yes; N = No; U = Unknown)

Whoop? (Y = Yes; N = No; U = Unknown)

Posttussive Vomiting? (Y = Yes; N = No; U = Unknown)

Apnea? (Y = Yes; N = No; U = Unknown)

Final Interview Date (Month, Day, Year)

Cough at Final Interview? (Y = Yes; N = No; U = Unknown)

Duration of Cough at Final Interview (Days) 0–150; 999 = Unknown

COMPLICATIONS

Chest X-ray for Pneumonia (P = Positive; N = Negative; X = Not Done; U = Unknown)

Seizures Due to Pertussis (Y = Yes; N = No; U = Unknown)

Acute Encephalopathy Due to Pertussis (Y = Yes; N = No; U = Unknown)

Hospitalized? (Y = Yes; N = No; U = Unknown)

Days Hospitalized? 0-998; 999 = Unknown

Died? (Y = Yes; N = No; U = Unknown)

TREATMENT

Were Antibiotics Given? (Y = Yes; N = No; U = Unknown)

1 = Erythromycin (incl. pediazole, ilosone); 2 = Cotrimoxazole (bactrim/septra); 3 = Clarithromycin/azithromycin; 4 = Tetracycline/Doxycycline; 5 = Amoxicillin/Penicillin/Ampicillin/Augmentin/Cector/Cefixime; 6 = Other; 9 = Unknown

Date Started First Antibiotic (Month, Day, Year)

Days First Antibiotic Actually Taken 0-998; 999 = Unknown

Second Antibiotic Received See Choices for First Antibiotic Given

Date Started Second Antibiotic (Month, Day, Year)

Days Second Antibiotic Actually Taken 0-998; 999 = Unknown

LABORATORY

Was Laboratory Testing for Pertussis Done? (Y = Yes; N = No; U = Unknown)

	Result	Date Specimen Taken (Month, Day, Year)
Culture		
DFA		
Serology 1		
Serology 2		
PCR		

RESULT CODES: P = Positive; N = Negative; E = Pending; I = Indeterminate; X = Not Done; S = Parapertussis; U = Unknown

VACCINE HISTORY

Vaccinated? (Received any doses of diphtheria, tetanus, and/or pertussis-containing vaccines) (Y = Yes; N = No; U = Unknown)

Vaccination Date (Month, Day, Year)	Vaccine Type*	Vaccine Manuf*	Lot Number

Vaccine Type Codes: W = DTP Whole Cell; A = DTaP; H = DaTaP-Hib; D = DT or Td; T = DTP-Hib; P = Pertussis Only; X = Tdap; V = DTaP-IPV-Hep B; N = DTaP-IPV-Hib; K = DTaP-IPV; O = Other; U = Unknown

Vaccine Manufacturer Codes: C = Sanofi Pasteur; L = Wyeth; S = GlaxoSmithKline; M = Massachusetts Health Department; I = Michigan Health Department; N = North American Vaccine; O = Other; U = Unknown

*Record for each dose

Date of Last Pertussis-Containing Vaccine Prior to Illness Onset (Month, Day, Year)

Number of Doses of Pertussis-Containing Vaccine Prior to Illness Onset 0-6; 9 = Unknown

Reason Not Vaccinated With ≥ 3 Doses of Pertussis Vaccine

1 = Religious Exemption; 2 = Medical Contraindication; 3 = Philosophical Exemption; 4 = Previous Pertussis Confirmed by Culture or MD; 5 = Parental Refusal; 6 = Age Less Than 7 Months; 7 = Other; 9 = Unknown

EPIDEMIOLOGIC INFORMATION

Date First Reported to a Health Department (Month, Day, Year)

Date Case Investigation Started (Month, Day, Year)

Outbreak Related? (Y = Yes; N = No; U = Unknown)

Epi-Linked? (Y = Yes; N = No; U = Unknown)

Outbreak Name (Name of outbreak this case is associated with)

If patient <12 months old:

What was the mother's age at infant's birth: _____

What was the weight of the infant at birth:

_____ lb _____ oz *OR* _____ kg _____ g

Transmission Setting (Where did this patient acquire pertussis)?

1 = Day Care; 2 = School; 3 = Doctor's Office; 4 = Hospital Ward; 5 = Hospital ER; 6 = Hosp. Outpatient Clinic; 7 = Home; 8 = Work; 9 = Unknown; 10 = College; 11 = Military; 12 = Correctional Facility; 13 = Church; 14 = International Travel; 15 = Other

Setting (Outside Household) of Further Documented spread From This Case

Use same codes as for Transmission Settings, except: 7 = >1 Setting Outside Household; 16 = No Documented Spread Outside Household

Number of Contacts in Any Setting Recommended Antibiotics 0-998; 999 = Unknown

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The information below is epidemiologically imporant, but not included on NETSS screens.

Age of the person from whom this patient contracted pertussis	Age	Age Type
	☐☐☐ 999 = Unknown	☐ 0 = 0-120 years, 1 = 0-11 months, 2 = 0-52 weeks, 3 = 0-28 days, 9 = Age unknown

Setting	In which setting was pertussis acquired? (Please specify)	In which setting was there secondary spread? (Please specify)
Day Care		
School		
Doctor's Office		
Hospital (Ward/Outpatient/Clinic)		
Home		
Travel (International/ Domestic)		
Other		
Unknown		

Name of Contact	Birthdate	Relation to Case-Patient	Case?	Case ID#	Cough Onset Date (If Present)	# of PCVs*	Date of Last PCV	Parent's Name and Phone # (If Applicable)

**PCV=Pertussis-Containing Vaccine*

Comments

Clinical Case Definition*:
A cough illness lasting ≥ 2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop", or posttussive vomiting, without apparent cause

Case Classification*:

Probable: **A case that meets the clinical cas definition, is not laboratory confirmed, and is not epidemiologically linked to a laboratory-confirmed case.**

Confirmed: **1) A case that is culture positive, and in which an acute illness of any duration is present, or**
2) a case that meets the clinical case definition and is confirmed by PCR, or
3) a case that meets the clinical case definition and is epidemiologically linked directly to a case confirmed by either culture or PCR.

***CDC Case Definitions for Infectious Conditions Under Public Health Surveillance. MMWR 1997;46 (No. RR-10):39**

Case ID:_____ First Name:_____ Last Name:_____

Psittacosis Human Case Surveillance Report

Return to CDFax@ADPH.state.AL.US or 334-206-3734

Investigation Information			
Report Date ____/____/_____ MM/DD/YYYY	**Patient Status** □ Inpatient □ Outpatient □ Deceased	**Diagnosis Date** ____/____/_____ MM/DD/YYYY	**Onset Date** ____/____/_____ MM/DD/YYYY

Patient Information			
Patient ID	**Last**	**First**	**Middle**
Street Address			
City	**County**	**State**	**Zip**
Home Phone (Ext.) ###-###-####	**Current Occupation**	**Other Phone □ Work / Business □ Cell** ###-###-####	**Ext.**

Parent/Guardian (if patient < 18yr.)		
Last	**First**	**Middle**

Demographics		
Gender □ Male □ Female □ Unknown	**Date of Birth** ____/____/_____ MM/DD/YYYY	**Age □ Years □ Months**

Race
□ Caucasian □ African America □ American Indian/Alaska Native □ Hawaiian/Pacific Islander □ Asian
□ Unknown □ Other (Specify)_____

Ethnicity
□ Hispanic/Latino □ Non-Hispanic/Latino □ Unknown

If female, pregnant? □ Yes □ No

Report Information				
Person Providing Report				
First	**Last**	**Phone** ###-###-####	**Ext.**	**Email**
City	**County**	**State**	**Zip**	**City**
Primary Physician				
First	**Last**	**Phone** ###-###-####	**Ext.**	**Email**
Street Address				
City	**County**	**State**	**Zip**	

Case ID:_____ First Name:_____ Last Name:_____

Clinical Information

Brief clinical description (Symptoms and signs, note maximum temperature, etc.)

□ Fever; Maximum temperature: _____□ F □ C
□ Cough □ Pneumonia (□ **CXR confirmed or** □ **clinical diagnosis)**
□ Myalgia □ Rash
□ Chills □ Photophobia
□ Headache □ Other (describe/details):

Underlying Medical Conditions:

□ CSF leak	□ Hodgkin's disease	□ IVDU
□ Alcohol abuse	□ Asthma	□ Atherosclerotic cardiovascular disease (ASCVD)/CAD
□ Burns	□ Cerebral vascular accident (CVA) stroke	□ Chronic GI illness/diarrhea
□ Cirrhosis/liver failure	□ Cochlear implant	□ Current smoker
□ Deaf/profound hearing loss	□ Diabetes mellitus (insulin):□No □Unk □Yes	□ Emphysema/COPD
□ Gastric surgery (type): _____	□ Heart failure	□ Hematologic disease (type): _____
□ Immunodeficiency (type): _____	□ Immunoglobulin deficiency	□ Immunosuppressive therapy (steroids, chemotherapy)
□ Leukemia	□ Multiple myeloma	□ Nephrotic Syndrome
□ None	□ Organ transplant (organ): _____	□ Other liver disease (type): _____
□ Other malignancy (type): _____	□ Other prior illness (type): _____	□ Other renal disease (type): _____
□ Peptic ulcer	□ Renal failure/dialysis	□ Sickle cell anemia
□ Splenectomy/asplenia	□ Systemic lupus erythematosus (SLE)	□ Unknown

Specific therapy: (Specify products, dosage, and dates of treatment)

Outcome:	**If the patient died, date of death:**
□ Hospitalized □ Required ICU care □ Recovered □ Unknown Date of discharge: ____/____/____ MM/DD/YYYY	____/____/____ MM/DD/YYYY

Laboratory Information

Test Name/Test Method	Date Specimen Collected MM/DD/YYYY	Test Result	Name of Laboratory
PCR *(preferred)* □ blood □ sputum □ other (specify): _____	____/____/_____		
Respiratory secretions culture *(preferred)* □ sputum □ BAL □ other (specify): _____	____/____/_____		
Fourfold increase in antibody titer **Acute-phase serum** □ CF □ MIF **Convalescent-phase serum** **□ CF □ MIF**	____/____/_____ ____/____/____	**IgM:**_____ **IgG:** _____	
Autopsy **□ lung** **□ other:** _____	____/____/_____		

Chest X-ray done:	**If yes, date:**	**If yes, results:**
□ Yes □ No □ Unknown	____/____/_____ MM/DD/YYYY	

Case ID:_____ First Name:_____ Last Name:_____

Epidemiologic Information

Occupation at date of onset:	**Specific duties:**

At the time of exposure which of the following personal protective equipment was in place?

□ Respiratory Protective Equipment: □ Surgical Mask □ N95 □ N99 □ N100
□ Gloves
□ Rubber boots/disposable overshoes
□ Disposable surgical cap
□ Overalls □ Other (describe/details):

Indicate which of the following contacts the patients had during the 5 weeks prior to onset:
(Check all that apply)

□ Birds □ Human case of Psittacosis (specify)_____
□ Other (specify) _____ □ No known exposure

If exposure to birds, complete following table:

Type of Bird	**Species**	**Approximate number**	**Were birds healthy?** (Y=Yes N=No UNK=Unknown)
Psittacines*			
Pigeons			
Domestic Fowl			
Other birds			

If birds were not healthy, please elaborate:

*Psittacine birds include: Cockatoos, Cockatiels, Macaws, Parakeets, Conuers, Parrots

Epidemiologic Information cont.

Indicate where the exposure occurred. If the patient had multiple contacts, specify to what they were exposed at each place of exposure.

Type of Establishment	**Owner of Establishment**	**Address of Establishment**	**Exposure To (Species)**	**Exposure setting**	**Date of Exposure**
1=Private home 2=Private aviary 3=Commercial aviary 4=Pet shop 5=Pigeon loft 6=Poultry establishment 7=Bird fair/show 8=Backyard poultry 9=Healthcare 10=Long term/Nursing Home 11=Swap meet 12=Other 13=Unknown				I=Indoors O=outdoors	

If other, specify:

If pet birds, domestic pigeons, or fowl are implicated as the source of the human psittacosis, or if any such bird is shown by laboratory methods to be infected, it is important to learn where these birds originated and where they were subsequently purchased or obtained by the present owner. These birds may have acquired a latent form of the infection at any place where they have been detained since hatching.

List the address of every known place where the birds were harbored, including approximate dates.

Case ID:_____ First Name:_____ Last Name:_____

Additional Relevant Information		
Submitted by:	**Date:** ____/____/_____ MM/DD/YYYY	**Health Depart.**
Phone number: ###-###-#####	**Ext.**	

Return to CDFax@ADPH.state.AL.US or 334-206-3734

Q FEVER, ACUTE OR CHRONIC INVESTIGATION FORM

Dates

Onset	Physician Date	ER Visit	Hsp Admit	Rep to Area/County
__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __

Basic Demographic Data

Last Name: _____ First Name:_____

Middle Name:_____ Suffix: _____

DOB: __ __/__ __/__ __ __ __ Age: _____ □ month / □ years Current Sex: □ Female □ Male □ Unknown

Street Address 1: _____

Street Address 2: _____

City: _____ State:_____

Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____

Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Cell Phone: (__ __ __) -- __ __ __ - __ __ __ __

Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __ Message: (__ __ __) -- __ __ __ - __ __ __ __

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race : □ Unknown □ American Indian or Alaska Native □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Investigation Summary

Investigation Start Date: __ __/__ __/__ __ __ __ Investigation Status: □ Open □ Closed

Investigator:_____ Date assigned: __ __/__ __/__ __ __

Reporting Source

Date of Report: __ __/__ __/__ __ __ __

Reporting Source:_____

Earliest Date Reported to: County: __ __/__ __/__ __ __ __ State: __ __/__ __/__ __ __ __

Reporter:_____

Clinical

Physician's Name:_____ Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Was patient hospitalized for this illness? □ No □ Unknown □ Yes

If yes: Hospital Name:_____

Admission Date : __ __/__ __/__ __ __ __ Discharge Date: __ __/__ __/__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __/__ __/__ __ __ __ Illness Onset Date: __ __/__ __/__ __ __ __

Illness End Date: __ __/__ __/__ __ __ __ Illness Duration: ____ Circle: days/hrs./minutes/months/unknown/weeks/years

Age at Onset: _____ Circle: days/hrs./minutes/months/unknown/weeks/years

Is the patient pregnant?	No	Unknown	Yes		
Does the patient have pelvic inflammatory disease?	No	Unknown	Yes		

Did the patient die from this illness? □ No □ Unknown □ Yes Date of Death: __ __/__ __/__ __ __ __

Epidemiologic

Is this patient associated with a day care facility?	No	Unknown	Yes	Is this patient a food handler?	No	Unknown	Yes
Is this case part of an outbreak?	No	Unknown	Yes	If yes, outbreak name:			

Where was the disease acquired?

Indigenous within jurisdiction	Out of Country	Out of jurisdiction, from another jurisdiction
Out of state	Unknown	

If the answer is out of Country, Jurisdiction, or State, where was it acquired?

Imported Country:	Imported State:
Imported City:	Imported County:

Transmission Mode

Airborne	Bloodborne	Dermal	Foodborne	Indeterminate	Mechanical
Nosocomial	Sexually Transmitted	Vectorborne	Waterborne	Zoonotic	Other

Confirmation Method

Active Surveillance	Case Outbreak Investigation	Clinical Diagnosis	Epidemiologically Linked
Laboratory Confirmed	Laboratory Report	Local/State Specified	Medical Record Review
No information given	Occupational Disease Surveillance	Provider Certified	Other

Confirmation Date: __ __ / __ __ / __ __ __ __
CASE STATUS (Required for Notification) ☐ **Confirmed** ☐ **Not a Case** ☐ **Probable** ☐ **Suspect** ☐ **Unknown**
MMWR Week: _____ **MMWR Year:** _____

Administrative

General Comments:_____

_____

Custom Fields

Date Due: __ __ / __ __ / __ __ __ __ Investigation ready for Supervisor review:_____

Date investigation ready for supervisor review: __ __ / __ __ / __ __ __ __

Condition Specific Custom Fields

Does the physician feel the patient has Q Fever? ☐ No ☐ Unknown ☐ Yes

Is/was the patient pregnant? ☐ No ☐ Unknown ☐ Yes If yes, did fetal death/abortion occur due to Q Fever? ☐ No ☐ Unknown ☐ Yes

Clinical

Fever: ☐ No ☐ Unknown ☐ Yes Highest Temp: _____°F

Retrobulbar Headache (behind eyes): ☐ No ☐ Unknown ☐ Yes

Confusion: ☐ No ☐ Unknown ☐ Yes

Fatigue: ☐ No ☐ Unknown ☐ Yes

Night-sweats: ☐ No ☐ Unknown ☐ Yes

Dyspnea: ☐ No ☐ Unknown ☐ Yes

Chest Pain: ☐ No ☐ Unknown ☐ Yes

Non-productive cough: ☐ No ☐ Unknown ☐ Yes

Nausea: ☐ No ☐ Unknown ☐ Yes

Vomiting: ☐ No ☐ Unknown ☐ Yes

Abdominal Pain: ☐ No ☐ Unknown ☐ Yes

Diarrhea: ☐ No ☐ Unknown ☐ Yes

Were the following manifestations of Acute Q-Fever diagnosed:

1. acute hepatitis? — 1. ☐ No ☐ Unknown ☐ Yes
2. atypical pneumonia with abnormal radiograph? — 2. ☐ No ☐ Unknown ☐ Yes
3. meningoencephalitis? — 3. ☐ No ☐ Unknown ☐ Yes

Were the following manifestations of Chronic Q-Fever diagnosed:

1. infection lasting > 6 months? — 1. ☐ No ☐ Unknown ☐ Yes
2. infection of aneurysm? — 2. ☐ No ☐ Unknown ☐ Yes
3. infection of vascular protheses? — 3. ☐ No ☐ Unknown ☐ Yes
4. suspect vascular aneurysm infection? — 4. ☐ No ☐ Unknown ☐ Yes
5. suspect vascular prosthesis infection? — 5. ☐ No ☐ Unknown ☐ Yes
6. acute, culture-neg. endocarditis? — 6. ☐ No ☐ Unknown ☐ Yes
7. osteomyelitis of unknown etiology? — 7. ☐ No ☐ Unknown ☐ Yes
8. chronic hepatitis of unknown etiology? — 8. ☐ No ☐ Unknown ☐ Yes
9. pneumonitis of unknown etiology? — 9. ☐ No ☐ Unknown ☐ Yes

Exposure History

Has the patient been exposed to:

goats? ☐ No ☐ Unknown ☐ Yes sheep? ☐ No ☐ Unknown ☐ Yes other livestock? ☐ No ☐ Unknown ☐ Yes

If yes, did exposure occur during parturition (birthing)? ☐ No ☐ Unknown ☐ Yes

Laboratory Information

Did the patient have:

Leukocytosis (high WBCs)? ☐ No ☐ Unknown ☐ Yes

Thrombocytopenia (low platelets)? ☐ No ☐ Unknown ☐ Yes

Elevated hepatic transaminase levels? ☐ No ☐ Unknown ☐ Yes _____ ALT / _____ AST

CONFIRMATORY:

1. 4-fold IgG titer increase to *C. burnetii* phase II antigen between acute and convalescent serum by IFA — 1. ☐ No ☐ Unknown ☐ Yes
2. *C. burnetii* DNA detected by PCR — 2. ☐ No ☐ Unknown ☐ Yes
3. *C. burnetii* demonstrated in a clinical specimen by IHC — 3. ☐ No ☐ Unknown ☐ Yes
4. Positive culture (*C. burnetii* organism isolated) — 4. ☐ No ☐ Unknown ☐ Yes
5. Elevated IgG titer (≥1:800) to phase I antigen by IFA (phase I titer > phase II titer if both available) — 5. ☐ No ☐ Unknown ☐ Yes

SUPPORTIVE:

1. Single elevated IgG titer (≥1:128) to phase II antigen by IFA — 1. ☐ No ☐ Unknown ☐ Yes
2. Elevated IgG or IgM by EIA, ELISA, dot-ELISA, or LA. — 2. ☐ No ☐ Unknown ☐ Yes
3. IgG titer to phase I antigen ≥1:128 but <1:800 by IFA. — 3. ☐ No ☐ Unknown ☐ Yes

KEY: EIA/ELISA = Enzyme (-linked) Immuno(absorbent) Assay; IFA = Immunoflorescent Antibody; IHC = Immunohistochemical (methods); LA = Latex Agglutination; PCR = Polymerase Chain Reaction.

Case Classification		
1	For Acute Q-Fever, did the patient have fever (≥100.4°F)?	□ No □ Unknown □ Yes
2	For Acute Q-Fever, did the patient have at least one of the following? □ Rigors □ Acute Hepatitis □ Pneumonia □ Elevated Liver Enzymes □ Severe Retrobulbar Headache (behind the eyes)	□ No □ Unknown □ Yes
3	For Acute Q-Fever, was at least one of the following confirmatory laboratory results demonstrated? □ 4-fold IgG titer increase to *C. burnetii* phase II antigen between acute and convalescent serum by IFA; □ *C. burnetii* DNA detected by PCR; □ *C. burnetii* demonstrated in a clinical specimen by IHC; and/or □ Positive culture (*C. burnetii* organism isolated).	□ No □ Unknown □ Yes
4	For Acute Q-Fever, was at least one of the following supportive laboratory results demonstrated? □ Single elevated IgG titer (≥1:128) to phase II antigen by IFA; and/or □ Elevated phase II IgG or IgM by EIA, ELISA, dot-ELISA, or LA.	□ No □ Unknown □ Yes
5	For Acute Q-Fever, is the patient epi-linked to a laboratory confirmed case of Acute Q-Fever?	□ No □ Unknown □ Yes
6	For Chronic Q-Fever, did the patient have at least one of the following? □ Acute, culture-negative endocarditis; □ Suspect vascular aneurysm or vascular prosthesis infection; and/or □ Chronic hepatitis, osteomyelitis, osteoarthritis, or pneumonitis with unknown etiology.	□ No □ Unknown □ Yes
7	For Chronic Q-Fever, was at least one of the following confirmatory laboratory results demonstrated? □ Elevated IgG titer (≥1:800) to phase I antigen by IFA (phase I titer > phase II titer if both available); □ *C. burnetii* DNA detected by PCR; □ *C. burnetii* demonstrated in a clinical specimen by IHC; and/or □ Positive culture (*C. burnetii* organism isolated).	□ No □ Unknown □ Yes
8	For Chronic Q-Fever, was the following supportive laboratory result demonstrated? □ IgG titer to phase I antigen ≥1:128 but <1:800 by IFA.	□ No □ Unknown □ Yes

ACUTE Q-FEVER:	**Confirmed:**	**1, 2, & 3**	**or**	**3 & 5**	**Probable: 1, 2, & 4**
CHRONIC Q-FEVER:	**Confirmed:**	**6 & 7**			**Probable: 6 & 8**

HUMAN RABIES INVESTIGATION FORM

STOP: PRIOR TO CREATING THIS INVESTIGATION, YOU MUST NOTIFY & CONSULT WITH CENTRAL OFFICE (800) 338-8374 (24-HOUR COVERAGE)

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Weight: _____lbs _____oz OR _____kg OR ☐Unknown

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

SYMPTOMS

Did the patient have:

Fever: ☐No ☐Unknown ☐Yes (Temp_____) Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Headache: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Weakness: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Discomfort: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Anxiety: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Confusion: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Agitation: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Delirium: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Abnormal Behavior: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Specify abnormal behavior: _____

Insomnia: ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Prickling/Itching at site of scratch or bite? ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Did the patient have encephalomyelitis? ☐No ☐Unknown ☐Yes Onset date: __ __ / __ __ /__ __ __ __ Duration (in days): _____

Did the patient progress to coma or death within 10 days of illness onset? ☐No ☐Unknown ☐Yes

OTHER CLINICAL

Has the patient received pre-exposure prophylaxis (PrEP)?

Has the patient started post-exposure vaccination? ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __

Has the patient received Rabies immunoglobulin (RIG) post-exposure? ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Was the patient exposed to an animal? ☐No ☐Unknown ☐Yes

If yes, what kind of animal? _____

Date of exposure to animal: __ __ / __ __ /__ __ __ __

Was the animal tested? ☐No ☐Unknown ☐Yes If yes, results: _____

Description of Exposure (kiss, bite, scratch, laboratory acquired, organ donation, etc.): _____

Location of Exposure: _____ Sought medical evaluation? _____

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

RUBELLA INVESTIGATION FORM

Comments:_____
_____
_____

Basic Demographic Data

Last Name: _____ First Name:_____

Middle Name:_____ Suffix: _____

DOB: __ __ / __ __ /__ __ __ __ Current Sex*:* ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Deceased Date: __ __ / __ __ /__ __ __ __

Marital Status: (Circle) S / M / D / W/ Annulled/ Cohabitating/ Legally Separated/ Polygamous/Unknown

SSN: __ __ __ / __ __ /__ __ __ __

Street Address 1: _____

Street Address 2: _____

City:_____ State:_____

Zip Code*:* __ __ __ __ __-__ __ __ __ County:_____ Country:_____

Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race : ☐Unknown ☐ American Indian or Alaska Native ☐Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __

Reporting Source:_____

Earliest Date Reported to: County : __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __

Reporter's Name:_____

Clinical

Physician's Name: _____

Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Physician's Address: _____

City:_____State:_____ Zip Code: __ __ __ __ __- __ __ __ __

County:_____ Country

Hospital

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes

If yes: Hospital Name: _____

Admission Date__ __ / __ __ /__ __ __ __ Discharge Date __ __ / __ __ /__ __ __ __

Total Duration of stay within hospital _____days

Condition

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __

Illness End Date: __ __ / __ __ /__ __ __ __

Illness Duration: _____Circle: days/hrs./minutes/months/unknown/weeks/years

Did/does the patient have:		
Maculopapular Rash?	☐No ☐Unknown ☐Yes	Rash Onset Date : __ __ / __ __ /__ __ __ __ Rash Duration: _____ days
A fever?	☐No ☐Unknown ☐Yes	Highest Measured Temperature: _____° ☐F ☐C

Symptoms

Arthralgia/Arthritis: ☐No ☐Unknown ☐Yes	Lymphadenopathy: ☐No ☐Unknown ☐Yes	Conjunctivitis: ☐No ☐Unknown ☐Yes

Complications

Arthralgia/Arthritis: ☐No ☐Unknown ☐Yes	Encephalitis: ☐No ☐Unknown ☐Yes	Thrombocytopenia: ☐No ☐Unknown ☐Yes
Other Complications: ☐No ☐Unknown ☐Yes	Specify Other: _____	

Did the patient die from rubella or complications (including a secondary infection) associated with rubella?	☐No ☐Unknown ☐Yes
Cause of Death:	

Laboratory						
Was laboratory testing done for rubella?					□No □Unknown □Yes	
Rubella IgM EIA (1st)?					□No □Unknown □Yes	
Which method was used? □Capture □Indirect □ Unknown □Other					Date of Test: __ __/ __ __/__ __ __ __	
Test Result:	□Indeterminate □ Negative □Not Done □Pending □Positive □Unknown					
Test Result Value:						
Rubella IgM EIA (2nd)?	□No □Unknown □Yes					
Which method was used? □Capture □Indirect □ Unknown □Other					Date of Test: __ __/ __ __/__ __ __ __	
Test Result:	□Indeterminate □ Negative □Not Done □Pending □Positive □Unknown					
Test Result Value:						
Rubella IgM Other?	□No □Unknown □Yes				***Specify Other Rubella IgM?*** _____	
Date of Other __ __/ __ __/__ __ __ __						
Other Result	□Indeterminate □ Negative □Not Done □Pending □Positive □Unknown					
Test Result Value:						
Rubella IgG, EIA - Acute?	□No □Unknown □Yes					
Date of Test: __ __/ __ __/__ __ __ __						
Test Result Value:						
Rubella IgG, EIA - Convalescent?	□No □Unknown □Yes					
Date of Test: __ __/ __ __/__ __ __ __						
Test Result Value:						
Difference Between Acute/Convalescent: IgG EIA Tests						
□ Indeterminate	□ No significant rise in IgG	□ Not done	□ Pending	□ Significant rise in IgG	□ Unknown	
Hemagglutination Inhibition Test - Acute?	□No □Unknown □Yes					
Date of Test: __ __/ __ __/__ __ __ __						
Test Result Value:						
Hemagglutination Inhibition Test Convalescent?	□No □Unknown □Yes					
Date of Test: __ __/ __ __/__ __ __ __						
Test Result Value:						
Difference Between Acute/Convalescent: Hemagglutination Inhibition Tests						
□ Indeterminate	□ No significant rise in IgG	□ Not done	□ Pending	□ Significant rise in IgG	□ Unknown	
Complement Fixation Test - Acute?	□No □Unknown □Yes					
Date of Test: __ __/ __ __/__ __ __ __						
Test Result Value:						
Complement Fixation Test - Convalescent?	□No □Unknown □Yes					
Date of Test: __ __/ __ __/__ __ __ __						
Test Result Value:						
Difference Between Acute/Convalescent: Complement Fixation Tests						
□ Indeterminate	□ No significant rise IgG	□ Not done	□ Pending	□ Significant rise in IgG	□ Unknown	
Rubella IgG, Other (#1)?	□No □Unknown □Yes					
Specify Other				Date of Other: __ __/ __ __/__ __ __ __		
Other Result:	□Indeterminate □ Negative □Not Done □Pending □Positive □Unknown					
Test Result Value:						
Rubella IgG, Other (#2)?	□No □Unknown □Yes					
Specify Other				Date of Other: __ __/ __ __/__ __ __ __		
Other Result:	□Indeterminate □ Negative □Not Done □Pending □Positive □Unknown					
Test Result Value:						
Rubella IgG, Other (#3)?	□No □Unknown □Yes					
Specify Other				Date of Other: __ __/ __ __/__ __ __ __		
Other Result:	□Indeterminate □ Negative □Not Done □Pending □Positive □Unknown					
Test Result Value:						
Virus Isolation Performed? □No □Unknown □Yes				Date of Virus Isolation: __ __/ __ __/__ __ __ __		
Source of Specimen:	□Blood □Cerebrospinal fluid □Nasopharyngeal □Throat □Urine □Other					
If other, Other Source:						
Virus Isolation Result:	□ Indeterminate □ Negative □ Not Done □ Pending □ Positive □ Unknown					

RT-PCR Performed?: ☐No ☐Unknown ☐Yes	Date of RT-PCR: __ __ / __ __ /__ __ __ __
Source of RT-PCR:	☐Blood ☐Cerebrospinal fluid ☐Nasopharyngeal ☐Throat ☐Urine ☐Other
If other, Other Source:	
RT-PCR Result:	☐ Indeterminate ☐ Not done ☐ Pending ☐ Rubella virus detected ☐ Rubella virus not detected ☐ Unknown
Test Result Value:	
Latex Agglutination Test Performed? ☐No ☐Unknown ☐Yes	Date of Test: __ __ / __ __ /__ __ __ __
Test Result:	☐Indeterminate ☐ Negative ☐Not Done ☐Pending ☐Positive ☐Unknown
Test Result Value:	
Immunofluorescent Antibody Assays Performed? ☐No ☐Unknown ☐Yes	Date of Assays: __ __ / __ __ /__ __ __ __
Source of Assays:	☐Blood ☐Cerebrospinal fluid ☐Nasopharyngeal ☐Throat ☐Urine ☐Other
If other, Other Source:	
Assays Result:	☐Indeterminate ☐ Negative ☐Not Done ☐Pending ☐Positive ☐Unknown
Test Result Value:	
Other Laboratory Testing for Rubella?	☐No ☐Unknown ☐Yes
Specify Other Rubella Test:	Date of Other Rubella Test: __ __ / __ __ /__ __ __ __
Other Result:	
Test Result Value:	
Were the clinical specimens sent to CDC for genotyping (molecular typing)?	☐No ☐Unknown ☐Yes
Date sent for Genotyping: __ __ / __ __ /__ __ __ __	
Was the (Rubella) virus genotype sequenced ☐No ☐Unknown ☐Yes	If 'Yes' identify the genotype Specify other sequence:
Specimen Type ☐Blood ☐Cerebrospinal fluid ☐Nasopharyngeal ☐Throat ☐Urine ☐Other	
Other Type	
Vaccine Information	
Did the patient receive rubella-containing vaccine?	☐No ☐Unknown ☐Yes
If No, Reason:	
If yes, number of doses patient received ON or AFTER first birthday	
Epidemiologic	
Is this case epi-linked to another laboratory confirmed case?	☐No ☐Unknown ☐Yes
Transmission Setting:	
Is this case part of an outbreak of 3 or more cases?	☐No ☐Unknown ☐Yes
If yes, Outbreak Name:	
Source of Infection (i.e.Person ID, Country...)	
Did rash onset occur 14 to 23 days upon entering the USA, following any travel or living outside the USA?	☐No ☐Unknown ☐Yes
Is this case traceable (linked) to an international import?	☐No ☐Unknown ☐Yes
Where was this disease acquired	
☐ Indigenous within jurisdiction ☐ Out of Country ☐ Out of jurisdiction, from another jurisdiction	
☐ Out of state ☐Unknown	
If the answer is out of Country, Jurisdiction, or State	
Imported Country:	Imported State:
Imported City:	Imported County:
CASE STATUS: (Required for Notification) ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐Unknown MMWR Week _____ MMWR Year _____	
Confimation Method	
☐ Clinical Diagnosis ☐Epidemiologically Linked ☐ Laboratory Confirmed	

Medical History	
Length of Time in US: _____ years	
Country of Birth:	
If this is a female, is she pregnant? □No □Unknown □Yes	What is the expected delivery date of the pregnancy? __ __/ __ __/__ __ __ __
Expected Place of Delivery:	Number of Weeks Gestation at Time of Rubella Disease_____
Trimester of Gestation at Time of Rubella Disease:	□First □Second □Third □Unknown
Please follow-up on this case 2 weeks prior to delivery date to determine whether or not the baby has Congenital Rubella Syndrome (CRS) or Congenital Rubella Infection (CRI).	
Is there documentation of previous rubella immunity testing?	□No □Unknown □Yes
Result of Immunity Testing:	□ Indeterminate □ Negative □ Not Done □ Pending □ Positive □ Unknown
Year of Immunity Testing:	Age of the Woman at Time of Immunity Testing_____ years
Did the woman ever have rubella disease prior to this pregnancy?	□No □Unknown □Yes
Was previous rubella disease serologically confirmed by a physician?	□No □Unknown □Yes
Year of the Previous Disease:	Age of the Woman at Time of Previous Disease_____ years
What was the outcome of the current pregnancy?	□ Live Birth □ Not a Live Birth □ Unknown □ Other
If "Live birth", choose type:	□ Live birth with CRS □ Live birth with infection only □ Live birth without CRS or infection
If "Not a live birth", choose type	□ Elective termination □ Fetal Death □ Spontaneous abortion □ Stillbirth
At the time of cessation of pregnancy, what was the age of the fetus? _____weeks	
If "Not a live birth", was autopsy/pathology study conducted?	□No □Unknown □Yes
Result of autopsy/pathology Study	
Custom Fields	
Date Due __ __/ __ __/__ __ __ __ Investigation Ready for Supervisor Review: □Reviewed (Complete) □Reviewed (Incomplete) □Reviewed (Not a case) □Yes Date Investigation ready for supervisor review: __ __/ __ __/__ __ __ __	
Detection of Measles by PCR	
Was PCR testing performed?	□No □Unknown □Yes
Based on the person's age and current recommendations, has the case received the recommended doses of vaccine for the disease under investigation?	□No □Yes
If yes, to associated with a school or daycare? Answer questions below:	
Name of school or daycare: City of school or daycare: County of school or daycare:	
What grades attend the school (ie: K-12, K-6, 7-12, 7-8, 5-8, 9-12)	What grade is the case in at the school?
Are there other cases in the classroom or other cases in the school building, or both? Explain:	
Clinical criteria for case classification	
Acute onset of generalized maculopapular rash:	□No □Unknown □Yes
Temperature greater than 99.0 Deg. F (greater than 37.2 Deg. C), if measured:	□No □Unknown □Yes
Arthralgia/arthritis, lymphadenopathy, or conjunctivitis:	□No □Unknown □Yes
Epidemiologically linked to a laboratory confirmed case:	□No □Unknown □Yes

Laboratory criteria for case classification	
Isolation of rubella virus	□ no □ not tested □ unknown □ yes
Significant rise between acute- and convalescent-phase titers in serum rubella IgG antibody level:	□ no □ not tested □ unknown □ yes
Positive serologic test for rubella IgM antibody:	□ no □ not tested □ unknown □ yes

Vaccination Record (Use Manage Vaccinations to add)	
Date Administered:	__ __ / __ __ /__ __ __ __
Age at Vaccination: _____ (Circle): days/hrs./minutes/months/unknown/weeks/years	
Vaccination Anatomical Site: ☐ Left Arm ☐ Left Gluteus Maximus ☐ Left Naris ☐ Left Thigh ☐ Oral Cavity ☐ Right Arm ☐ Right Gluteus Maximus ☐ Right Naris ☐ Right Thigh ☐ Other	
Given By	
Provider:	
Organization:	
Vaccine Administered:	
Vaccine Manufacturer	
Lot Number:	
Expiration Date: __ __ / __ __ /__ __ __ __	

SALMONELLOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments: _____

_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

LABORATORY

Isolation of *Salmonella* species from a clinical specimen? ☐No ☐Not tested ☐Unknown ☐Yes

Salmonella serotype, if known: _____

IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

SIGNS AND SYMPTOMS (

Fever:	☐No ☐Unknown ☐Yes	Highest Temp: _____°F	Bloating:	☐No ☐Unknown ☐Yes
Diarrhea:	☐No ☐Unknown ☐Yes	No. stools in 24 hours: _____	Vomiting:	☐No ☐Unknown ☐Yes
Bloody Stools:	☐No ☐Unknown ☐Yes		Weight Loss:	☐No ☐Unknown ☐Yes
Mucoid Stools:	☐No ☐Unknown ☐Yes		Malaise:	☐No ☐Unknown ☐Yes
Flatulence:	☐No ☐Unknown ☐Yes		Abdominal Pain:	☐No ☐Unknown ☐Yes

EXPOSURES

What is the patient's primary occupation? _____ Name and location of employer: _____

In the **3 days** prior to onset of symptoms did patient have exposure to or contact with any of the following? *Please be specific.*

Institution for the mentally challenged: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____
Circumstances: _____

Nursing Home: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____
Circumstances: _____

Seafood: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____
Circumstances: _____

Meal away from home: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____
Circumstances: _____

Undercooked/raw meat: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____
Circumstances: _____

Raw eggs or lightly cooked eggs: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____
Circumstances: _____

Raw/unpasteurized milk or dairy products: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____
Circumstances:

Antibiotic medications: ☐No ☐Unknown ☐Yes Date: __ __ / __ __ /__ __ __ __ Location: _____

Circumstances: _____

DAY CARE

Attend a day care center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes

Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____

What type of day care facility: ☐Adult day health care ☐Adult day social care ☐Alzheimer's specific day care
☐Child care center ☐Child care provided by friend, relative, neighbor ☐In-home care giver

Is food prepared at this facility? ☐No ☐Unknown ☐Yes Does this facility care for diapered persons? ☐No ☐Unknown ☐Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? ☐No ☐Unknown ☐Yes

Last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __ Where was the patient a foodhandler?_____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is: **1 – 3 days**

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated?
☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated?
☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the **3 days** prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **3 days** prior to illness? ☐No ☐Unknown ☐Yes

What was the recreational water exposure type? (select all that apply)

☐Hot Spring ☐Hot Tub-Whirlpool-Jacuzzi-Spa ☐Interactive Fountain ☐Lake-Pond-River-Stream
☐Ocean ☐Other _____ ☐Recreational Water Park ☐Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐Camp Pool ☐Hospital/Therapy Pool ☐Hotel/Motel/Resort Vacation Pool
☐Kiddie/Wading Pool ☐Municipal/Community Pool ☐Neighborhood/subdivision/Apartment/Condo Pool
☐Other, specify_____ ☐Private Club/Membership Pool ☐Private Home Pool, not a kiddie/wading pool
☐School/College/University Pool ☐Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **3 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select type of animal: ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard ☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown ☐Other, specify: _____

Name or location of animal contact: _____

Did a patient come into contact with animal food/feed(s) in the **3 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select associated animal food/feed(s): ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard ☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown ☐Other, specify: _____

If applicable, please list food brand(s): _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐CSF leak
☐Alcohol abuse
☐Burns
☐Cirrhosis/liver failure
☐Deaf/profound hearing loss
☐Gastric surgery (type): _____
☐Immunodeficiency (type): _____
☐Leukemia
☐None
☐Other malignancy (type): _____
☐Peptic ulcer
☐Splenectomy/asplenia
☐Hodgkin's disease
☐Asthma
☐Cerebral vascular accident (CVA) stroke
☐Cochlear implant
☐Diabetes mellitus (insulin):☐No ☐Unk ☐Yes
☐Heart failure
☐Immunoglobulin deficiency
☐Multiple myeloma
☐Organ transplant (organ): _____
☐Other prior illness (type): _____
☐Renal failure/dialysis
☐Systemic lupus erythematosus (SLE)
☐IVDU
☐Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐Chronic GI illness/diarrhea
☐Current smoker
☐Emphysema/COPD
☐Hematologic disease (type): _____
☐Immunosuppressive therapy (steroids, chemotherapy)
☐Nephrotic Syndrome
☐Other liver disease (type): _____
☐Other renal disease (type): _____
☐Sickle cell anemia
☐Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐No ☐Unknown ☐Yes

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the ALNBS Investigation.

SARS-CoV† Investigation Form

STOP: Prior to Creating this Investigation, you MUST Notify & Consult with Central Office
(800) 338-8374 (24-hour coverage)

†*Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)*

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

SEVERE ACUTE RESPIRATORY SYNDROME

Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS) Version 2

Supplement B: SARS Surveillance

Appendix B2: SARS Domestic Case Reporting Form

Form Approved
OMB No. 0920-0008

Person Details

1. IDs	
CDC ID #: *CDC ID WILL BE AUTOMATICALLY GENERATED*	Date reported to CDC: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
State ID #: _____	Jurisdiction:
Date reported to state or local health department: __ __ / __ __ / __ __ __ __ (m m d d y y y y)	

[redacted]

2. Submitted By	
Last Name:	First Name:
State:	Affiliation:
Phone:	E-mail:
3. Patient Information	
City of Residence:	
County of Residence:	
State of Residence:	
Age at onset: _____ ☐ Years ☐ Months	Sex: ☐ Male ☐ Female
Ethnicity: ☐ Non Hispanic ☐ Hispanic	Race *(Mark one or more)* ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown
Nationality/Citizenship:	
Residency: ☐ US Residency ☐ Non-US Residency	
4. Optional Patient Information	
Last Name: _____	First Name: _____

January 8, 2004 Page 1 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Supplement B: SARS Surveillance
(continued from previous page)

Was patient ever placed on mechanical ventilation?	☐ Yes ☐ No ☐ Unknown
Did patient die as a result of his/her illness?	☐ Yes ☐ No ☐ Unknown
If yes: Date of Death: __ __ / __ __ / __ __ __ __ m m d d y y y y	
Was an autopsy performed?	☐ Yes ☐ No ☐ Unknown
Was pathology consistent with pneumonia or RDS?	☐ Yes ☐ No ☐ Unknown

Epidemiologic Risk Factors

7. Occupation	
Is the individual a healthcare worker?* ** A person who has close contact to patients, patient care areas (e.g., patient room) or patient care items (e.g. linens, patient specimens).*	☐ Yes ☐ No ☐ Unknown
If yes: Specify healthcare worker type:	☐ Physician ☐ Nurse/PA ☐ Lab ☐ Other Specify: _____
Does patient have DIRECT patient care responsibilities?	☐ Yes ☐ No ☐ Unknown
If not a healthcare worker, please list occupation: _____	

8. Contact and Travel	
In the 10 days prior to symptom onset, did the patient have the following?	
A. Close contact in the 10 days prior to symptom onset with a confirmed SARS-CoV case or a probable SARS-CoV case? * ** SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS*	☐ Yes If yes, go to section 9, then return ☐ No ☐ Unknown
B. Close contact with a person considered an RUI-2 or RUI-3? * ** SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS*	☐ Yes If yes, go to section 9, then return ☐ No ☐ Unknown

Supplement B: SARS Surveillance
(continued from previous page)

Was patient ever placed on mechanical ventilation?	☐ Yes ☐ No ☐ Unknown
Did patient die as a result of his/her illness?	☐ Yes ☐ No ☐ Unknown
If yes: Date of Death: __ __ / __ __ / __ __ __ __ m m d d y y y y	
Was an autopsy performed?	☐ Yes ☐ No ☐ Unknown
Was pathology consistent with pneumonia or RDS?	☐ Yes ☐ No ☐ Unknown

Epidemiologic Risk Factors

7. Occupation	
Is the individual a healthcare worker?* ** A person who has close contact to patients, patient care areas (e.g., patient room) or patient care items (e.g. linens, patient specimens).*	☐ Yes ☐ No ☐ Unknown
If yes: Specify healthcare worker type:	☐ Physician ☐ Nurse/PA ☐ Lab ☐ Other Specify: _____
Does patient have DIRECT patient care responsibilities?	☐ Yes ☐ No ☐ Unknown
If not a healthcare worker, please list occupation: _____	

8. Contact and Travel	
In the 10 days prior to symptom onset, did the patient have the following?	
A. Close contact in the 10 days prior to symptom onset with a confirmed SARS-CoV case or a probable SARS-CoV case? * ** SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS*	☐ Yes If yes, go to section 9, then return ☐ No ☐ Unknown
B. Close contact with a person considered an RUI-2 or RUI-3? * ** SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS*	☐ Yes **If yes, go to section 9, then return** ☐ No ☐ Unknown

C. Travel to **foreign** or **domestic** area with documented or suspected recent local transmission of SARS cases? *(See list of areas at end of document)*

☐ Yes Enter Destination Below
☐ No
☐ Unknown

If yes to C, list travel destination(s) *(See list of areas at end of document)*

Destination: ______________________________

Date of Arrival: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Date of Departure: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Destination: ______________________________

Date of Arrival: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Date of Departure: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Destination: ______________________________

Date of Arrival: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Date of Departure: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Destination: ______________________________

Date of Arrival: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Date of Departure: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Contact History

9. Information on Ill Contacts

Add Contact information for ill contacts identified by question 8A or 8B above. These ill contacts should have been identified previously and have been given either a CDC or STATE ID. If an ID has not been given, enter contact name, but update when ID number is available.

Contact Information (1)

Contact CDC ID: ____________________ **OR** Contact STATE ID: ______________________

OR *(only if ID unavailable)* Name of Contact (first, middle initial, last):____

Supplement B: SARS Surveillance
(continued from previous page)

Classification of Contact (SEE APPENDIX B1):	Nature of contact:	Contact Start:
□ RUI–2 □ RUI–3 □ Probable SARS CoV case □ Confirmed SARS CoV case	□ Same household □ Coworker □ Healthcare environment □ Other _____	__ __ / __ __ / __ __ __ __ m m d d y y y y Contact End: __ __ / __ __ / __ __ __ __ m m d d y y y y

Did the **ill contact** recently travel to an area with SARS transmission?
(see list of areas at end of document)
□ Yes
□ No
□ Unknown

If Yes, where? _____

Contact Information (2)

Contact CDC ID: _____ **OR** Contact STATE ID: _____

OR *(only if ID unavailable)* Name of Contact (first, middle initial, last): _____

Classification of Contact (SEE APPENDIX B1):	Nature of contact:	Contact Start:
□ RUI–2 □ RUI–3 □ Probable SARS CoV case □ Confirmed SARS CoV case	□ Same household □ Coworker □ Healthcare environment □ Other _____	__ __ / __ __ / __ __ __ __ m m d d y y y y Contact End: __ __ / __ __ / __ __ __ __ m m d d y y y y

Did the **ill contact** recently travel to an area with SARS transmission?
(see list of areas at end of document)
□ Yes
□ No
□ Unknown

If Yes, where? _____

Contact Information (3)

Contact CDC ID: _____ **OR** Contact STATE ID: _____

OR *(only if ID unavailable)* Name of Contact (first, middle initial, last): _____

Supplement B: SARS Surveillance
(continued from previous page)

Classification of Contact (SEE APPENDIX B1):	Nature of contact:	Contact Start:
☐ RUI-2 ☐ RUI-3 ☐ Probable SARS CoV case ☐ Confirmed SARS CoV case	☐ Same household ☐ Coworker ☐ Healthcare environment ☐ Other _____	__ __ / __ __ / __ __ __ __ m m d d y y y y Contact End: __ __ / __ __ / __ __ __ __ m m d d y y y y

Did the **ill contact** recently travel to an area with SARS transmission? *(see list of areas at end of document)* *If Yes, where?* _____	☐ Yes ☐ No ☐ Unknown

Travel History

10. Patient Travel Information	
If recent foreign travel, did the patient receive a **Health Alert** or other SARS educational information on arrival in the United States?	☐ Yes ☐ No ☐ Unknown
Was the patient **symptomatic** during travel from a SARS affected area of within 24 hours of return to the US or local area?	☐ Yes ☐ No ☐ Unknown
If yes: 1) Please provide to the CDC the name of the SARS suspect who has traveled *(enter name from section 3)*	
2) If yes, list all travel either by public conveyance (airplane, train bus) or with a tour group, 24 hours before onset of fever or symptoms and thereafter:	
List each portion or leg or the trip below:	

Trip or portion (1)			
Departure Date: __ __ / __ __ / __ __ __ __ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: ☐ Auto ☐ Airline ☐ Tour Group ☐ Train ☐ Other ☐ Cruise ☐ Bus
Transport Company:		Transport No:	
Comment:			

Trip or portion (2)			
Departure Date: __ __ / __ __ / __ __ __ __ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: ☐ Auto ☐ Airline ☐ Tour Group ☐ Train ☐ Other ☐ Cruise ☐ Bus

Supplement B: SARS Surveillance
(continued from previous page)

Transport Company:	Transport No:		
Comment:			
Trip or portion (3)			
Departure Date: __ __ / __ __ / __ __ __ __ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus
Transport Company:	Transport No:		
Comment:			
Trip or portion (4)			
Departure Date: __ __ / __ __ / __ __ __ __ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus
Transport Company:	Transport No:		
Comment:			

(This page may be duplicated if needed)

Classification of Patient

11. Classification of patient by state of municipality (using CSTE/CDC definitions): SEE APPENDIX B1	
Initial Classification (check one only): *Report Under Investigation (RUI)* ☐ RUI–1 ☐ RUI–2 ☐ RUI–3 ☐ RUI–4 *OR SARS disease classification* ☐ Probable SARS–CoV Case ☐ Confirmed SARS–CoV Case	Updated Classification (check one only): ☐ RUI–1 ☐ RUI–2 ☐ RUI–3 ☐ RUI–4 ☐ Probable SARS–CoV Case ☐ Confirmed SARS–CoV Case ☐ Not a case: negative serology (>28 days post onset) ☐ Not a case: alternative diagnosis accounts for illness
	Date Updated (most recent): __ __ / __ __ / __ __ __ __ m m d d y y y y

Supplement B: SARS Surveillance
(continued from previous page)

Laboratory Evaluation

12. Local SARS testing

Chose from the following specimens to enter for each test:
Whole blood, serum (acute), serum (convalescent), NP swab, NP aspirate, Broncheoalveolar lavage specimen, OP swab, urine, stool, tissue.

Specimen 1

Specimen:	If 'Tissue,' specify:	Date Collected:
_____	_____	__ __ / __ __ / __ __ __ __ (m m d d y y y y)

Test Requested:	Source of Local Testing:	Result:
☐ PCR	☐ Public Health Lab	☐ Positive
☐ Convalescent serology	☐ LRN	☐ Negative
☐ Acute serology	☐ Commercial lab	☐ Pending
☐ Culture	☐ other	☐ Indeterminate

Specimen 2

Specimen:	If 'Tissue,' specify:	Date Collected:
_____	_____	__ __ / __ __ / __ __ __ __ (m m d d y y y y)

Test Requested:	Source of Local Testing:	Result:
☐ PCR	☐ Public Health Lab	☐ Positive
☐ Convalescent serology	☐ LRN	☐ Negative
☐ Acute serology	☐ Commercial lab	☐ Pending
☐ Culture	☐ other	☐ Indeterminate

Specimen 3

Specimen:	If 'Tissue,' specify:	Date Collected:
_____	_____	__ __ / __ __ / __ __ __ __ (m m d d y y y y)

Test Requested:	Source of Local Testing:	Result:
☐ PCR	☐ Public Health Lab	☐ Positive
☐ Convalescent serology	☐ LRN	☐ Negative
☐ Acute serology	☐ Commercial lab	☐ Pending
☐ Culture	☐ other	☐ Indeterminate

Specimen 4

Specimen:	If 'Tissue,' specify:	Date Collected:
_____	_____	__ __ / __ __ / __ __ __ __ (m m d d y y y y)

Test Requested:	Source of Local Testing:	Result:
☐ PCR	☐ Public Health Lab	☐ Positive
☐ Convalescent serology	☐ LRN	☐ Negative
☐ Acute serology	☐ Commercial lab	☐ Pending
☐ Culture	☐ other	☐ Indeterminate

Supplement B: SARS Surveillance
(continued from previous page)

Specimen 5		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: ☐ PCR ☐ Convalescent serology ☐ Acute serology ☐ Culture	Source of Local Testing: ☐ Public Health Lab ☐ LRN ☐ Commercial lab ☐ other	Result: ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate
Specimen 6		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: ☐ PCR ☐ Convalescent serology ☐ Acute serology ☐ Culture	Source of Local Testing: ☐ Public Health Lab ☐ LRN ☐ Commercial lab ☐ other	Result: ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate
Specimen 7		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: ☐ PCR ☐ Convalescent serology ☐ Acute serology ☐ Culture	Source of Local Testing: ☐ Public Health Lab ☐ LRN ☐ Commercial lab ☐ other	Result: ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate
Specimen 8		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: ☐ PCR ☐ Convalescent serology ☐ Acute serology ☐ Culture	Source of Local Testing: ☐ Public Health Lab ☐ LRN ☐ Commercial lab ☐ other	Result: ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate

13. Alternative Diagnosis	
Was an alternative respiratory pathogen detected?	☐ Yes ☐ No ☐ Unknown
If yes indicate which one (see list below): _____	

Supplement B: SARS Surveillance
(continued from previous page)

Alternative pathogen (e.g., Influenza A, Influenza B, RSV, rhinovirus, adenovirus, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Mycoplasma*, *Chlamydia pneumoniae*, human parainfluenza virus 1, human parainfluenza 2, human parainfluenza 3, human metapneumovirus, *Legionella* sp., other.):

14. List specimens sent to the CDC

Chose from the following specimens to enter below:
Whole blood, plasma, serum (acute), serum (convalescent), NP swab, NP aspirate, broncheoalveolar lavage specimen, OP swab, tracheal aspirate, pleural tap, urine, stool, tissue.

Specimen 1: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 2: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 3: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 4: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 5: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 6: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 7: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 8: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Supplement B: SARS Surveillance
(continued from previous page)

Notes

15. Notes:

Supplement B: SARS Surveillance
(continued from previous page)

Note: List of areas with current confirmed or suspected SARS transmission

(If SARS-CoV transmission recurs, the list of foreign or domestic areas with documented or suspected recent local transmission of SARS-CoV will be listed here.)

Types of locations specified will vary (e.g., country, airport, city, building, floor of building). The last date a location may be a criterion for exposure for illness onset is 10 days (one incubation period) after removal of that location from CDC travel alert status. The patient's travel should have occurred on or before the last date the travel alert was in place. Transit through a foreign airport meets the epidemiologic criteria for possible exposure in a location for which a CDC travel advisory is in effect. Information regarding CDC travel alerts and advisories and assistance in determining appropriate dates are available at http://www.cdc.gov/ncidod/sars/travel.htm.

For more information, visit www.cdc.gov/ncidod/sars or call the CDC public response hotline at (888) 246-2675 (English), (888) 246-2857 (Español), or (866) 874-2646 (TTY)

SHIGA TOXIN-PRODUCING *ESCHERICHIA COLI* (STEC) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments: _____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

SIGNS AND SYMPTOMS

Diarrhea: ☐No ☐Unknown ☐Yes

Abdominal Cramps: ☐No ☐Unknown ☐Yes

PHEP PROJECT

Presumptive diagnosis date: __ __ / __ __ /__ __ __ __

Initial report method: ☐ELR ☐E-mail ☐Fax ☐Mail ☐Phone ☐Other_____

Initial report to Public Health provided by: ☐ELR ☐Emergency Room ☐Infection Preventionist/Hospital ☐Microbiologist/Hospital ☐Patient ☐Physician/Practitioner ☐Other_____

Control Measures:

Date control measures implemented: __ __ / __ __ /__ __ __ __

Education of case/contacts: ☐No ☐Unknown ☐Yes

Exclusion from food handling: ☐No ☐Unknown ☐Yes

Exclusion from healthcare: ☐No ☐Unknown ☐Yes

Exclusion from daycare/school: ☐No ☐Unknown ☐Yes

Identification of exposed individuals: ☐No ☐Unknown ☐Yes

Identification of additional cases: ☐No ☐Unknown ☐Yes

Identification of possible source of infection: ☐No ☐Unknown ☐Yes

Collection of food: ☐No ☐Unknown ☐Yes

Other measure: _____

Restaurants and Grocery Stores

*Did you eat out at any restaurants (including fast food restaurants, delis, and take-out or home delivery meals) during the **10 days** before your illness?*

☐No ☐Unknown ☐Yes

If Yes, list names and locations of restaurants.

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

*Where did you purchase groceries that were eaten during the **10 days** before your illness (including specialty stores, produce or fruit stands, dairy marts, etc.)?*

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

Detailed Food History

*Now, I would like to ask you about specific food items eaten during the **10 days** before you got sick.*

A. Poultry, Meats, and Fish

Did you handle raw ground beef? ☐No ☐Unknown ☐Yes

Did you eat or handle ground beef at home? ☐No ☐Unknown ☐Yes

If yes, purchase location for ground beef handled or eaten at home_____

Was the ground beef eaten at home purchased as pre-made patties? ☐No ☐Unknown ☐Yes

Did you eat ground beef outside the home? For example, hamburger, beef taco, burrito, etc…) ☐No ☐Unknown ☐Yes

If yes, purchase location for ground beef eaten outside the home_____

Did you eat steak at home? ☐No ☐Unknown ☐Yes
If yes, purchase location for steak eaten at home _____

Did you eat steak outside the home? ☐No ☐Unknown ☐Yes
If yes, purchase location for steak eaten outside the home_____
Did you eat any of the following?
Bison ☐No ☐Unknown ☐Yes
Venison ☐No ☐Unknown ☐Yes
Elk ☐No ☐Unknown ☐Yes
Boar ☐No ☐Unknown ☐Yes
Other wild game ☐No ☐Unknown ☐Yes
If other, please specifiy:_____ _____
Did you eat dried or fermented meat such as jerky, pepperoni, salami, or summer sausage?
If yes, type of dried or fermented meat eaten: _____

B. Fresh/uncooked Salads and Vegetables

Did you eat iceberg lettuce at home? (For example, whole leaf or shredded, on salad, burger, taco, or sandwich) ☐No ☐Unknown ☐Yes
If yes, brand, variety of iceberg lettuce eaten at home_____
If yes, was the iceberg lettuce ☐loose and/or ☐prepackaged

Did you eat iceberg lettuce outside the home? (For example, whole leaf or shredded, on salad, burger, taco, or sandwich) ☐No ☐Unknown ☐Yes
If yes, purchase location: _____

Did you eat romaine lettuce at home? (For example, whole leaf or shredded, on salad, wrap, or sandwich) ☐No ☐Unknown ☐Yes
If yes, brand, variety of romaine lettuce eaten at home_____
If yes, was the romaine lettuce eaten at home ☐ loose and/or ☐prepackaged

Did you eat romaine lettuce outside the home? (For example, whole leaf or shredded, on salad, wrap, or sandwich) ☐No ☐Unknown ☐Yes
If yes, purchase location: _____

Did you eat fresh spinach at home? (For example, whole leaf or chopped, on salad, wrap, or sandwich) ☐No ☐Unknown ☐Yes
If yes, brand, variety of spinach eaten at home_____
If yes, was the spinach eaten at home ☐loose and/or ☐prepackaged

Did you eat spinach outside the home? ☐No ☐Unknown ☐Yes
If yes, purchase location: _____

Did you eat any other leafy green vegetable such as mesclun or red leaf lettuce? ☐No ☐Unknown ☐Yes
If yes, please specify type of other leafy green _____
Did you eat sprouts (for example, from a salad bar or on a sandwich)? ☐No ☐Unknown ☐Yes

C. Dairy or Juice

Did you drink raw milk? ☐No ☐Unknown ☐Yes
Did you eat cheese made from raw milk (such as queso fresco or queso blanco)? ☐No ☐Unknown ☐Yes
Did you eat artisanal or gourmet cheese? ☐No ☐Unknown ☐Yes
Did you drink unpasteurized juice or cider? ☐No ☐Unknown ☐Yes

DAY CARE

Attend a child or adult daycare center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes
Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____
What type of day care facility: ☐Adult day health care ☐Adult day social care ☐Alzheimer's specific day care
☐Child care center ☐Child care provided by friend, relative, neighbor ☐In-home care giver
Is food prepared at this facility? ☐No ☐Unknown ☐Yes Does this facility care for diapered persons? ☐No ☐Unknown ☐Yes

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is: **10 days**

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

_____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated?

☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated?

☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the **10 days** prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **10 days** prior to illness? ☐No ☐Unknown ☐Yes

What was the recreational water exposure type? (select all that apply)

☐Hot Spring ☐Hot Tub-Whirlpool-Jacuzzi-Spa ☐Interactive Fountain ☐Lake-Pond-River-Stream

☐Ocean ☐Other _____ ☐Recreational Water Park ☐Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐Camp Pool ☐Hospital/Therapy Pool ☐Hotel/Motel/Resort Vacation Pool

☐Kiddie/Wading Pool ☐Municipal/Community Pool ☐Neighborhood/subdivision/Apartment/Condo Pool

☐Other, specify_____ ☐Private Club/Membership Pool ☐Private Home Pool, not a kiddie/wading pool

☐School/College/University Pool ☐Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **10 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select type of animal: ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard
☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown
☐Other, specify: _____

Name or location of animal contact: _____

Did a patient come into contact with animal food/feed(s) in the **10 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select associated animal food/feed(s): ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard
☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown
☐Other, specify: _____

If applicable, please list food brand(s): _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

- ☐ CSF leak
- ☐ Alcohol abuse
- ☐ Burns
- ☐ Cirrhosis/liver failure
- ☐ Deaf/profound hearing loss
- ☐ Gastric surgery (type): _____
- ☐ Immunodeficiency (type): _____
- ☐ Leukemia
- ☐ None
- ☐ Other malignancy (type): _____
- ☐ Peptic ulcer
- ☐ Splenectomy/asplenia
- ☐ Hodgkin's disease
- ☐ Asthma
- ☐ Cerebral vascular accident (CVA) stroke
- ☐ Cochlear implant
- ☐ Diabetes mellitus (insulin): ☐ No ☐ Unk ☐ Yes
- ☐ Heart failure
- ☐ Immunoglobulin deficiency
- ☐ Multiple myeloma
- ☐ Organ transplant (organ): _____
- ☐ Other prior illness (type): _____
- ☐ Renal failure/dialysis
- ☐ Systemic lupus erythematosus (SLE)
- ☐ IVDU
- ☐ Atherosclerotic cardiovascular disease (ASCVD)/CAD
- ☐ Chronic GI illness/diarrhea
- ☐ Current smoker
- ☐ Emphysema/COPD
- ☐ Hematologic disease (type): _____
- ☐ Immunosuppressive therapy (steroids, chemotherapy)
- ☐ Nephrotic Syndrome
- ☐ Other liver disease (type): _____
- ☐ Other renal disease (type): _____
- ☐ Sickle cell anemia
- ☐ Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐ No ☐ Unknown ☐ Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐ No ☐ Unknown ☐ Yes

Are the other cases related to this one? ☐ No, sporadic ☐ Unknown ☐ Yes, household ☐ Yes, not household ☐ Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the ALNBS Investigation.

SHIGELLOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments: _____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

LABORATORY

Shigella species, if known: ☐boydii ☐dysenteriae ☐flexneri ☐sonnei

DAY CARE

Attend a day care center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes

Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____

What type of day care facility: ☐Adult day health care ☐Adult day social care ☐Alzheimer's specific day care
☐Child care center ☐Child care provided by friend, relative, neighbor ☐In-home care giver

Is food prepared at this facility? ☐No ☐Unknown ☐Yes Does this facility care for diapered persons? ☐No ☐Unknown ☐Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? ☐No ☐Unknown ☐Yes

What was the last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __

Where was the patient a foodhandler?_____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is: **1 – 7 days**

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated?
☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated?
☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the **7 days** prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **7 days** prior to illness? ☐No ☐Unknown ☐Yes

What was the recreational water exposure type? (select all that apply)

☐Hot Spring ☐Hot Tub-Whirlpool-Jacuzzi-Spa ☐Interactive Fountain ☐Lake-Pond-River-Stream
☐Ocean ☐Other _____ ☐Recreational Water Park ☐Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐Camp Pool ☐Hospital/Therapy Pool ☐Hotel/Motel/Resort Vacation Pool
☐Kiddie/Wading Pool ☐Municipal/Community Pool ☐Neighborhood/subdivision/Apartment/Condo Pool
☐Other, specify_____ ☐Private Club/Membership Pool ☐Private Home Pool, not a kiddie/wading pool
☐School/College/University Pool ☐Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **7 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select type of animal: ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard
☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown
☐Other, specify: _____

Name or location of animal contact: _____

Did a patient come into contact with animal food/feed(s) in the **7 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

If yes, select associated animal food/feed(s): ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard
☐Poultry ☐Rodent ☐Sheep ☐Swine ☐Turtle ☐Unknown
☐Other, specify: _____

If applicable, please list food brand(s): _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐CSF leak ☐Hodgkin's disease ☐IVDU
☐Alcohol abuse ☐Asthma ☐Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐Burns ☐Cerebral vascular accident (CVA) stroke ☐Chronic GI illness/diarrhea
☐Cirrhosis/liver failure ☐Cochlear implant ☐Current smoker
☐Deaf/profound hearing loss ☐Diabetes mellitus (insulin):☐No ☐Unk ☐Yes ☐Emphysema/COPD
☐Gastric surgery (type): _____ ☐Heart failure ☐Hematologic disease (type): _____
☐Immunodeficiency (type): _____ ☐Immunoglobulin deficiency ☐Immunosuppressive therapy (steroids, chemotherapy)
☐Leukemia ☐Multiple myeloma ☐Nephrotic Syndrome
☐None ☐Organ transplant (organ): _____ ☐Other liver disease (type): _____
☐Other malignancy (type): _____ ☐Other prior illness (type): _____ ☐Other renal disease (type): _____
☐Peptic ulcer ☐Renal failure/dialysis ☐Sickle cell anemia
☐Splenectomy/asplenia ☐Systemic lupus erythematosus (SLE) ☐Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐No ☐Unknown ☐Yes

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the ALNBS Investigation.

SMALLPOX INVESTIGATION FORM

STOP: PRIOR TO CREATING THIS INVESTIGATION, YOU MUST NOTIFY & CONSULT WITH CENTRAL OFFICE (800) 338-8374 (24-HOUR COVERAGE)

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

SIGNS AND SYMPTOMS

Did the patient have acute onset of a **high fever** (≥101°F) that began to fall after 2-4 days? ☐No ☐Unknown ☐Yes

Did a vesicular or pustular rash develop after the fever broke? ☐No ☐Unknown ☐Yes

Were all vesicles or pustules in the same stage of development in a given area? ☐No ☐Unknown ☐Yes

Were all vesicles or pustules firm and deep seated (i.e., button-like upon palpation/not blisters easily broken)? ☐No ☐Unknown ☐Yes

Did the rash begin distally and travel centrally from the extremities and face towards the trunk (centrifugal distribution)? ☐No ☐Unknown ☐Yes

Were the palms of the hands and soles of the feet affected? ☐No ☐Unknown ☐Yes

Did the rash progress within 3-4 weeks from macules to papules to vesicles to pustules to crusted scabs that fell off? ☐No ☐Unknown ☐Yes

Has a physician ruled out other apparent causes (e.g., chickenpox)? ☐No ☐Unknown ☐Yes

Form 3A: Smallpox Case Exposure Investigation Form

1. STATE ☐☐ 2. **Case #** _____

OMB NO. 0920-0008
Exp. Date: 06/2003

Case Exposure/Source Information

3. INTERVIEW DATE: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

Case Information

4. CASE NAME: _____ / _____ / _____
(Last) (First) (Middle) (Suffix) (Nickname)

5. ADDRESS: _____ ☐☐ ☐☐☐☐☐
Street Address, Apt #. City State Zip Code

6. Case Classification: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Unknown

Information on possible source of infection - INDIVIDUALS

7. DO YOU KNOW FROM WHOM YOU CAUGHT THIS ILLNESS? ☐ **Yes** ☐ **No** ☐ **Unknown**
IF NO OR UNKNOWN, GO TO QUESTION 10.

IF YES, GIVE NAME, ADDRESS, AND TELEPHONE NUMBER

_____ ☐☐ ☐☐☐☐☐ ☐☐☐-☐☐☐-☐☐☐☐
Name (LAST, FIRST) Street Address, Apt #. City State Zip Code Area Code Number

8. DATE OF LAST EXPOSURE: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

9. DID THE PERSON HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS (MARK ALL THAT APPLY):

☐ RASH: PAPULES/BUMPS ☐ FEVER ☐ SEVERELY ILL ☐ OTHER, DESCRIBE: _____
☐ RASH: VESICLES ☐ COUGH ☐ IMMOBILE
☐ RASH: PUSTULES (FLUID FILLED)
☐ RASH: CRUSTS/SCABS

10. DO YOU KNOW OF ANY OTHER PERSON WITH AN ILLNESS LIKE YOURS: ☐ Yes ☐ No ☐ Unknown
IF YES, GIVE NAME, ADDRESS, AND TELEPHONE NUMBER

_____ ☐☐ ☐☐☐☐☐ ☐☐☐-☐☐☐-☐☐☐☐
Name (LAST, FIRST) Street Address, Apt #. City State Zip Code Area Code Number

11. DURING THE DATES FROM _____ TO _____ BEFORE YOUR RASH ONSET, WERE YOU IN CONTACT WITH
(Insert date: 21 days before rash onset) (Insert date: 7 days before rash onset)

DO YOU KNOW OF ANYONE WHO APPREARED TO HAVE:

11a. CHICKENPOX: ☐ Yes ☐ No ☐ Unknown

11b. A SEVERE RASH ON THE FACE AND/OR ARMS: ☐ Yes ☐ No ☐ Unknown

IF YES TO 11a OR 11b, GIVE THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE INDIVIDUALS:

_____ ☐☐ ☐☐☐☐☐ ☐☐☐-☐☐☐-☐☐☐☐
Name (LAST, FIRST) Street Address, Apt #. City State Zip Code Area Code Number

DATE OF LAST EXPOSURE: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

_____ ☐☐ ☐☐☐☐☐ ☐☐☐-☐☐☐-☐☐☐☐
Name (LAST, FIRST) Street Address, Apt #. City State Zip Code Area Code Number

DATE OF LAST EXPOSURE: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

Information on possible source of infection - PLACE

12. DO YOU KNOW WHERE YOU CAUGHT THIS ILLNESS? ☐ Yes ☐ No ☐ Unknown

IF YES, NAME OF PLACE/EVENT: _____ TYPE OF PLACE/EVENT: _____
(i.e., restaurant, store, theater, sports event, office, etc)

ADDRESS / LOCATION: _____ ☐☐ ☐☐☐☐☐
Street Address, Apt #. City State Zip Code

DESCRIBE LOCATION: _____ TELEPHONE: ☐☐☐-☐☐☐-☐☐☐☐
Area Code Number

13. POSSIBLE DATE OF EXPOSURE: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

14. TIME: _____ AM / PM

15. ESTIMATED NUMBER OF PERSONS POTENTIALLY EXPOSED AT THE SAME PLACE AND TIME AS CASE: _____

LIST OTHERS POTENTIALLY EXPOSED (NAME, ADDRESS, TELEPHONE) ON REVERSE SIDE OF THIS FORM OR ON AN ADDITIONAL PIECE OF PAPER.

Form 3A: Smallpox Case Exposure Investigation Form

STATE ☐☐ Case # _____

LIST OF NAMES AND ADDRESSES/TELEPHONE NUMBERS:

Name/Location	Street Address, Apt #	City	State	Zip Code	Area Code	Number

SAMPLE QUESTIONS FOR FORM 3B: SMALLPOX CASE TRAVEL/ACTIVITY WORKSHEET – EXPOSURE PERIOD:

For the next few questions, I'd like you to think back to the 14 day period between 1 and 3 weeks before you developed a rash that we have marked on the calendar. Let's start with weekdays. (Offer dates, holidays, etc., as available to anchor the case's recall to this time period. Consider routine weekday activities in a systematic way going either back from day 7 or forward from day 21 from fever onset depending on what seems easier to do.)

For weekends, ask about usual routines and then occasional activities. Prompt especially for attendance at public events. A question to capture this type of attendance follows after questions regarding usual activities.

WHAT IS YOUR USUAL ROUTINE:

DO YOU WORK? ☐ Yes ☐ No VOLUNTEER ON A REGULAR BASIS? ☐ Yes ☐ No

DO YOU GO TO SCHOOL? ☐ Yes ☐ No HAVE ANOTHER EVERY DAY ACTIVITY? ☐ Yes ☐ No

DURING THIS 14-DAY PERIOD AS SHOWN ON THIS CALENDAR, DID YOU SPEND ANY TIME REGULARLY (3 OR MORE TIMES A WEEK) IN THE FOLLOWING PLACES? (Check all that apply.)

WORK: ☐ Yes ☐ No SCHOOL: ☐ Yes ☐ No RESTAURANT: ☐ Yes ☐ No

YOUR CHILD'S SCHOOL OR DAY CARE CENTER: ☐ Yes ☐ No GROCERY STORE: ☐ Yes ☐ No

OTHER, SUCH AS PLACE OF WORSHIP, GYM, ETC: ☐ Yes ☐ No IF YES, SPECIFY: _____

Please complete FORM 3C – CASE EXPOSURE TRANSPORTATION WORKSHEET for all transportation questions.

IF YOU WORK, GO TO SCHOOL, OR TRANSPORT YOUR CHILDREN OR OTHER FAMILY MEMBERS, HOW DO YOU TRAVEL TO AND FROM THESE PLACES?

CAR ALONE, BICYCLE, WALK: ☐ Yes ☐ No CAR WITH OTHER PEOPLE IN THE VEHICLE AT LEAST SOMETIMES: ☐ Yes ☐ No

BUS, TRAIN OR SUBWAY: ☐ Yes ☐ No TAXI: ☐ Yes ☐ No

OTHER, SPECIFY (E.G. PLANE): ☐ Yes ☐ No IF YES, SPECIFY: _____

NOTE: For regular travel schedule such as to and from work, indicate range of days and times if this is the same each day.

DURING THE 14-DAY TIME PERIOD DESIGNATED ABOVE, DID YOU TRAVEL OUT OF TOWN (IF CITY, OUT OF URBAN AREA, IF RURAL, OUT OF COUNTY)? ☐ Yes ☐ No

DURING THE 14-DAY TIME PERIOD DESIGNATED ABOVE, DID YOU VISIT ANY OF THE FOLLOWING ACTIVITIES AT LEAST ONCE:

HOTEL/CONVENTION CENTER: ☐ Yes ☐ No CHURCH, TEMPLE, MOSQUE OR OTHER PLACE OF WORSHIP: ☐ Yes ☐ No

SHOPPING MALL OR LARGE STORE: ☐ Yes ☐ DOCTOR'S OFFICE, EMERGENCY ROOM, CLINIC OR HOSPITAL: ☐ Yes ☐ No

AIRPORT: ☐ Yes ☐ No THEATER (MOVIES/PLAY): ☐ Yes ☐ No

CONCERT: ☐ Yes ☐ No PUBLIC SPORTING EVENT: ☐ Yes ☐ No

BUS, TRAIN OR SUBWAY: ☐ Yes ☐ No FAIR, FESTIVAL OR CARNIVAL: ☐ Yes ☐ No

ANY OTHER GATHERING WITH MORE THAN 100 OTHER PEOPLE: ☐ Yes ☐ No IF YES, SPECIFY: _____

SPOTTED FEVER RICKETTSIOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Where was the disease acquired? ☐Indigenous within jurisdiction ☐Out of Country ☐Out of jurisdiction, from another jurisdiction ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

SIGNS AND SYMPTOMS

Any reported "fever": ☐No ☐Unknown ☐Yes

Rash: ☐No ☐Unknown ☐Yes

Eschar: ☐No ☐Unknown ☐Yes

Headache: ☐No ☐Unknown ☐Yes

Myalgia: ☐No ☐Unknown ☐Yes

Anemia: ☐No ☐Unknown ☐Yes

Thrombocytopenia: ☐No ☐Unknown ☐Yes

Any elevated ALT/AST: ☐No ☐Unknown ☐Yes

EXPOSURE

Was patient exposed to a potential tick habitat (wooded, brushy, or grassy area) within **14 days** prior to onset date? ☐No ☐Unknown ☐Yes

If yes, occupation: _____

TETANUS INVESTIGATION FORM

Comments

_____

_____

_____

Basic Demographic Data

Last Name: _____ First Name:_____
Middle Name:_____ Suffix: _____
DOB: __ __ / __ __ /__ __ __ __ Current Sex: □Female □Male □Unknown
Is the patient deceased? □No □ Unknown □Yes Deceased Date: __ __ / __ __ /__ __ __ __
Marital Status: (Circle) S / M / D / W/ Annulled/ Cohabitating/ Legally Separated/ Polygamous/Unknown
SSN: __ __ __ / __ __ /__ __ __ __
Street Address 1: _____
Street Address 2: _____
City: _____ State:_____
Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____
Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race : □ Unknown □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Investigation Summary

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: □Open □Closed
Investigator:_____ Date assigned: __ __ / __ __ /__ __ __ __

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __
Reporting Source: _____
Earliest Date Reported to: County: __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __
Reporter: _____

Clinical

Physician's Name: _____
Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Physician's Address: _____
City:_____ State:_____
Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country:_____
Was patient hospitalized for this illness? □No □ Unknown □Yes
If yes: hospital name: _____
Admission Date__ __ / __ __ /__ __ __ __ Discharge Date __ __ / __ __ /__ __ __ __ Duration of Stay _____days

Condition Section

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __
Illness End Date: __ __ / __ __ /__ __ __ __Illness Duration: _____ Circle: days/hrs./minutes/months/unknown/weeks/years
Age at Onset: _____ Circle: days/hrs./minutes/months/unknown/weeks/years
Did the patient die from this illness? □No □Unknown □Yes

Epidemiologic Section

Is this patient associated with a day care facility?	□No □Unknown □Yes	Is this patient a food handler?	□No □Unknown □Yes
Is this case part of an outbreak?	□No □Unknown □Yes	If yes, outbreak name:	

Where was the disease acquired?

□ Indigenous within jurisdiction	□ Out of Country	□Out of jurisdiction, from another jurisdiction
□ Out of state	□Unknown	

Confimation Method

□ Active Surveillance	□ Case Outbreak Investigation	□ Clinical Diagnosis	□Epidemiologically Linked
□ Laboratory Confirmed	□ Laboratory Report	□ Local/State Specified	□ Medical Record Review
□ No information given	□ Occupational Disease Surveillance	□ Provider Certified	□Other

CASE STATUS: (Required for Notification) ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐Unknown

Confirmation Date: : __ __/ __ __/__ __ __ __

MMWR Week _____ MMWR Year _____

Custom Fields

Date Due __ __/ __ __/__ __ __ __

Investigation Ready for Supervisor Review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete) ☐ Reviewed (Not a case) ☐Yes

Date Investigation ready for supervisor review: __ __/ __ __/__ __ __ __

Condition Specific Custom Fields

If yes, to associated with a school or daycare?

Name of school or daycare:

City of school or daycare:

County of school or daycare:

What grades attend the school (ie: K-12, K-6, 7-12, 7-8, 5-8, 9-12)	What grade is the case in at the school?

Are there other cases in the classroom or other cases in the school building, or both? Explain:

Clinical - Hospital	
Was this patient in the Intensive Care Unit (ICU)?	☐No ☐Unknown ☐Yes
Number of days patient was in ICU:	_____ days
Was this case mechanically ventilated?	☐No ☐Unknown ☐Yes
Number of days patient received mechanical ventilation:	_____ days
Clinical - Condition	
Date of tetanus symptom onset:	__ __/ __ __/__ __ __ __
Type of tetanus:	☐Cephalic ☐Generalized ☐ Localized ☐ Unknown
Condition Leading to Tetanus	
Was there an acute wound or injury?	☐No ☐Unknown ☐Yes
Date acute wound or injury occurred:	__ __/ __ __/__ __ __ __
Was the acute wound or injury work related?	☐No ☐Unknown ☐Yes

What was the environment where acute wound or injury occurred?

☐ Auto	☐ Construction site	☐ Farm/Yard/Garden	☐Home	☐ Indoors	☐ Other outdoors	☐ Unknown

Circumstances of acute wound or injury (e.g., stepped on a nail):

Principle anatomic site of acute wound or injury:

☐ Head	☐ Lower extremity	☐ More than 1 site	☐ Trunk	☐ Upper extremity

Principle acute wound or injury type:

☐ Abrasion	☐ Animal bite	☐ Body piercing	☐ Burn	
☐ Crush/Blunt injury	☐ Fracture	☐ Frostbite	☐ Human bite	
☐ Insect bite/Sting	☐ Laceration	☐ More than 1 wound type	☐ Puncture	
☐ Surgery	☐ Tattoo	☐ Tramatic amputation	☐ Unknown	☐Other

Prior to symptom onset	
Was medical care obtained for the acute wound or injury before tetanus symptom onset?	☐No ☐Unknown ☐Yes
Date of wound care:	__ __/ __ __/__ __ __ __
Was tetanus toxoid (Td, TT, DT, DTaP) administered for the acute wound or injury before tetanus symptom onset?	☐No ☐Unknown ☐Yes
Date patient received tetanus toxoid (Td, TT, DT, DTaP):	__ __/ __ __/__ __ __ __
Was tetanus immune globulin (TIG) prophylaxis given as part of wound care before tetanus symptom onset?	☐No ☐Unknown ☐Yes
Date patient received TIG prophylaxis:	__ __/ __ __/__ __ __ __
Prophylactic TIG dosage (units):	
Were there signs of infection at the time of care for the acute wound or injury?	☐No ☐Unknown ☐Yes
If there was no acute wound or injury, was there one or more non-acute conditions associated with the tetanus illness (e.g., abcess, ulcer)?	☐No ☐Unknown ☐Yes

Did/does the patient have

Abcess/Cellulitus:	☐No ☐Unknown ☐Yes	Ulcer:	☐No ☐Unknown ☐Yes
Blister:	☐No ☐Unknown ☐Yes	Gangrene:	☐No ☐Unknown ☐Yes
Cancer:	☐No ☐Unknown ☐Yes	Dental Infection/Gingivitis:	☐No ☐Unknown ☐Yes
Ear infection:	☐No ☐Unknown ☐Yes	Injection drug use:	☐No ☐Unknown ☐Yes
Other:	☐No ☐Unknown ☐Yes	Specify other:	

Was medical care obtained for the non-acute condition before tetanus symptom onset?	□No □Unknown □Yes
Date of medical care:	__ __/__ __/__ __ __ __
Was tetanus toxoid (Td, TT, DT, DTaP) administered for the non-acute condition before tetanus symptoms onset?	□No □Unknown □Yes
Date patient received tetanus toxoid (Td, TT, DT, DTaP):	__ __/__ __/__ __ __ __
Treatment of tetanus illness	
Was the wound infected at the time of tetanus diagnosis?	□No □Unknown □Yes
Was tetanus immune globulin (TIG) therapy given after tetanus symptom onset?	□No □Unknown □Yes
Date of TIG therapy:	__ __/__ __/__ __ __ __
Total therapeutic TIG dosage:	
Final outcome:	□Died □Recovered □Unknown
Laboratory	
Was a tetanus antibody test performed?	□No □Unknown □Yes
Date of tetanus antibody test:	__ __/__ __/__ __ __ __
Result of tetanus antibody test: ____ IU/mL(.01 thru 100):	
Vaccine Information	
Has the patient ever received tetanus toxoid (Td, TT, DT, DTaP)?	□No □Unknown □Yes
Total # doses: □1 □2 □3 □4 □More than 4 doses □Number unknown	
If known, enter date of patient's last tetanus dose:	__ __/__ __/__ __ __ __
OR, If known, enter year of patient's last tetanus dose:	___ ___ ___ ___
OR, approximate number of years since the patient's last tetanus dose:	
If the patient is unsure about his/her tetanus vaccination history, did the patient have:	
Immunizations in childhood?	False □ True □
Immunizations for school?	False □ True □
Immunizations for work?	False □ True □
Immunizations for military?	False □ True □
Immunizations for travel?	False □ True □
Immunizations for immigration?	False □ True □
Immunizations for other reasons?	False □ True □

If patient never received tetanus vaccination, give reason: .

□ Born outside the U.S.	□ Medical contraindication	□ Never offered vaccine	□ OtherParent/Patient forgot to vaccinate	
□ Parent/Patient refusal	□ Philosophical objection	□ Religious exemption	□ Under age for vaccination	□ Unknown

Epidemiologic	
Patient's primary occupation:	
Does the patient have diabetes?	□No □Unknown □Yes
Is the diabetic insulin dependent?	□No □Unknown □Yes
Is there a history of injection drug use?	□No □Unknown □Yes
Was the patient born in the U.S.?	□No □Unknown □Yes
If not U.S. born, patient's birth country:	
Neonatal Tetanus Case	
Was this patient less than 2 months old at time of tetanus illness?	□No □Unknown □Yes
Mother's Information	
Mother's age in years	
Mother's date of birth:	__ __/__ __/__ __ __ __
Mother's primary occupation:	
Was the mother born in the U.S.?	□No □Unknown □Yes
If not U.S. born, mother's birth country:	
If not U.S. born, date mother first resided in the U.S.:	__ __/__ __/__ __ __ __
OR, year mother first resided in the U.S.:	
OR, approximate length of time mother has been in the U.S.: _____years:	
Had the mother ever received tetanus vaccination prior to the infant's (case's) birth?	□No □Unknown □Yes
If Yes, then give the number of known doses:	□1 □2 □3 □4 □More than 4 doses □Number unknown

How long has it been since the mother received her last tetanus vaccination? _____
(units for the previous question): □ Months □ Years

If never vaccinated, give reason: :

□ Born outside the U.S.	□ Medical contraindication	□ Never offered vaccine	□ Other
□ Parent/Patient forgot to vaccinate		□ Parent/Patient refusal	□ Philosophical objection
□ Religious exemption		□ Under age for vaccination	□ Unknown

Number of previous pregnancies: _____ Number of live births (total): _____	
Has mother given birth previously in the U.S.? □No □Unknown □Yes If Yes, number of births delivered in the U.S.: _____	If Yes, list the dates (years): _____
Was prenatal care obtained during the pregnancy with the neonatal tetanus case?	□No □Unknown □Yes
Number of prenatal visits:	
Infant's (case's) birth place location:	□Home □Hospital □Unknown □ Other
Specify other birth place:	

Birth attendees:

□ EMS technician(s)	□ Family	□ Licensed midwife	□ Nurse
□ Physician	□ Unknown	□ Unlicensed midwife	□ Other

Clinical criteria for case classification

Acute onset of hypertonia:	□No □Unknown □Yes
Painful muscular contractions and generalized muscle spasms:	□no □not tested □unknown □ yes

Vaccination Record (Use Manage Vaccinations to add)

Date Administered: __ __ / __ __ /__ __ __ __

Age at Vaccination: _____ (Circle): days/hrs./minutes/months/unknown/weeks/years

Vaccination Anatomical Site:
□Left Arm □ Left Gluteus Maximus □Left Naris □Left Thigh □Oral Cavity
□Right Arm □Right Gluteus Maximus□Right Naris □Right Thigh □Other

Given By	
Provider:	
Organization:	
Vaccine Administered:	
Vaccine Manufacturer	
Lot Number:	

Expiration Date: __ __ / __ __ /__ __ __ __

Date Administered: __ __ / __ __ /__ __ __ __

Age at Vaccination: _____ (Circle): days/hrs./minutes/months/unknown/weeks/years

Vaccination Anatomical Site:
□Left Arm □ Left Gluteus Maximus □Left Naris □Left Thigh □Oral Cavity
□Right Arm □Right Gluteus Maximus□Right Naris □Right Thigh □Other

Given By	
Provider:	
Organization:	
Vaccine Administered:	
Vaccine Manufacturer	
Lot Number:	

Expiration Date: __ __ / __ __ /__ __ __ __

TRICHINELLOSIS/TRICHINOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

FOOD HANDLER

Did the patient work as a food handler after onset of illness? ☐No ☐Unknown ☐Yes

What was the last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __

Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is: **1 – 12 days**

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _ _____

ANIMAL CONTACT

Did the patient come in contact with an animal? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is : **1 – 12 days**

If yes, select type of animal: ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Goats ☐Lizard ☐Rodent ☐Sheep ☐Turkey ☐Turtle ☐Unknown ☐Other, specify: _____

Name or location of animal contact: _____

Did a patient acquire a pet prior to onset of illness? ☐No ☐Unknown ☐Yes

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐CSF leak
☐Alcohol abuse
☐Burns
☐Cirrhosis/liver failure
☐Deaf/profound hearing loss
☐Gastric surgery (type): _____
☐Immunodeficiency (type): _____
☐Leukemia
☐None
☐Other malignancy (type): _____
☐Peptic ulcer
☐Splenectomy/asplenia
☐Hodgkin's disease
☐Asthma
☐Cerebral vascular accident (CVA) stroke
☐Cochlear implant
☐Diabetes mellitus (insulin):☐No ☐Unk ☐Yes
☐Heart failure
☐Immunoglobulin deficiency
☐Multiple myeloma
☐Organ transplant (organ): _____
☐Other prior illness (type): _____
☐Renal failure/dialysis
☐Systemic lupus erythematosus (SLE)
☐IVDU
☐Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐Chronic GI illness/diarrhea
☐Current smoker
☐Emphysema/COPD
☐Hematologic disease (type): _____
☐Immunosuppressive therapy (steroids, chemotherapy)
☐Nephrotic Syndrome
☐Other liver disease (type): _____
☐Other renal disease (type): _____
☐Sickle cell anemia
☐Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐No ☐Unknown ☐Yes

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

Note: Please enter name and Case ID of epi-linked case(s) in the ALNBS General Comments section.

SIGNS AND SYMPTOMS

Did the patient have Eosinophilia? ☐No ☐Unknown ☐Yes If yes, specify amount: _____ ☐Percentage ☐Numeric

Fever: ☐No ☐Unknown ☐Yes Highest Temp: _____°F

Did the patient have any of the following signs or symptoms of Trichinellosis: ☐Myalgia ☐Other _____ ☐Periorbital edema

SUSPECTED FOOD

What suspected food did patient eat? ☐Non-pork ☐Pork ☐Unknown

Patient's Name _____

Street Address _____ (Last) _____ (First) _____ (M.I.) _____ (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2014

REPORT OF VERIFIED CASE OF TUBERCULOSIS

1. Date Reported
Month | Day | Year

2. Date Submitted
Month | Day | Year

3. Case Numbers
Year Reported (YYYY) | State Code | Locally Assigned Identification Number

- **State Case Number**
- **City/County Case Number**
- Reason:
- **Linking State Case Number**
- **Linking State Case Number**

4. Reporting Address for Case Counting
City
Within City Limits *(select one)* ☐ Yes ☐ No
County
ZIP CODE ____

5. Count Status *(select one)*

Countable TB Case
☐ Count as a TB case

Noncountable TB Case
☐ Verified Case: Counted by another U.S. area (e.g., county, state)
☐ Verified Case: TB treatment initiated in another country *Specify*_____
☐ Verified Case: Recurrent TB within 12 months after completion of therapy

6. Date Counted
Month | Day | Year

7. Previous Diagnosis of TB Disease *(select one)*
☐ Yes ☐ No
If YES, enter year of previous TB disease diagnosis:

8. Date of Birth
Month | Day | Year

9. Sex at Birth *(select one)*
☐ Male ☐ Female

10. Ethnicity *(select one)*
☐ Hispanic or Latino
☐ Not Hispanic or Latino

11. Race *(select one or more)*
☐ American Indian or Alaska Native
☐ Asian: *Specify*_____
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander: *Specify*_____
☐ White

12. Country of Birth
"U.S.-born" (or born abroad to a parent who was a U.S. citizen) *(select one)* ☐ Yes ☐ No
Country of birth: *Specify*_____

13. Month-Year Arrived in U.S.
Month | Year

14. Pediatric TB Patients (<15 years old)
Country of Birth for Primary Guardian(s): *Specify*
Guardian 1_____
Guardian 2_____
Patient lived outside U.S. for >2 months? *(select one)* ☐ Yes ☐ No ☐ Unknown
If YES, list countries, *specify*: _____

15. Status at TB Diagnosis *(select one)*
☐ Alive ☐ Dead
If DEAD, enter date of death: Month | Day | Year
If DEAD, was TB a cause of death? *(select one)*
☐ Yes ☐ No ☐ Unknown

16. Site of TB Disease *(select all that apply)*
☐ Pulmonary
☐ Pleural
☐ Lymphatic: Cervical
☐ Lymphatic: Intrathoracic
☐ Lymphatic: Axillary
☐ Lymphatic: Other
☐ Lymphatic: Unknown
☐ Laryngeal
☐ Bone and/or Joint
☐ Genitourinary
☐ Meningeal
☐ Peritoneal
☐ Other: Enter anatomic code(s) *(see list)*:
☐ Site not stated
1 ____
2 ____
3 ____

REPORT OF VERIFIED CASE OF TUBERCULOSIS

17. Sputum Smear *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected: Month Day Year

18. Sputum Culture *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected: Month Day Year

Date Result Reported: Month Day Year

Reporting Laboratory Type *(select one)*: ☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

19. Smear/Pathology/Cytology of Tissue and Other Body Fluids *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected: Month Day Year

Enter anatomic code *(see list)*:

Type of exam *(select all that apply)*: ☐ Smear ☐ Pathology/Cytology

20. Culture of Tissue and Other Body Fluids *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Collected: Month Day Year

Enter anatomic code *(see list)*:

Date Result Reported: Month Day Year

Reporting Laboratory Type *(select one)*: ☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

21. Nucleic Acid Amplification Test Result *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown
☐ Indeterminate

Date Collected: Month Day Year

Enter specimen type: ☐ Sputum
OR
If not Sputum, enter anatomic code *(see list):*

Date Result Reported: Month Day Year

Reporting Laboratory Type *(select one)*: ☐ Public Health Laboratory ☐ Commercial Laboratory ☐ Other

Initial Chest Radiograph and Other Chest Imaging Study

22A. Initial Chest Radiograph *(select one)*

☐ Normal ☐ Abnormal* (consistent with TB) ☐ Not Done ☐ Unknown

* For ABNORMAL Initial Chest Radiograph: Evidence of a cavity *(select one)*: ☐ Yes ☐ No ☐ Unknown

Evidence of miliary TB *(select one)*: ☐ Yes ☐ No ☐ Unknown

22B. Initial Chest CT Scan or Other Chest Imaging Study *(select one)*

☐ Normal ☐ Abnormal* (consistent with TB) ☐ Not Done ☐ Unknown

* For ABNORMAL Initial Chest CT Scan or Other Chest Imaging Study: Evidence of a cavity *(select one)*: ☐ Yes ☐ No ☐ Unknown

Evidence of miliary TB *(select one)*: ☐ Yes ☐ No ☐ Unknown

23. Tuberculin (Mantoux) Skin Test at Diagnosis *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown

Date Tuberculin Skin Test (TST) Placed: Month Day Year

Millimeters (mm) of induration:

24. Interferon Gamma Release Assay for *Mycobacterium tuberculosis* at Diagnosis *(select one)*

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown
☐ Indeterminate

Date Collected: Month Day Year

Test type:
*Specify*_____

25. Primary Reason Evaluated for TB Disease *(select one)*

☐ TB Symptoms
☐ Abnormal Chest Radiograph (consistent with TB)
☐ Contact Investigation
☐ Targeted Testing
☐ Health Care Worker
☐ Employment/Administrative Testing
☐ Immigration Medical Exam
☐ Incidental Lab Result
☐ Unknown

REPORT OF VERIFIED CASE OF TUBERCULOSIS

26. HIV Status at Time of Diagnosis *(select one)*

☐ Negative ☐ Indeterminate ☐ Not Offered ☐ Unknown
☐ Positive ☐ Refused ☐ Test Done, Results Unknown

If POSITIVE, enter:
State HIV/AIDS Patient Number: ☐☐☐☐☐☐☐☐☐☐ City/County HIV/AIDS Patient Number: ☐☐☐☐☐☐☐☐☐☐

27. Homeless Within Past Year *(select one)*

☐ No ☐ Yes ☐ Unknown

28. Resident of Correctional Facility at Time of Diagnosis *(select one)* ☐ No ☐ Yes ☐ Unknown

If YES, *(select one)*:
☐ Federal Prison ☐ Local Jail ☐ Other Correctional Facility
☐ State Prison ☐ Juvenile Correction Facility ☐ Unknown

If YES, under custody of Immigration and Customs Enforcement? *(select one)*
☐ No ☐ Yes

29. Resident of Long-Term Care Facility at Time of Diagnosis *(select one)* ☐ No ☐ Yes ☐ Unknown

If YES, *(select one)*:
☐ Nursing Home ☐ Residential Facility ☐ Alcohol or Drug Treatment Facility ☐ Unknown
☐ Hospital-Based Facility ☐ Mental Health Residential Facility ☐ Other Long-Term Care Facility

30. Primary Occupation Within the Past Year *(select one)*

☐ Health Care Worker ☐ Migrant/Seasonal Worker ☐ Retired ☐ Not Seeking Employment (e.g. student, homemaker, disabled person)
☐ Correctional Facility Employee ☐ Other Occupation ☐ Unemployed ☐ Unknown

31. Injecting Drug Use Within Past Year *(select one)*
☐ No ☐ Yes ☐ Unknown

32. Non-Injecting Drug Use Within Past Year *(select one)*
☐ No ☐ Yes ☐ Unknown

33. Excess Alcohol Use Within Past Year *(select one)*
☐ No ☐ Yes ☐ Unknown

34. Additional TB Risk Factors *(select all that apply)*

☐ Contact of MDR-TB Patient (2 years or less) ☐ Incomplete LTBI Therapy ☐ Diabetes Mellitus ☐ Other *Specify* _____
☐ Contact of Infectious TB Patient (2 years or less) ☐ TNF-α Antagonist Therapy ☐ End-Stage Renal Disease ☐ None
☐ Missed Contact (2 years or less) ☐ Post-organ Transplantation ☐ Immunosuppression (not HIV/AIDS)

35. Immigration Status at First Entry to the U.S. *(select one)*

☐ Not Applicable
- "U.S.-born" (or born abroad to a parent who was a U.S. citizen)
- Born in 1 of the U.S. Territories, U.S. Island Areas, or U.S. Outlying Areas

☐ Immigrant Visa ☐ Tourist Visa ☐ Asylee or Parolee
☐ Student Visa ☐ Family/Fiancé Visa ☐ Other Immigration Status
☐ Employment Visa ☐ Refugee ☐ Unknown

36. Date Therapy Started

Month ☐☐ Day ☐☐ Year ☐☐☐☐

37. Initial Drug Regimen *(select one option for each drug)*

	No	Yes	Unk		No	Yes	Unk		No	Yes	Unk
Isoniazid	☐	☐	☐	Ethionamide	☐	☐	☐	Moxifloxacin	☐	☐	☐
Rifampin	☐	☐	☐	Amikacin	☐	☐	☐	Cycloserine	☐	☐	☐
Pyrazinamide	☐	☐	☐	Kanamycin	☐	☐	☐	Para-Amino Salicylic Acid	☐	☐	☐
Ethambutol	☐	☐	☐	Capreomycin	☐	☐	☐	Other	☐	☐	☐
Streptomycin	☐	☐	☐	Ciprofloxacin	☐	☐	☐	*Specify* _____			
Rifabutin	☐	☐	☐	Levofloxacin	☐	☐	☐	Other	☐	☐	☐
Rifapentine	☐	☐	☐	Ofloxacin	☐	☐	☐	*Specify* _____			

Comments:

_____
_____
_____
_____

Patient's Name _____
(Last) (First) (M.I.)

Street Address _____ _____
(Number, Street, City, State) (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2014

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Initial Drug Susceptibility Report (Follow Up Report – 1)

Year Counted ☐☐☐☐

State Case Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City/County Case Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Submit this report for all culture-positive cases.

38. Genotyping Accession Number

Isolate submitted for genotyping *(select one)*: ☐ No ☐ Yes

If YES, genotyping accession number for episode: ☐☐☐☐☐☐☐☐☐☐☐☐

39. Initial Drug Susceptibility Testing

Was drug susceptibility testing done? *(select one)* ☐ No ☐ Yes ☐ Unknown

If NO or UNKNOWN, do not complete the rest of Follow Up Report –1

If YES, enter date FIRST specimen collected on which initial drug susceptibility testing was done:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

Enter specimen type: ☐ Sputum

OR

If not Sputum, enter anatomic code *(see list)*: ☐☐

40. Initial Drug Susceptibility Results *(select one option for each drug)*

	Resistant	Susceptible	Not Done	Unknown
Isoniazid	☐	☐	☐	☐
Rifampin	☐	☐	☐	☐
Pyrazinamide	☐	☐	☐	☐
Ethambutol	☐	☐	☐	☐
Streptomycin	☐	☐	☐	☐
Rifabutin	☐	☐	☐	☐
Rifapentine	☐	☐	☐	☐
Ethionamide	☐	☐	☐	☐
Amikacin	☐	☐	☐	☐
Kanamycin	☐	☐	☐	☐

	Resistant	Susceptible	Not Done	Unknown
Capreomycin	☐	☐	☐	☐
Ciprofloxacin	☐	☐	☐	☐
Levofloxacin	☐	☐	☐	☐
Ofloxacin	☐	☐	☐	☐
Moxifloxacin	☐	☐	☐	☐
Other Quinolones	☐	☐	☐	☐
Cycloserine	☐	☐	☐	☐
Para-Amino Salicylic Acid	☐	☐	☐	☐
Other	☐	☐	☐	☐
Specify _____				
Other	☐	☐	☐	☐
Specify _____				

Comments:

Public reporting burden of this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

Patient's Name _____
(Last) (First) (M.I.)

Street Address _____ _____
(Number, Street, City, State) (ZIP CODE)

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2014

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Case Completion Report

(Follow Up Report – 2)

Year Counted ☐☐☐☐

State Case Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City/County Case Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Submit this report for all cases in which the patient was alive at diagnosis.

41. Sputum Culture Conversion Documented *(select one)* ☐ No ☐ Yes ☐ Unknown

If YES, enter date specimen collected for FIRST consistently negative sputum culture:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

If NO, enter reason for not documenting sputum culture conversion *(select one)*:

☐ No Follow-up Sputum Despite Induction
☐ Patient Refused
☐ Patient Lost to Follow-Up
☐ No Follow-up Sputum and No Induction
☐ Other *Specify* _____
☐ Died
☐ Unknown

42. Moved

Did the patient move during TB therapy? *(select one)* ☐ No ☐ Yes

If YES, moved to where *(select all that apply)*:

☐ In state, out of jurisdiction *(enter city/county)* *Specify* _____ *Specify* _____

☐ Out of state *(enter state)* *Specify* _____ *Specify* _____

☐ Out of the U.S. *(enter country)* *Specify* _____ *Specify* _____

If moved out of the U.S., transnational referral? *(select one)* ☐ No ☐ Yes

43. Date Therapy Stopped

Month ☐☐ Day ☐☐ Year ☐☐☐☐

44. Reason Therapy Stopped or Never Started *(select one)*

☐ Completed Therapy
☐ Not TB
☐ Lost
☐ Died
☐ Uncooperative or Refused
☐ Other
☐ Adverse Treatment Event
☐ Unknown

If DIED, indicate cause of death *(select one)*:

☐ Related to TB disease
☐ Unrelated to TB disease
☐ Related to TB therapy
☐ Unknown

45. Reason Therapy Extended >12 months *(select all that apply)*

☐ Rifampin Resistance
☐ Non-adherence
☐ Clinically Indicated – other reasons
☐ Adverse Drug Reaction
☐ Failure
☐ Other *Specify* _____

46. Type of Outpatient Health Care Provider *(select all that apply)*

☐ Local/State Health Department (HD)
☐ IHS, Tribal HD, or Tribal Corporation
☐ Inpatient Care Only
☐ Unknown
☐ Private Outpatient
☐ Institutional/Correctional
☐ Other

Comments:

Public reporting burden of this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

Patient's Name _____ (Last) (First) (M.I.)

State Case No. _____

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

FORM APPROVED OMB NO. 0920-0026 Exp. Date 05/31/2014

REPORT OF VERIFIED CASE OF TUBERCULOSIS

Case Completion Report - *Continued*

(Follow Up Report – 2)

47. Directly Observed Therapy (DOT) *(select one)*

☐ No, Totally Self-Administered

☐ Yes, Totally Directly Observed

☐ Yes, Both Directly Observed and Self-Administered

☐ Unknown

Number of weeks of directly observed therapy (DOT) ☐☐☐

48. Final Drug Susceptibility Testing

Was follow-up drug susceptibility testing done? *(select one)* ☐ No ☐ Yes ☐ Unknown

If NO or UNKNOWN, do not complete the rest of Follow Up Report –2

If YES, enter date FINAL specimen collected on which drug susceptibility testing was done:

Month ☐☐ Day ☐☐ Year ☐☐☐☐

Enter specimen type: ☐ Sputum

OR

If not Sputum, enter anatomic code *(see list):* ☐☐

49. Final Drug Susceptibility Results *(select one option for each drug)*

	Resistant	Susceptible	Not Done	Unknown
Isoniazid	☐	☐	☐	☐
Rifampin	☐	☐	☐	☐
Pyrazinamide	☐	☐	☐	☐
Ethambutol	☐	☐	☐	☐
Streptomycin	☐	☐	☐	☐
Rifabutin	☐	☐	☐	☐
Rifapentine	☐	☐	☐	☐
Ethionamide	☐	☐	☐	☐
Amikacin	☐	☐	☐	☐
Kanamycin	☐	☐	☐	☐

	Resistant	Susceptible	Not Done	Unknown
Capreomycin	☐	☐	☐	☐
Ciprofloxacin	☐	☐	☐	☐
Levofloxacin	☐	☐	☐	☐
Ofloxacin	☐	☐	☐	☐
Moxifloxacin	☐	☐	☐	☐
Other Quinolones	☐	☐	☐	☐
Cycloserine	☐	☐	☐	☐
Para-Amino Salicylic Acid	☐	☐	☐	☐
Other	☐	☐	☐	☐
Specify _____				
Other	☐	☐	☐	☐
Specify _____				

Comments:

TULAREMIA INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ unknown ☐ weeks ☐ years

Did the patient die from this illness? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐ No ☐ Unknown ☐ Yes Is this patient a food handler? ☐ No ☐ Unknown ☐ Yes

Is this case part of an outbreak? ☐ No ☐ Unknown ☐ Yes If yes, outbreak name:_____

Where was the disease acquired? ☐ Indigenous within jurisdiction ☐ Out of Country ☐ Out of jurisdiction, from another jurisdiction ☐ Out of State ☐ Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐ Yes ☐ No

IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE (SUSPECT CASE STATUS). OTHERWISE CONTINUE INVESTIGATION.

SYMPTOMS AND SIGNS OF CURRENT EPISODE

Clinical Data

Was there an initial lesion indicating site of infection? ☐ No ☐ Unknown ☐ Yes
If yes, where? _____ Duration of lesion: _____

Was this case: ☐ Mild ☐ Severe Duration of illness: _____

Clinical Data

Type of exposure: ☐ Biting flies ☐ Rabbits ☐ Squirrel ☐ Ticks ☐ Wild Bird ☐ Other If other or Wild bird, specify: _____

Describe circumstances of exposure: _____

In what geographic locality was infection probably acquired? County: _____ Specific locality, if known: _____

Clinical criteria for case classification

A. Ulceroglandular (cutaneous ulcer with regional lymphadenophathy): ☐ No ☐ Unknown ☐ Yes
B. Glandular (regional lymphadenophathy with no ulcer): ☐ No ☐ Unknown ☐ Yes
C. Oculoglandular (conjunctivitis with preauricular lymphadenopathy): ☐ No ☐ Unknown ☐ Yes
D. Oropharyngeal (stomatitis or pharyngitis or tonsillitis and cervical lymphadenopathy): ☐ No ☐ Unknown ☐ Yes
E. Intestinal (intestinal pain, vomiting, and diarrhea): ☐ No ☐ Unknown ☐ Yes
F. Pneumonic (primary pleurpulmonary disease): ☐ No ☐ Unknown ☐ Yes
G. Typhoidal (febrile illness without early localizing signs and symptoms): ☐ No ☐ Unknown ☐ Yes

EXPOSURE

Does the patient have a history of tick or deerfly bite? ☐ No ☐ Unknown ☐ Yes

Was the patient exposed to tissues of a mammalian host of Francisella tularensis? ☐ No ☐ Unknown ☐ Yes

Was the patent exposed to potentially contaminated water? ☐ No ☐ Unknown ☐ Yes

LABORATORY CRITERIA

Clinical criteria for case classification

A. Was Francisella tularensis isolated from a clinical specimen? ☐ No ☐ Unknown ☐ Not tested ☐ Yes
B. Was there a demonstration of Francisella tularensis by immunofluorescence? ☐ No ☐ Unknown ☐ Not tested ☐ Yes
C. Was there a fourfold or greater rise in serum antibody titer to Francisella tularensis antigen? ☐ No ☐ Unknown ☐ Not tested ☐ Yes
D. Was there a single elevated serum antibody titer(s) to Francisella tularensis antigen? ☐ No ☐ Unknown ☐ Not tested ☐ Yes
E. Was there no history of tularemia vaccination? ☐ No ☐ Unknown ☐ Not tested ☐ Yes
F. Was there detection of Francisella tularensis in a clinical specimen by fluorescent assay? ☐ No ☐ Unknown ☐ Not tested ☐ Yes

PHEP - GENERAL

Presumptive diagnosis date: __ __ / __ __ /__ __ __ __

Method of initial report to Public Health: ☐ ELR ☐ E-mail ☐ Fax ☐ Mail ☐ Phone ☐ Online REPORT card

Which reporter type (or designee) provided initial report to Public Health?: ☐ Day care director ☐ Dentist ☐ Physician ☐ Hospital administrator ☐ Lab director ☐ Medical examiner ☐ Nurse ☐ Nursing home administrator ☐ Other state health department or CDC ☐ Patient ☐ School principal

PHEP PROJECT – CONTROL MEASURES IMPLEMENTED (Answer all)

Date first control measures implemented: __ __ / __ __ /__ __ __ __ Other measures: _____

Education case/contacts:	☐ No ☐ Unknown ☐ Yes ☐ N/A	Exclusion from foodhandling:	☐ No ☐ Unknown ☐ Yes ☐ N/A
Exclusion from healthcare:	☐ No ☐ Unknown ☐ Yes ☐ N/A	Exclusion from daycare/school:	☐ No ☐ Unknown ☐ Yes ☐ N/A
Immunizations:	☐ No ☐ Unknown ☐ Yes ☐ N/A	Prophylaxis:	☐ No ☐ Unknown ☐ Yes ☐ N/A
Identification of exposed individuals:	☐ No ☐ Unknown ☐ Yes ☐ N/A	Identification of additional cases:	☐ No ☐ Unknown ☐ Yes ☐ N/A
Identification of likely source of infection:	☐ No ☐ Unknown ☐ Yes ☐ N/A	Collection of food:	☐ No ☐ Unknown ☐ Yes ☐ N/A

Notify state/federal partner agencies/organizations: ☐ No ☐ Unknown ☐ Yes ☐ N/A

CASE CLASSIFICATION

Note: If physician does NOT feel the patient has LD, it is Not a Case.

1	Did patient have one of the following: • Ulceroglandular: cutaneous ulcer with regional lymphadenopathy • Glandular: regional lymphadenopathy with no ulcer • Oculoglandular: conjunctivitis with preauricular lymphadenopathy • Oropharyngeal: stomatitis or pharyngitis or tonsillitis and cervical lymphadenopathy • Intestinal: intestinal pain, vomiting, and diarrhea • Pneumonic: primary pleuropulmonary disease • Typhoidal: febrile illness without early localizing signs and symptoms	☐ No ☐ Unknown ☐ Yes
2	Detection of *F. tularensis* isolated from a clinical specimen:	☐ No ☐ Unknown ☐ Yes
3	Fourfold or greater change in serum antibody titer to *F. tularensis* antigen:	☐ No ☐ Unknown ☐ Yes
4	Elevated serum antibody titer(s) to F. tularensis antigen (without documented fourfold or greater change) in a patient with no history of tularemia vaccination:	☐ No ☐ Unknown ☐ Yes
5	Detection of *F. tularensis* in a clinical specimen:	☐ No ☐ Unknown ☐ Yes

Confirmed: 1 & 2 or 1 & 3 | **Probable: 1 & 4 or 1 & 5**

Typhoid and Paratyphoid Fever Investigation Form

☐ Typhoid Fever (Create ALNBS Typhoid Fever Investigation) ☐ Paratyphoid Fever (Create ALNBS Salmonellosis Investigation)

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Where was the disease acquired? ☐Indigenous within jurisdiction ☐Out of Country ☐Out of jurisdiction, from another jurisdiction ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments: _____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CLINICAL EVIDENCE

Fever: ☐No ☐Unknown ☐Yes Relative Bradycardia: ☐No ☐Unknown ☐Yes

Diarrhea: ☐No ☐Unknown ☐Yes Abdominal Pain: ☐No ☐Unknown ☐Yes

Constipation: ☐No ☐Unknown ☐Yes

Anorexia: ☐No ☐Unknown ☐Yes

EXPOSURES

If not a U.S. Citizen, country of origin: _____

If Antibiotic sensitivity testing was performed, was isolate resistant to: ☐Ampicillin ☐Trimethoprim-sulfamethoxazole ☐Chloramphenicol ☐Fluoroquinolones (e.g., Ciprofloxacine)

If patient received Typhoid vaccination, was it administered within **5 years** before illness onset? ☐No ☐Unknown ☐Yes

Typhoid vaccine received: ☐Standard killed ☐Oral Ty21a or Vivotif (Berna) 4 pill series ☐ViCPS or Typhim Vi shot (Pasteur Merieux)

DAY CARE

Attend a day care center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes

Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____

What type of day care facility: ☐Adult day health care ☐Adult day social care ☐Alzheimer's specific day care ☐Child care center ☐Child care provided by friend, relative, neighbor ☐In-home care giver

Is food prepared at this facility? ☐No ☐Unknown ☐Yes Does this facility care for diapered persons? ☐No ☐Unknown ☐Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? ☐No ☐Unknown ☐Yes

Last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __ Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel outside the U.S. within **30 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated?

☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated?

☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the **14 days** prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **14 days** prior to illness? ☐No ☐Unknown ☐Yes

What was the recreational water exposure type? (select all that apply)

☐Hot Spring ☐Hot Tub-Whirlpool-Jacuzzi-Spa ☐Interactive Fountain ☐Lake-Pond-River-Stream
☐Ocean ☐Other _____ ☐Recreational Water Park ☐Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐Camp Pool ☐Hospital/Therapy Pool ☐Hotel/Motel/Resort Vacation Pool
☐Kiddie/Wading Pool ☐Municipal/Community Pool ☐Neighborhood/subdivision/Apartment/Condo Pool
☐Other, specify_____ ☐Private Club/Membership Pool ☐Private Home Pool, not a kiddie/wading pool
☐School/College/University Pool ☐Unknown

Name or location of water exposure: _____

SEAFOOD EXPOSURE

Has the patient eaten seafood in the last **14 days**? ☐No ☐Unknown ☐Yes

Date raw seafood consumed: __ __ / __ __ / __ __ __ __ Time raw seafood consumed: __ __ : __ __ ☐AM ☐PM

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐No ☐Unknown ☐Yes

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the ALNBS Investigation.

OTHER CLINICAL DATA

Is the patient a U.S. Citizen? ☐No ☐Unknown ☐Yes

Was the patient symptomatic for **Typhoid** or **Paratyphoid Fever**? ☐No ☐Unknown ☐Yes

Was the case traced to a **Typhoid** or **Paratyphoid** carrier? ☐No ☐Unknown ☐Yes, carrier previously known to HD
☐Yes, carrier previously unknown to HD ☐Yes, unsure if carrier previously known to HD

VANCOMYCIN-INTERMEDIATE AND VANCOMYCIN-RESISTANT *STAPHYLOCOCCIS AUREUS* (VISA/VRSA) INVESTIGATION FORM

A HARD COPY OF THIS INVESTIGATION FORM MUST BE PROVIDED TO CENTRAL OFFICE VIA CD FAX (334) 206-3734

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness or did VISA/VRSA contribute to death? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes

Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

EXPOSURE

In the past year did the patient have:

☐Dialysis ☐Surgery ☐Invasive device or catheter in place at least 1 day before *S. aureus* culture collected

☐Prior hospitalization If yes, Date: __ __ / __ __ /__ __ __ __ Location: _____

☐Residence in a nursing home or other long-term care facility If yes, Date: __ __ / __ __ /__ __ __ __ Location: _____

Does the patient have prior history of Methacillin-Resistant *S. aureus* (MRSA)? ☐No ☐Unknown ☐Yes

If yes, Date of most recent MRSA positive culture: __ __ / __ __ /__ __ __ __ Culture Site: _____

Does the patient have prior history of Vancomycin-Resistant *Enterococcus* (VRE)? ☐No ☐Unknown ☐Yes

If yes, Date of most recent VRE positive culture: __ __ / __ __ /__ __ __ __ Culture Site: _____

Has the patient received vancomycin in the past year? ☐No ☐Unknown ☐Yes

If yes, Dates patient received vancomycin: __ __ / __ __ /__ __ __ __ to __ __ / __ __ /__ __ __ __

Is the patient a healthcare worker? ☐No ☐Unknown ☐Yes If yes, Location: _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐Alcohol Abuse	☐Current Smoker	☐HIV/AIDS	☐Neoplastic Disease	☐Renal Disease
☐Asthma	☐Cystic Fibrosis	☐Immunosuppressive Therapy	☐Neurologic/Neuromuscular Disease	
☐Cerebrovascular Disease	☐Diabetes Mellitus	☐IVDU	☐Other Drug Use	
☐Congestive Heart Failure	☐Emphysema/COPD	☐Liver Disease	☐Other, specify: _____	

LABORATORY TESTING

Was the isolate: ☐VISA (MIC = 4-8 µg/mL) ☐VRSA (MIC ≥ 16 µg/mL) If yes, vancomycin MIC _____ µg/mL

Was VISA/VRSA confirmed by a State Public Health Laboratory (SPHL)? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

Was VISA/VRSA confirmed by the Centers for Disease Control & Prevention (CDC)? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

VARICELLA (CHICKENPOX) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING INFORMATION

State Case ID: _____

Reporting Physician/Nurse: _____ Reporting Source: _____

Date of Report: __ __ / __ __ /__ __ __ __ Earliest Date Reported to: County: __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __

CLINICAL INFORMATION

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Which diagnosis did physician make? ☐Chickenpox (varicella) ☐Shingles (zoster)

Rash Onset Date: __ __ / __ __ /__ __ __ __ Rash Location: ☐Focal ☐Generalized ☐Unknown

If Focal, Dermatome: _____

If Generalized, Location First Noted (Select all that apply): ☐Arms ☐Face/Head ☐Inside Mouth ☐Legs ☐Other:_____ ☐Trunk

Total number of lesions: ☐<50 ☐>500 ☐250-499 ☐50-249 Number of lesion (if < 50): _____

Macules (flat) present: ☐No ☐Unknown ☐Yes Number of Macules: _____

Papules (raised) present: ☐No ☐Unknown ☐Yes Number of Papules: _____

Vesicles (fluid) present: ☐No ☐Unknown ☐Yes Number of Vesicles: _____

Character of lesions (all categories 1 to > 500):

Mostly Macular/Papular: ☐No ☐Unknown ☐Yes Hemorrhagic: ☐No ☐Unknown ☐Yes Crops/Waves: ☐No ☐Unknown ☐Yes

Mostly Vesicular: ☐No ☐Unknown ☐Yes Itchy: ☐No ☐Unknown ☐Yes Scabs: ☐No ☐Unknown ☐Yes

Did the rash crust: ☐No ☐Unknown ☐Yes Number of days until all lesions crusted over: _____ Number of days rash lasted: _____

Did the patient have a fever: ☐No ☐Unknown ☐Yes

Fever Onset: __ __ / __ __ /__ __ __ __ Highest Temp: _____°F Total number of days with fever: _____

Is the patient Immunocompromised due to medical condition or treatment: ☐No ☐Unknown ☐Yes

Specify medical condition or treatment: _____

Did the patient visit a healthcare provider during the illness: ☐No ☐Unknown ☐Yes

Did the patient develop any complication that were diagnosed by a healthcare provider: ☐No ☐Unknown ☐Yes

Skin/Soft Tissue Infection: ☐No ☐Unknown ☐Yes Dehydration: ☐No ☐Unknown ☐Yes

Cerebellitis/Ataxia: ☐No ☐Unknown ☐Yes Hemorrhagic Condition: ☐No ☐Unknown ☐Yes

Encephalitis: ☐No ☐Unknown ☐Yes Pneumonia: ☐No ☐Unknown ☐Yes

How was pneumonia diagnosed: ☐Medical Doctor (MD) ☐Unknown ☐X-ray

Other Complications: ☐No ☐Unknown ☐Yes Specify "Other Complications": _____

Was the patient treated with acyclovir, famvir, or any licensed antiviral for this illness: ☐No ☐Unknown ☐Yes

Name of Medication: ☐Acyclovir ☐Famvir ☐Other ☐Valacyclovir ☐Other Medication: _____

Start Date of Medication: __ __ / __ __ /__ __ __ __ Stop Date of Medication: __ __ / __ __ /__ __ __ __

Was the patient hospitalized for this illness: ☐No ☐Unknown ☐Yes Total duration of stay in the hospital (in days): _____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __

Hospital Information: _____

Did the patient die from varicella or complications (including secondary infection)? ☐No ☐Unknown ☐Yes

Date of Death: __ __ / __ __ /__ __ __ __ Autopsy performed: ☐No ☐Unknown ☐Yes Cause of Death: _____

LABORATORY INFORMATION

Was laboratory testing done for varicella? ☐No ☐Unknown ☐Yes

Direct fluorescent antibody (DFA) testing performed? ☐No ☐Unknown ☐Yes Date of DFA: __ __ / __ __ /__ __ __ __

DFA Result: ☐Indeterminate ☐Negative ☐Not Done ☐Pending ☐Positive ☐Unknown

Polymerase Chain Reaction (PCR) specimen? ☐No ☐Unknown ☐Yes Date of PCR Specimen: __ __ / __ __ /__ __ __ __

Source of PCR Specimen (Select all that apply): ☐Blood ☐Buccal swab ☐Macular scraping ☐Other _____
☐Saliva ☐Scab ☐Tissue culture ☐Urine ☐Vesicluar scab

PCR Result: ☐Indeterminate ☐Negative ☐Not Done ☐Other_____ ☐Pending ☐Positive ☐Unknown

Culture performed? ☐No ☐Unknown ☐Yes Date of Culture: __ __ / __ __ /__ __ __ __

Culture Result: ☐Indeterminate ☐Negative ☐Not Done ☐Pending ☐Positive ☐Unknown

Other Laboratory testing performed? ☐No ☐Unknown ☐Yes

Specify Other Test: ☐Electron microscopy ☐Tzanck smear Date of Other Test: __ __ / __ __ /__ __ __ __

Culture Result: ☐Indeterminate ☐Negative ☐Not Done ☐Pending ☐Positive ☐Unknown Other Test result value: _____

Serology performed? ☐No ☐Unknown ☐Yes

IgM performed: ☐No ☐Unknown ☐Yes Type of IgM Test: ☐Capture ELISA ☐Indirect ELISA ☐Other _____ ☐Unknown

IgM Collection Date: __ __ / __ __ /__ __ __ __ IgM Result: ☐Indeterminate ☐Negative ☐Not Done ☐Pending ☐Positive ☐Unknown

IgM Test result value: _____

IgG performed: ☐No ☐Unknown ☐Yes Type of IgG Test: ☐FAMA ☐gp ELISA, manufacturer MERCK ☐Latex Bead Agglutination
☐Other _____ ☐Whole Cell ELISA, manufacturer _____

Acute IgG Collection Date: __ __ / __ __ /__ __ __ __

Acute IgG Result: ☐Indeterminate ☐Negative ☐Not Done ☐Pending ☐Positive ☐Unknown Acute IgG Test result value: _____

Convalescent IgG Collection Date: __ __ / __ __ /__ __ __ __

Convalescent IgG Result: ☐Indeterminate ☐Negative ☐Not Done ☐Pending ☐Positive ☐Unknown Conv. IgG Test result value: _____

Were specimens sent to CDC for genotyping (molecular typing)? ☐No ☐Unknown ☐Yes Date sent to CDC: __ __ / __ __ /__ __ __ __

Was specimen sent for strain (wild or vaccine-type) identification? ☐No ☐Unknown ☐Yes

Strain Type: ☐Unknown ☐Vaccine Type Strain ☐Wild Type Strain

VARICELLA-CONTAINING VACCINE INFORMATION

Did the patient receive Varicella -containing vaccine? ☐No ☐Unknown ☐Yes

If No, Reason why patient did not receive varicella -containing vaccine:

☐Born outside the United States ☐Lab evidence of previous disease ☐MD diagnosis of previous disease

☐Medical contraindication ☐Never offered vaccine ☐Other _____

☐Parent/Patient forgot to vaccinate ☐Parent/Patient refusal ☐Parent/Patient report of previous disease

☐Philosophical objection ☐Religious exemption ☐Under age for vaccination ☐Unknown

Number of doses received on or after first birthday: _____

Reason patient is ≥6 years old and received one dose on or after 6th birthday but never received second dose:

☐Born outside the United States ☐Lab evidence of previous disease ☐MD diagnosis of previous disease

☐Medical contraindication ☐Never offered vaccine ☐Other _____

☐Parent/Patient forgot to vaccinate ☐Parent/Patient refusal ☐Parent/Patient report of previous disease

☐Philosophical objection ☐Religious exemption ☐Under age for vaccination ☐Unknown

Based on the person's age and current recommendations, has the case received the recommended doses of vaccine? ☐No ☐Unknown ☐Yes

VACCINE RECORD

1st Vaccination Date: __ __/__ __/__ __ __ __ Vaccine: ☐MMRV ☐Varicella Manufacturer: Merck Lot Number: _____

2nd Vaccination Date: __ __/__ __/__ __ __ __ Vaccine: ☐MMRV ☐Varicella Manufacturer: Merck Lot Number: _____

3rd Vaccination Date: __ __/__ __/__ __ __ __ Vaccine: ☐MMRV ☐Varicella Manufacturer: Merck Lot Number: _____

4th Vaccination Date: __ __/__ __/__ __ __ __ Vaccine: ☐MMRV ☐Varicella Manufacturer: Merck Lot Number: _____

5th Vaccination Date: __ __/__ __/__ __ __ __ Vaccine: ☐MMRV ☐Varicella Manufacturer: Merck Lot Number: _____

EPIDEMIOLOGIC INFORMATION

Patient History

Has this **Patient** ever been diagnosed with varicella before: ☐No ☐Unknown ☐Yes

Age at Diagnosis: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Previous case diagnosed by: ☐Other _____ ☐Parent/Friend ☐Physician/Health Care Provider

Where was the patient born (country): ☐ United States ☐Other Country _____

Epi-Link

Is this case **Epi-linked** to another confirmed or probable case: ☐No ☐Unknown ☐Yes

Type of case this case is epi -linked to: ☐Confirmed Varicella Case ☐Herpes Zoster Case ☐Probable Varicella Case

Transmission Setting (Setting of Exposure): ☐ Athletics ☐College ☐Community ☐Correctional Facility

☐Daycare ☐Doctor`s Office ☐Home ☐Hospital ER

☐Hospital Outpatient Clinic ☐Hospital Ward ☐International Travel ☐Military

☐Other _____ ☐Place of Worship ☐School ☐Unknown ☐Work

Is this case a healthcare worker? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak of 5 or more cases? ☐No ☐Unknown ☐Yes Outbreak Name: _____

Exemptions at institution: ☐No ☐Unknown ☐Yes Religious: _____ Medical: _____

If Transmission Setting is a school or daycare, is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes

Name of school or daycare: _____ City: _____ County: _____

What grades attend the school (i.e., K-12, K-6, 7-12, 7-8): _____

What grade is the case in at the school? ☐Pre-kindergarten ☐Kindergarten ☐1st ☐2nd ☐3rd ☐4th ☐5th ☐6th

☐Does not attend the school ☐Unknown ☐7th ☐8th ☐9th ☐10th ☐11th ☐12th

Are there other cases in the classroom or other cases in the school building, or both? Explain: _____

Case Status

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

Pregnant Women

Was the **Patient Pregnant** during this varicella illness? ☐No ☐Unknown ☐Yes

Number of weeks gestation at onset of illness (1 -45 weeks): _____ Trimester at Onset: ☐1st Trimester ☐2nd Trimester ☐3rd Trimester

GENERAL COMMENTS

_____

_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

Case Identifier: _____

VARICELLA (CHICKENPOX)

INVESTIGATION FORM

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____ Suffix: _____

DOB: _ _ /_ _ /_ _ _ _ Reported Age: _____ **d**ays hours minutes months unk weeks years

Current Sex*:* Female Male Unknown

Mortality Information as of Date: _ _ /_ _ /_ _ _ _ Is Patient Deceased? No Unk Yes Deceased Date: _ _ /_ _ /_ _ _ _

Marital Status as of Date: _ _ /_ _ /_ _ _ _ Marital Status? Annulled Cohabiting Divorced **L**egally separated Married Polygamous Single/Never Married Unk Widowed

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____

Zip*:* __ __ __ __ __- __ __ __ __ County:_____ Country:_____

Home Phone: (__ __ __) -- __ __ __ - __ __ __ __

Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __ __ Cell Phone: (__ __ __) -- __ __ __ - __ __ __ __

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race : American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Unknown

Investigation Information

Case Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: Open Closed

Investigator:_____ Date assigned: __ __ / __ __ /__ __ __

Reporting Information

State Case ID: [ ]

Reporting Physician/Nurse: _____

Reporting Source:_____

Date of Report: __ __ / __ __ /__ __ __ __

Earliest Date Reported to: County: __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __

Clinical Information

Diagnosis date: __ __ / __ __ /__ __ __ __

Illness Onset Date: __ __ / __ __ /__ __ __ __

Age at Illness Onset: _____ **d**ays hours minutes months unk weeks years

Which diagnosis did physician make? Chickenpox (varicella) Shingles (zoster)

Case Identifier: _____

Clinical Information (continued)

Rash Onset Date: __ __/ __ __/__ __ __ __ Rash Location: Focal Generalized Unknown

If Focal, Specify Dermatone: _____

If Generalized, Location First Noted: (Select all that apply) Arms Face/Head Inside Mouth Legs Other Trunk

Other Generalized Rash Location: _____

Number of lesions in total: < 50 > 500 250 - 499 50 - 249 Number of lesions (if < 50): _____

Macules (flat) present: No Unknown Yes Number of Macules: _____

Papules (raised) present: No Unknown Yes Number of Papules: _____

Vesicles (fluid) present: No Unknown Yes Number of Vesicles: _____

Character of Lesions(all categories-1 to >500):

Mostly macular/papular:	No	Unk	Yes	Hemorrhagic:	No	Unk	Yes	Crops/Waves:	No	Unk	Yes
Mostly vesicular:	No	Unk	Yes	Itchy:	No	Unk	Yes	Scabs:	No	Unk	Yes

Did the rash crust? No Unk Yes Number of days until all lesions crusted over: _____

Number of days rash lasted: _____

Did the patient have a **Fever**: No Unk Yes Date of Fever Onset: _ _/_ _/_ _ _ _

Highest measured temperature: _____ Celsius Fahrenheit Total number of days with fever: _____

Is patient **Immunocompromised** due to medical condition or treatment: No Unk Yes

Specify Medical Condition or Treatment: _____

Did the patient visit a healthcare provider during this illness: No Unk Yes

Did the patient develop any **Complications** that were diagnosed by a healthcare provider: No Unk Yes

Skin/Soft Tissue Infection: No Unk Yes Dehydration No Unk Yes

Cerebellitis/Ataxia: No Unk Yes Hemorrhagic Condition: No Unk Yes

Encephalitis: No Unk Yes Pneumonia: No Unk Yes

How was pneumonia diagnosed: Medical Doctor (MD) Unknown X-ray

Other Complications: No Unk Yes Specify "Other Complications": _____

_____

Was the patient treated with acyclovir, famvir, or any licensed antiviral for this illness: No Unk Yes

Name of Medication: Acyclovir Famvir Other Valacyclovir Other Medication: _____

Start Date of Medication: _ _/_ _/_ _ _ _ Stop Date of Medication: _ _/_ _/_ _ _ _

Was the patient hospitalized for this illness: No Unk Yes Total duration of stay in the hospital (in days): _____

Admission Date: _ _/_ _/_ _ _ _ Discharge Date: _ _/_ _/_ _ _ _

Hospital Information: _____

Did the patient die from varicella or complications (including secondary infection) associated with varicella: No Unknown Yes

Date of Death: _ _/_ _/_ _ _ _ Autopsy performed: No Unk Yes

Cause of death: _____

Case Identifier: _____

Laboratory Information

Was laboratory testing done for varicella: No Unk Yes

Was **direct fluorescent antibody (DFA)** testing performed: No Unk Yes Date of DFA: _ _/_ _/_ _ _ _

DFA Result: Indeterminate Negative Not Done Pending Positive Unknown

PCR Specimen: No Unknown Yes Date of PCR Specimen: _ _/_ _/_ _ _ _

Source of PCR Specimen: (Select all that apply) Blood Buccal Swab Macular Scraping Other Saliva Scab Tissue Culture Urine Vesicular Swab Specify "Other" PCR Source: _____

PCR Result: Indeterminate Negative Not Done Other Pending Positive Unknown

Specify "Other" PCR Result: _____

Culture Performed: No Unknown Yes Date of Culture Specimen: _ _/_ _/_ _ _ _

Culture Result: Indeterminate Negative Not Done Pending Positive Unknown

Was **Other laboratory** testing done: No Unk Yes

Specify Other Test: Electron microscopy Tzanck smear Date of Other Test: _ _/_ _/_ _ _ _

Other Lab Test Result: Indeterminate Negative Not Done Pending Positive Unknown

Other Test Result Value: _____

Serology performed: No Unk Yes

IgM performed: No Unk Yes

Type of IgM Test: Capture ELISA Indirect ELISA Other Unk Specify "Other" IgM Test: _____

Date IgM Specimen Taken: _ _/_ _/_ _ _ _

IgM Test Result: Indeterminate Negative Not Done Pending Positive Unknown

IgM Test Result Value: _____

IgG performed: No Unk Yes

Type of IgG Test: FAMA gp ELISA Latex Bead Agglutination Other Whole Cell ELISA

If "Whole Cell ELISA," specify manufacturer: _____

If "gp ELISA," specify manufacturer: Merck

Specify "Other" IgG Test: _____

Date of IgG - Acute: _ _/_ _/_ _ _ _

IgG - Acute Result: Indeterminate Negative Not Done Pending Positive Unknown

IgG - Acute Test Result Value: _____

Date of IgG - Convalescent: _ _/_ _/_ _ _ _

IgG - Convalescent Result: Indeterminate Negative Not Done Pending Positive Unknown

IgG - Convalescent Test Result Value: _____

Were the specimens sent to the CDC for genotyping (molecular typing): No Unk Yes

Date sent for genotyping: _ _/_ _/_ _ _ _

Was specimen sent for strain (wild- or vaccine-type) identification: No Unk Yes

Strain Type: Unknown Vaccine Type Strain Wild Type Strain

Varicella-Containing Vaccine Information

Did the patient receive Varicella-containing vaccine: No Unk Yes

If No, Reason why patient did not receive varicella-containing vaccine: Born outside the United States

Lab evidence of previous disease MD diagnosis of previous disease Medical contraindication

Never offered vaccine Other Parent/Patient forgot to vaccinate Parent/Patient refusal

Parent/Patient report of previous disease Philosophical objection Religious exemption

Under age for vaccination Unknown Specify "Other" Reason: _____

Number of doses received on or after first birthday: _____

Reason patient is >= 6 years old and received one dose on or after 6th birthday but never received second dose:

Born outside the United States Lab evidence of previous disease MD diagnosis of previous disease

Medical contraindication Never offered vaccine Other Parent/Patient forgot to vaccinate

Parent/Patient refusal Parent/Patient report of previous disease Philosophical objection

Religious exemption Under age for vaccination Unknown Specify "Other": _____

Based on the person's age and current recommendations, has the case received the recommended doses of vaccine for the disease under investigation? No Unk Yes

Vaccination Record

1st Vaccination Date: _ _/_ _/_ _ _ _ Vaccine: MMRV Varicella Manufacturer: Merck Lot Number: _____

2nd Vaccination Date: _ _/_ _/_ _ _ _ Vaccine: MMRV Varicella Manufacturer: Merck Lot Number: _____

3rd Vaccination Date: _ _/_ _/_ _ _ _ Vaccine: MMRV Varicella Manufacturer: Merck Lot Number: _____

4th Vaccination Date: _ _/_ _/_ _ _ _ Vaccine: MMRV Varicella Manufacturer: Merck Lot Number: _____

5th Vaccination Date: _ _/_ _/_ _ _ _ Vaccine: MMRV Varicella Manufacturer: Merck Lot Number: _____

Epidemiologic Information

Has this **Patient** ever been diagnosed with varicella before: No Unknown Yes

Age at Diagnosis : _____ **d**ays hours minutes months unknown weeks years

Previous case diagnosed by: Other Parent/Friend Physician/Health Care Provider

Specify "Other": _____

Where was the patient born (country): United States _____

Is this case **Epi-linked** to another confirmed or probable case: No Unknown Yes

Type of case this case is epi-linked to: Confirmed Varicella Case Herpes Zoster Case Probable Varicella Case

Transmission Setting (Setting of Exposure): Athletics College Community Correctional Facility Daycare

Doctor`s Office Home Hospital ER Hospital Outpatient Clinic Hospital Ward International Travel

Military Other Place of Worship School Unknown Work

Specify "Other" Transmission Setting: _____

Case Identifier: _____

Is this case a healthcare worker: No Unk Yes

Is this case part of an outbreak of 5 or more cases: No Unk Yes

Outbreak Name: _____

Exemptions at institution: No Unk Yes Religious _____ Medical _____

Does the patient have exemptions: No Unk Yes Religious (Patient) _____ Medical (Patient) _____

If Transmission Setting is a school or daycare, is this patient associated with a day care facility? No Unk Yes

Name of school or daycare _____

City of school or daycare _____

County of school or daycare _____

What grades attend the school (ie: K-12, K-6, 7-12, 7-8) _____

What grade is the case in at the school? Pre-kindergarten Kindergarten 1st 2nd 3rd 4th 5th 6th

7th 8th 9th 10th 11th 12th Does not attend the school Unknown

Are there other cases in the classroom or other cases in the school building, or both? Explain: _____

_____

Case Status: (Required for Notification) Confirmed Not a Case Probable Suspect Unknown

MMWR Week: _____ MMWR Year: _____

Confirmation Method (Select all that apply) Active Surveillance Case/Outbreak Investigation

Clinical diagnosis (non-laboratory confirmed) Epidemiologically-linked Laboratory-confirmed

Laboratory report Local/State specified Medical record review No information given

Occupational disease surveillance Provider certified Other

Date Due: _ _/_ _/_ _ _ _

Was there a recent known exposure to a person with shingles prior to the onset of symptoms? No Unk Yes

Was the **Patient Pregnant** during this varicella illness? No Unk Yes

Number of weeks gestation at onset of illness (1-45 weeks): _____

Trimester at Onset of Illness: 1st Trimester 2nd Trimester 3rd Trimester

Investigation Comments

_____

_____

_____

_____

_____

_____

YELLOW FEVER INVESTIGATION FORM

PATIENT DEMOGRAPHIC INFORMATION

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ E-mail: _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

TREATMENT & OUTCOME

Physician Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes, hospital:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __ Age at Onset: _____ ☐days ☐months ☐unknown ☐years

Did patient die as a result of (or complication from) yellow fever infection? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Where was the disease acquired? ☐Indigenous (within county) ☐In State (out of county) ☐Out of Country ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Probable ☐Not a Case ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

Select "Yes" only if case meets Confirmed or Probable Case Status: Is this case report published in ArboNET? ☐Yes ☐No

TYPE OF ARBOVIRUS *(Select Yellow Fever)*

☐CHIK Chikungunya	☐EEE Eastern Equine Encephalitis	☐Non-LaCrosse California Serogroup†	☐VEE Venezuelan Equine Encephalitis
☐CTF Colorado Tick Fever	☐Flavivirus Non Specified	☐Other Arbovirus	☐WEE Western Equine Encephalitis
☐CV Cache Valley	☐JE Japanese Encephalitis	☐POW Powassen	☐WNV West Nile Virus
☐DEN Dengue	☐LAC LaCrosse	☐SLE St Louis Encephalitis	☐YF Yellow Fever

† *California, Jamestown, Canyon, Keystone, Snowshoe hare, & Trivittatus*

GENERAL COMMENTS

_____

_____

_____

SUPERVISOR REVIEW (PHA 4)

Date Due: __ __ / __ __ /__ __ __ __ Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete) ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐AM ☐PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐Yes ☐No

IF NO CLINICAL INFORMATION AVAILABLE STOP HERE. ANSWER REMAINING REQUIRED FIELDS UNKNOWN IN ALNBS.

CLINICAL

Initial Signs & Symptoms

Did patient experience:	Acute Onset?	☐No	☐Unknown	☐Yes
	Constitutional (generalized) Symptoms?	☐No	☐Unknown	☐Yes
	Brief Remission?	☐No	☐Unknown	☐Yes

Recurrent Signs & Symptoms

Did the patient experience a recurrence of:	Fever (≥100.4°F)?	☐No	☐Unknown	☐Yes	Hepatitis?	☐No	☐Unknown	☐Yes
	Albuminuria?	☐No	☐Unknown	☐Yes	Renal Failure?	☐No	☐Unknown	☐Yes
	Generalized Hemorrhages?	☐No	☐Unknown	☐Yes	Shock?	☐No	☐Unknown	☐Yes

Clinical Syndrome

☐Asymptomatic (i.e., no fever or symptoms)	☐Encephalitis/Meningoencephalitis	☐Other Clinical
☐Dengue Fever	☐Hepatitis/Jaundice	☐Uncomplicated Fever
☐Dengue Fever with Hemorrhage	☐Meningitis	☐Unknown
☐Dengue Hemorrhagic Fever/Dengue Shock Syndrome	☐Multi-System Organ Failure	

RISK FACTORS

Blood

Was the patient identified by blood donor screening? ☐No ☐Unknown ☐Yes

Did the patient donate blood within **6 days** prior to onset? ☐No ☐Unknown ☐Yes Donation Date: __ __ / __ __ /__ __ __ __

Did the patient receive a blood transfusion within **6 days** prior to onset? ☐No ☐Unknown ☐Yes

Organ

Did the patient donate an organ within **6 days** prior to onset? ☐No ☐Unknown ☐Yes

Did the patient receive an organ transplant within **6 days** prior to onset? ☐No ☐Unknown ☐Yes

Infant

Is the patient a breast fed infant/child? ☐No ☐Unknown ☐Yes

Is the patient an infant infected in utero (i.e., mother infected while pregnant)? ☐No ☐Unknown ☐Yes

Occupation

Does the patient work with arboviral agents in a laboratory? ☐No ☐Unknown ☐Yes

Does the patient work in an outside setting? ☐No ☐Unknown ☐Yes Time worked outside: _____hrs/day

Mosquito

During the **6 days** prior to onset, did patient get bit by a mosquito? ☐No ☐Unknown ☐Yes

During the **6 days** prior to onset, what is the average number or hours spent outdoors? _____hrs/day

How often is mosquito repellent used during time spent outside? ☐Always ☐Sometimes ☐Never

If mosquito repellent was used, did it contain DEET? ☐No ☐Unknown ☐Yes

History of

Central European encephalitis vaccine?	☐No	☐Unknown	☐Yes	Military service?	☐No	☐Unknown	☐Yes
Dengue fever infection?	☐No	☐Unknown	☐Yes	Previous arboviral infection?	☐No	☐Unknown	☐Yes
Japanese encephalitis vaccine?	☐No	☐Unknown	☐Yes	Yellow fever vaccine?	☐No	☐Unknown	☐Yes

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐No ☐Unknown ☐Yes Applicable incubation period for this illness is: **3 – 6 days**

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

_____