



Q Fever

County _____

Case name (last, first) _____
 Birth date ___/___/___ Age at symptom onset _____ Years Months
 Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHM Case ID (optional) _____

LHM notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHM _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply)

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (*specify:* Amer Ind *and/or* AK Native) Asian Black or African American
 Native HI/Pacific Islander (*specify:* Native HI *and/or* Pacific Islander) White Patient declined to respond Unk

Additional race information:

Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
 Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
 Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
 Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
 Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
 Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
 Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
 South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
 Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
 Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
 Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
 Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
 Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
 Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____

OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never

Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed

Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____

Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk

Clinical Features

Identified as acute or chronic Acute Chronic Unk

Y N Unk

Any fever, subjective or measured If yes, Temp measured? Yes No Highest measured temp _____°F

Chills or rigors

Cough

Fatigue

Malaise

Diarrhea (3 or more loose stools within a 24 hour period)

Nausea

Vomiting

Headache

Severe retrobulbar headache

Rash

Sweats

Y N Unk

Myalgia (muscle aches or pain)

Pneumonia

Diagnosed by X-Ray CT MRI Provider Only

Result Positive Negative Indeterminate Not tested Other _____

Elevated liver enzyme levels

Acute hepatitis

Chronic hepatitis

Chronic osteoarthritis

Chronic osteomyelitis

Chronic pneumonitis

Culture-negative endocarditis (particularly in a patient with previous valvulopathy or compromised immune system)

Hepatomegaly

Splenomegaly

Suspected infection of a vascular aneurysm

Suspected infection of a vascular prosthesis

Meningitis/meningoencephalitis

Predisposing Conditions

Y N Unk

Immunosuppressive therapy or condition, or disease Specify _____

Valvular heart disease or vascular graft

Hospitalization

Y N Unk

- Hospitalized at least overnight for this illness Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
- Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
- Mechanical ventilation or intubation required
- Still hospitalized As of ___/___/___

Y N Unk

- Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
- Autopsy performed
- Death certificate lists disease as a cause of death or a significant contributing condition

Pregnancy

Pregnancy status at time of symptom onset

- Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____
OB name, phone, address _____
Outcome of pregnancy Still pregnant Fetal death (miscarriage or stillbirth) Abortion
 Other _____
 Delivered – full term Delivered – premie Delivered – Unk
Delivery method Vaginal C-section Unk
- Postpartum (Estimated) delivery date ___/___/___
OB name, phone, address _____
Outcome of pregnancy Fetal death (miscarriage or stillbirth) Abortion
 Other _____
 Delivered – full term Delivered – premie Delivered – Unk
Delivery method Vaginal C-section Unk
- Neither pregnant nor postpartum Unk

RISK AND RESPONSE (Ask about exposures 3-30 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

- Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country _____
- Does the case know anyone else with similar symptoms or illness Ill contact's onset date ___/___/___
Contact setting/relationship to case Common Event Common meal Day care Female sexual partner
 Male sexual partner Friend Household contact Workplace
 Travel contact Other _____
- Household contact of person with occupational exposure

Y N Unk

- Unpasteurized milk (cow)**
- Other unpasteurized dairy** Specify _____
- Any contact with pet animals at home or elsewhere**
- Cats or kittens**
- Other pets** _____
- Any contact with farm animals, including chickens or ducks**
- Cows or calves**
- Goats**
- Sheep**

Y N Unk

- Other animal contact** _____
- Farm or dairy residence or work**
- Wildlife or wild animal exposure**
- Zoo, farm, fair or pet shop visit**
- Other exposure to animals** _____
- Source animal or bird identified Specify _____
- Blood transfusion or blood products (e.g., IG, factor concentrates) recipient Date of receipt ___/___/___
- Organ or tissue transplant recipient Date of receipt ___/___/___

Y N Unk

(Potential) Occupational exposure

Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse)

Specify animal _____

Animal birthing/placentas

Animal research

Dairy

Farm

Laboratory

Medical research

Rancher

Slaughterhouse

Tanning or rendering

Veterinary

Wool, felt, hair, or hides

Exposure and Transmission Summary

Y N Unk

Epidemiologic link to a confirmed human case

Likely geographic region of exposure In Washington – county _____ Other state _____

Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Foodborne Animal related Vectorborne Person to person Sexual

Blood products Unk Other _____

Describe _____

Suspected exposure setting Home Work College Military Correctional facility Laboratory

Long term care facility Homeless/shelter International travel Out of state travel Social event

Large public gathering Other _____

Describe _____

Exposure summary _____

Public Health Issues

Y N Unk

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

Date ___/___/___ Specify type of donation _____

Potential bioterrorism exposure

Notify FBI or Public Safety

Follow-up to assess exposure of laboratorians to specimen

Public Health Interventions/Actions

Y N Unk

Notified blood or tissue bank (if recent donation)

Letter sent Date ___/___/___ Batch date ___/___/___

Any other public health action _____

TREATMENT

Y N Unk

Did patient receive prophylaxis/treatment

Specify medication _____ Antibiotic Other _____

Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___

Prescribed dose _____ g mg ml Frequency _____ Duration _____ Days Weeks Months

Indication PEP Treatment for disease Incidental Other _____

Did patient take medication as prescribed Yes No - Why not _____ Unk

Prescribing provider _____

NOTES**LAB RESULTS**Lab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note _____

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest result status Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date ___/___/___

Upload documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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