

# PLAGUE (*YERSINIA PESTIS*) 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 daycare 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 MMWR Week: \_\_\_\_\_ MMWR Year: \_\_\_\_\_  
Where was the disease acquired?

**CONTROL MEASURES**

Date ADPH Investigator verbally provided patient, or patient representative, with control measures: \_\_\_/\_\_\_/\_\_\_\_\_

If control measures were not verbally provided (or not provided within the recommended timeframe), explain: \_\_\_\_\_

\_\_\_\_\_

Educations case/contacts: No Unknown Yes

Exclusion from foodhandling, healthcare, and/or daycare: No Unknown Yes

Prophylaxis including immunization of contacts: No Unknown Yes

Identification of additional cases/exposed individuals and contact tracing: No Unknown Yes

Identification/recovery of suspected source: No Unknown Yes

**ADMINISTRATIVE**

General Comments:

\_\_\_\_\_

\_\_\_\_\_

**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.*