Q FEVER INVESTIGATION FORM

☐ ACUTE ☐ CHRONIC

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:____

____

____

JEFFERSON COUNTY 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 CRITERIA FOR CASE CLASSIFICATION

Does the patient have an acute infection? ☐No ☐Unknown ☐Yes

- Fever: ☐No ☐Unknown ☐Yes
- Rigors: ☐No ☐Unknown ☐Yes
- Myalgia: ☐No ☐Unknown ☐Yes
- Malaise: ☐No ☐Unknown ☐Yes
- Retrobulbar headache: ☐No ☐Unknown ☐Yes
- Asymptomatic infection: ☐No ☐Unknown ☐Yes

Does the patient have a chronic infection? ☐No ☐Unknown ☐Yes

- Endocarditis: ☐No ☐Unknown ☐Yes
- Chronic fatigue like syndrome: ☐No ☐Unknown ☐Yes

Is patient epidemiologically linked to a confirmed case?: ☐No ☐Unknown ☐Yes
If yes, enter the associated NBS investigation ID(s): ____

LABORATORY CRITERIA FOR CASE CLASSIFICATION

Was there a fourfold or greater rise in antibody titer to Coxiella burnetii?: ☐No ☐Unknown ☐Yes ☐Not Tested

Was Coxiella burnetii isolated from a clinical specimen?: ☐No ☐Unknown ☐Yes ☐Not Tested

Was there demonstration of viral antigen or genomic sequence?: ☐No ☐Unknown ☐Yes ☐Not Tested

Was there a single supportive IgG or IgM titer?: ☐No ☐Unknown ☐Yes ☐Not Tested