

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: _____

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): _____

SYMPTOMS AND SIGNS

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 lymphadenopathy): No Unknown Yes
B. Glandular (regional lymphadenopathy 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 patient 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

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

CONTROL MEASURES IMPLEMENTED

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:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Prophylaxis:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> N/A
Identification of exposed individuals:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Identification of additional cases:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> N/A
Identification of likely source of infection:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Collection of food:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> N/A
Notify state/federal partner agencies/organizations:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> N/A		