



Psittacosis

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

Y N Unk
 Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F
 Chills or rigors
 Cough Onset date ___/___/___
 Dyspnea (shortness of breath)
 Headache
 Myalgia (muscle aches or pain)
 Photophobia (eyes sensitive to light)
 Pneumonia
 Diagnosed by X-Ray CT MRI Provider Only
 Result Positive Negative Indeterminate Not tested Other _____

Rash
 Endocarditis
 Hepatitis

Y N Unk
 Neurological complications _____

Predisposing Conditions

Y N Unk
 Immunosuppressive therapy or condition, or disease _____

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 – preemie 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 – preemie Delivered – Unk

Delivery method Vaginal C-section Unk

Neither pregnant nor postpartum Unk

RISK AND RESPONSE (Ask about exposures 5-28 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____	<input type="checkbox"/> County/City _____	<input type="checkbox"/> County/City _____
	<input type="checkbox"/> State _____	<input type="checkbox"/> State _____	<input type="checkbox"/> State _____
	<input type="checkbox"/> Country _____	<input type="checkbox"/> Country _____	<input type="checkbox"/> Country _____
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<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 _____

Contact with Psittacine bird (e.g., cockatoo, cockatiel, macaw, parakeet, parrot)

Contact with other pet bird Specify bird type _____

Contact with domestic fowl (e.g., chicken, turkey)

Contact with wild bird Specify bird type _____

Bird dropping or feather exposure without direct contact

Pet shop visit

Zoo visit

Source bird identified Species _____

Was source bird ill

Bird tested for psittacosis Yes – Positive test result Yes – Negative test result Not tested

Origin of infected bird Private home Private aviary Commercial aviary Pet shop Bird loft

Poultry establishment Unk Other _____

Address of origin location _____

(Potential) Occupational exposure Specify _____

Exposure and Transmission Summary

Y N Unk

Epidemiologic link to a confirmed or presumptive avian case

Epidemiologic link to a confirmed or presumptive 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 Animal related Person to person Health care associated Unk

Other _____

Describe _____

Suspected exposure setting Day care/Childcare School (not college) Doctor's office Hospital ward Hospital ER

Hospital outpatient facility Home Work College Military Correctional facility Place of worship

Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit

Social event Large public gathering Hotel/motel/hostel Other _____

Describe _____

Exposure summary _____

Public Health Interventions/Actions

Y N Unk

- Quarantine or treat infected birds
- Initiate trace-back investigation
- 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 Pending

Test 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 document

Ordering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____