Yellow 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 ______________________ LHJ Case ID (optional) ______________________

LHJ 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 ______________________ LHJ ______________________
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 childs) 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

Primary clinical syndrome ☐ Asymptomatic ☐ Uncomplicated fever ☐ Meningitis ☐ Encephalitis/meningoencephalitis
☐ Other neuroinvasive ☐ Hepatitis/jaundice ☐ Multi-organ failure
☐ Kidney (renal) abnormality or failure ☐ Unk
☐ Other clinical syndrome ________________________________

Y N Unk
☐ ☐ ☐ Asymptomatic (no clinical illness)
☐ ☐ ☐ **Any fever, subjective or measured** If yes, Temp measured? ☐ Yes ☐ No Highest measured temp _______ºF
If no, **Y N Unk**
☐ ☐ ☐ Has immunosuppressive condition (e.g., HIV/AIDS)
Specify ________________________________
☐ ☐ ☐ Used OTC medications that reduce fever
☐ ☐ ☐ Used treatments that suppress the immune system
☐ ☐ ☐ Other potential reason for lack of fever ____________________

Y N Unk
☐ ☐ ☐ **Chills or rigors**
☐ ☐ ☐ Hemorrhagic diathesis (gastrointestinal bleeding)
☐ ☐ ☐ Hemorrhagic signs
☐ ☐ ☐ Blood in vomitus, stool, urine
☐ ☐ ☐ Epistaxis (nose bleed)
☐ ☐ ☐ Gum bleeding
☐ ☐ ☐ Petechiae
☐ ☐ ☐ Positive tourniquet test
☐ ☐ ☐ Positive urinalysis
☐ ☐ ☐ Purpura/ecchymosis
☐ ☐ ☐ Vaginal Bleeding
☐ ☐ ☐ Other ________________________________
☐ ☐ ☐ **Pale stool, dark urine, yellowing of skin or eyes (jaundice)**
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Back pain
☐ ☐ ☐ **Myalgia (muscle aches or pain)**
☐ ☐ ☐ **Severe headache**
☐ ☐ ☐ Seizure new with disease
☐ ☐ ☐ Liver failure
☐ ☐ ☐ Proteinuria
☐ ☐ ☐ Kidney (renal) abnormality or failure
☐ ☐ ☐ Viral encephalitis in past (e.g., dengue, SLE, West Nile virus)

Case Name ________________________________ LHJ Case ID ________________________________

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

Vaccination

Y N Unk

☐ ☐ ☐ **Japanese encephalitis or yellow fever vaccination**

Vaccine information available ☐ Yes ☐ No

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________

Vaccine lot number ________________________________ Administering provider ________________________________

Clinical testing

Y N Unk

☐ ☐ ☐ **Albuminuria**

☐ ☐ ☐ Leukopenia

☐ ☐ ☐ Cross-reaction to other flaviviruses

☐ ☐ ☐ **Total bilirubin ≥ 3 mg/dl**

RISK AND RESPONSE (Ask about exposures 3-9 days before symptom onset)

Travel

Y N Unk

☐ ☐ ☐ **During the previous two weeks prior to onset of illness, travel to or residence in an area with a risk of yellow fever**

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City ____________ ☐ State ____________ ☐ Country ____________ ☐ Other ____________	☐ County/City ____________ ☐ State ____________ ☐ Country ____________ ☐ Other ____________	☐ County/City ____________ ☐ State ____________ ☐ Country ____________ ☐ 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 ____________________

☐ ☐ ☐ Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)

Activity ☐ Outdoor recreation ☐ Cabin ☐ Hunting ☐ Lawn mowing ☐ Other ____________________

Habitat ☐ Wooded/brushy ☐ Grassy ☐ Other ____________________

Where ☐ At home property ☐ Elsewhere ____________________

☐ ☐ ☐ In area with mosquito activity or remember bite Date ___/___/___

Location of exposure ☐ Multiple exposures ☐ Other country ☐ Other state ☐ Unk ☐ WA county __________

Specify location ____________________

Y N Unk
☐ ☐ ☐ Blood transfusion or blood products (e.g., IG, factor concentrates) recipient Date ___/___/___
☐ ☐ ☐ Organ or tissue transplant recipient Date ___/___/___
☐ ☐ ☐ (Potential) Occupational exposure
☐ ☐ ☐ Lab worker
☐ ☐ ☐ Veterinarian
☐ ☐ ☐ Other Occupation ___________________________________

Infant Only
☐ ☐ ☐ Birth mother had febrile illness
☐ ☐ ☐ Breast fed
☐ ☐ ☐ Confirmed infection in birth mother
☐ ☐ ☐ Neonatal infection

Exposure and Transmission Summary
Y N Unk
☐ ☐ ☐ **Epi-linked to a confirmed 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 ☐ Vectorborne ☐ Blood products ☐ Unk ☐ 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___________________________________

Public Health Interventions/Actions
Y N Unk
☐ ☐ ☐ Breastfeeding education provided
☐ ☐ ☐ Notified blood or tissue bank (if recent donation)
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action ___________________________________

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 ________________________________

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