Retrieve Data

Reset Form

Form Approved
OMB No. 0920-0009

Tularemia Case Investigation Report

Date of report: _____ **Case ID #:** _____

Reporting and Basic Contact Information

Person reporting the case:	**Person taking the report**:
Agency/affiliation:	**Agency/affiliation**:
Phone number/Email:	**Phone number/Email**:

Has the local health department been notified? ☐ Yes ☐ No

If yes, provide name, phone number and/or email of contact person:

Treating Physician(s)

Phone number and/or email of contact person:

Hospital: **City/State:** **Phone:**

Patient Demographics

Age: _____

Sex: ☐ Female ☐ Male ☐ Unknown

Patient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Patient race: (select all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown

Residence: State: _____ County: _____ Zip: _____

Occupation: _____ **Works primarily:** ☐ Indoors ☐ Outdoors ☐ Both ☐ Unknown

Medical History and Current Illness

Any underlying medical conditions? ☐ Yes ☐ No ☐ Unknown

If yes, please indicate all conditions that apply: ☐ Cancer ☐ Cardiovascular Disease ☐ For females - pregnant ☐ Diabetes Mellitus ☐ Immunocompromised ☐ Pulmonary Disease ☐ Renal Disease

Other (specify): _____

Date of initial symptom onset: ___/___/___ (mm dd yyyy)

Date first seen by medical person: ___/___/___ (mm dd yyyy)

Location where first seen: ☐ Emergency Department ☐ Hospital ☐ Outpatient clinic/office ☐ Urgent Care Center ☐ Unknown ☐ Other: _____

Symptoms at initial presentation:

	Yes	No	Unknown		Yes	No	Unknown
Fever	☐	☐	☐	Skin lesions (e.g. papules, ulcer)	☐	☐	☐
Sweats/chills/rigors	☐	☐	☐	Swollen/tender lymph nodes	☐	☐	☐
Headache	☐	☐	☐	Conjunctival irratition/discharge	☐	☐	☐
Cough	☐	☐	☐	Sore throat	☐	☐	☐
Myalgias	☐	☐	☐	Weakness/lethargy/malaise	☐	☐	☐
Chest pain	☐	☐	☐	Nausea, vomiting, and/or diarrhea	☐	☐	☐
Shortness of breath	☐	☐	☐	Abdominal pain	☐	☐	☐

Other(s): _____

CDC 0.56.50 (E), CDC Adobe Acrobat 5.0 Electronic Version, 1/2006

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).

Next Page

Medical History and Current Illness (continued)

If known, vital signs at initial presentation: ***(if unknown, check here*** ☐***)*** **Date:** ____/____/____ (mm dd yyyy)

Temperature: _____ Blood pressure: _____/_____ Heart rate: _____ Respiratory rate: _____

Physical findings:	Yes	No	Unk	Description (e.g. location, size, tenderness, erythema, etc…):
Skin ulcer	☐	☐	☐	
Adenopathy	☐	☐	☐	
Pharyngitis/tonsillitis	☐	☐	☐	
Conjunctivitis	☐	☐	☐	
Other:_____				

Radiographic and Laboratory Findings

Chest X-ray:
☐ Yes (date: ____/____/____) (mm dd yyyy)
☐ No
☐ Unknown

Results:
Clear/normal
Hilar adenopathy
Infiltrates, unilateral
Infiltrates, bilateral
Interstitial changes
Pleural effusion
Pulmonary abscess
Pulmonary nodules
Unknown

Initial blood tests: (date: ____/____/____) (mm dd yyyy)

WBC (x 10^3): _____ Differential (indicate %) Segs: _____ Bands: _____ Lymphs: _____

Hgb (mg/dl) or Hct: _____ Platelets (x 10^3): _____ BUN (U/dl): _____ Creatinine (mg/dl): _____

Tularemia testing:	Yes	No	Unk	Date specimen collected (mm / dd / yyyy)	Test(s) performed - Results (e.g. culture - positive, DFA - positive, PCR - negative)
Blood culture (1)	☐	☐	☐	____/____/____	
Blood culture (2)	☐	☐	☐	____/____/____	
Ulcer/wound swab	☐	☐	☐	____/____/____	
Lymph node aspirate	☐	☐	☐	____/____/____	
Sputum sample	☐	☐	☐	____/____/____	
_____	☐	☐	☐	____/____/____	

Serology: **S1:** Date drawn ____/____/____ (mm dd yyyy) Titer: _____ **S2:** Date drawn ____/____/____ (mm dd yyyy) Titer: _____

Francisella tularensis **subspecies identified:** ☐ Type A (i.e. *tularensis*) ☐ Type B (i.e. *holartica)*
☐ Other (specify: _____) ☐ Unknown

Clinical Course and Treatment

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown Admit date: ____/____ (mm / (dd)) Discharge date: ____/____ (mm / dd)

Was the patient isolated? ☐ No ☐ Respiratory ☐ Contact ☐ Unknown Date isolated: ____/____ (mm / dd)

Did the patient receive antibiotics? ☐ Yes ☐ No ☐ Unknown

If yes, please list all antibiotics:

	Date started	Date stopped	Dosage and schedule
1. _____	____/____	____/____	
2. _____	____/____	____/____	
3. _____	____/____ (mm / dd)	____/____ (mm / dd)	

Previous Page

Clinical Course and Treatment (continued)

If hospitalized, what was the maximum temperature noted within first 72 hours of hospitalization: _____
How many days elapsed from symptom onset until symptoms improved (i.e. afebrile for 24 hours): _____

Complications:	Yes	No	Unknown		Yes	No	Unknown
ARDS	☐	☐	☐	Multisystem (i.e. ≥ 2) organ failure	☐	☐	☐
Amputation/limb ischemia	☐	☐	☐	Renal failure (Cr >2.0 mg/dl)	☐	☐	☐
Bleeding/DIC	☐	☐	☐	Secondary pneumonia	☐	☐	☐
Cardiac arrest	☐	☐	☐	Shock (SBP <90 mmHg)	☐	☐	☐

Other(s): _____

Initial diagnosis given: _____
Number of days from initial diagnosis until tularemia diagnosis given: _____
Classification of clinical syndrome: ***(please check here if unknown ☐)***

	Pneumonic	Ulceroglandular	Glandular	Oculoglandular	Oropharyngeal	Intestinal	Typhoidal
Primary (select one)	☐	☐	☐	☐	☐	☐	☐
Secondary (select all that apply)	☐	☐	☐	☐	☐	☐	☐

Outcome:
- ☐ Recovered, no complications
- ☐ Recovered, complications (please specify): _____
- ☐ Recovered, unknown complications
- ☐ Died (please specify cause and date of death): _____
- ☐ Unknown

Epidemiologic and Environmental Investigation

Possible exposure source and location: ***(please check all that apply)***

	Yes (specify location below)	No	Unknown
Contact with sick or dead animals	☐	☐	☐
Hunting, including contact with wild animals	☐	☐	☐
Lawnmowing or landscaping	☐	☐	☐
Tick, deerfly, or other biting fly bite	☐	☐	☐
Laboratory worker	☐	☐	☐
Contact or ingestion of uncooked meat	☐	☐	☐
Contact or ingestion of soil or untreated water	☐	☐	☐
Other (specify): _____	☐	☐	☐

Pets: Are there pets in the home? ☐No ☐Dog(s) ☐Cat(s) ☐Pocket pet(s) (e.g. hamster) ☐Other (specify below)
If have pets, are any ill or have any died? ☐No ☐Yes ☐Unknown
If have pets, have they brought home dead animals? ☐No ☐Yes ☐Unknown

Is this patient's illness associated with any other human tularemia cases? ☐No ☐Yes (specify below) ☐Unknown

Comments regarding the environmental and epidemiologic investigation (including exposures during 10 days preceeding illness onset; any travel within or outside of the United States; and/or explanations from above):

_____

Save Data Print