



Send completed forms to DOH Communicable Disease Epidemiology
 Fax: 206-418-5515

LHJ Use ID
 Reported to DOH Date ___/___/___
LHJ Classification
 Confirmed
 Probable
 By: Lab Clinical
 Other: _____
 Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID
 Date Received ___/___/___
DOH Classification
 Confirmed
 Probable
 No count; reason: _____

Q Fever

County _____

REPORT SOURCE

Initial report date ___/___/___
 Reporter (check all that apply)
 Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No Don't know
 Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____
 Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____
 Birth date ___/___/___ Age _____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other

CLINICAL INFORMATION

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y N DK NA
 Fever Highest measured temp: _____ °F
 Type: Oral Rectal Other: _____ Unk
 Chills
 Retrobulbar headache
 Muscle aches or pain (myalgia)
 Headache
 Cough onset date: ___/___/___
 Malaise
 Rash

Hospitalization

Y N DK NA
 Hospitalized for this illness
 Hospital name _____
 Admit date ___/___/___ Discharge date ___/___/___
Y N DK NA
 Died from illness Death date ___/___/___
 Autopsy

Predisposing Conditions

Y N DK NA
 Immunosuppressive therapy or disease
 Pregnant
 Estimated delivery date ___/___/___
 OB name, address, phone: _____

 Valvular heart disease or vascular graft

Laboratory

Collection date ___/___/___
Y N DK NA
 C. burnetii isolation by culture (clinical specimen)
 C. burnetii antigen or nucleic acid detection (clinical specimen)
 C. burnetii IgG or IgM positive
 C. burnetii phase II or phase I antigen antibody titer shows => 4-fold rise (paired serum specimens ideally taken 3-6 weeks apart)
 Serum aminotransferase (SGOT (AST), SGPT (ALT)) elevated above normal

Clinical Findings

Y N DK NA
 Meningoencephalitis
 Hepatitis
 Hepatomegaly
 Splenomegaly
 Pneumonia or pneumonitis
 X-ray confirmed Y N DK NA
 Endocarditis

NOTES

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

Exposure period

Days from onset: -21 -14

Calendar dates:

o
n
s
e
t

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case knows anyone with similar symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologic link to a confirmed human case</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologically linked to a consistent exposure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized milk (cow)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other unpasteurized milk (e.g. sheep, goat)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case lives or works on farm or dairy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse) Animal birthing/placentas <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA Animal (specify): _____</p> <p><input type="checkbox"/> Patient could not be interviewed</p> <p><input type="checkbox"/> No risk factors or exposures could be identified</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Zoo, farm, fair or pet shop visit</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Animal hair, wool, hides, bones</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any contact with animals at home or elsewhere Cat or kitten <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA Cattle, cow or calf <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA Goat <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA Sheep <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wildlife or wild animal exposure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other exposure to animal or bird Specify animal or bird: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed in laboratory</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any medical or dental procedure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Organ or tissue transplant recipient, Date: ___/___/___</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood transfusion or blood products (e.g. IG, factor concentrates) Date of receipt/transfusion: ___/___/___</p>
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Most likely exposure/site: _____ Site name/address: _____

Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

PUBLIC HEALTH ISSUES

Y N DK NA

Source animal or bird identified

Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset? Date: ___/___/___
Agency and location: _____
Specify type of donation: _____

Potential bioterrorism exposure

Outbreak related

PUBLIC HEALTH ACTIONS

Notify blood or tissue bank

Follow-up/prophylaxis of laboratorians exposed to specimen

Other, specify: _____

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ___/___/___

Local health jurisdiction _____