County of Los Angeles Public Health

Acute Communicable Disease Control
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www.publichealth.lacounty.gov/acd

MELIOIDOSIS INTAKE FORM

VCMR ID: _____ Census Tract: _____ Health District: _____

Investigator Name		Report Date	Time ☐ AM ☐ PM
Reporter Name	☐ Call ☐ Email	Agency Name	
Telephone ( )	Alternate Telephone ( )	Email Address	

INITIAL IMPRESSION: ☐ Single Case ☐ Laboratory Exposure

DEMOGRAPHIC INFORMATION

Patient Name-Last	First	Middle Initial	Date of Birth	Age	Sex

Address- Number, Street, Apt #	City	State	ZIP Code

Telephone number

Home: Work: Cell:

Race (check one)

☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other:_____

Ethnicity (check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

If Asian/Pacific Islander, please check one: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian ☐ Japanese ☐ Korean ☐ Laotian ☐ Samoan ☐ Vietnamese ☐ Other: _____

Occupation

Country of birth _____

Pregnant? (if Female) ☐ Yes ☐ No ☐ Unknown If Yes, due date: _____

If not U.S. Born - Date of Arrival in U.S. _____

PRESENT ILLNESS

Symptomatic: ☐ Yes ☐ No ☐ Unknown *If No, Skip this section and go to Epidemiological Risk Factors section.*

	Yes	No	Unk		Yes	No	Unk
Abdominal discomfort	☐	☐	☐	Joint pain	☐	☐	☐
Abscess (Specify. _____)	☐	☐	☐	Localized pain or swelling	☐	☐	☐
Anorexia	☐	☐	☐	Muscle pain/tenderness	☐	☐	☐
Chest pain	☐	☐	☐	Respiratory distress	☐	☐	☐
Cough	☐	☐	☐	Seizures	☐	☐	☐
Disorientation	☐	☐	☐	Ulceration	☐	☐	☐
Fever (highest temp _____ Fº)	☐	☐	☐	Weight loss (lbs. _____)	☐	☐	☐
Headache	☐	☐	☐	Other symptom(s).			

Onset date	Duration of symptoms (in days)	Date of Diagnosis	Diagnosis

Hospitalized ☐ Yes ☐ No ☐ Unk	Hospital Name	Medical Record Number	Outcome ☐ Survived ☐ Died ☐ Unknown	Date of Death

Antibiotics given? ☐ Yes ☐ No ☐ Unk	Specify Antibiotic(s).	Date Antibiotic Started	No. of Days Taken

DIAGNOSTIC TESTS

Date Specimen Collected

Specimen Type: ☐ Blood ☐ Sputum ☐ Urine ☐ Pus ☐ Throat swab ☐ Swabs from organ abscesses/wounds ☐ Other: Specify._____

Lab exam(s) conducted: ☐ Culture ☐ BACTEC/automated system ☐ PCR ☐ IHA ☐ Other: Specify. _____ ☐ Unknown

Serology (IHA): ☐ Acute ☐ Convalescent

Laboratory Results

Laboratory Name	Physician Name

Patient Name (last, first) _____ Date of Birth _____ VCMR ID: _____

EPIDEMIOLOGIC RISK FACTORS

Was this individual part of a recognized cluster or outbreak of melioidosis? ☐ Yes ☐ No ☐ Unk *If Yes, complete page 1 for each case.*

If Yes, please list the name(s) of other associated case(s). _____

_____

Travel from U.S. to another country **OR** to Mississippi, Puerto Rico, or the U.S. Virgin Islands in the past year? Yes ☐ No ☐ Unk ☐

If Yes, what country/U.S. region? _____ Dates of travel: _____ to _____

Have any of the following known medical conditions? Check all that apply.

☐ Diabetes mellitus ☐ Alcoholism ☐ Renal disease ☐ Chronic lung disease ☐ Thalassemia ☐ Immunosuppression ☐ Unknown

☐ Other: Specify. _____

Have any of the following exposures? Check all that apply.

☐ Military Service: Specify place: _____ When: _____

☐ Soil or water contact in endemic country: Specify place: _____ When: _____

☐ Animal (mammal, reptile, bird) contact: Specify animal: _____ When: _____

LABORATORY EXPOSURE

Was there a laboratory exposure? ☐ Yes ☐ No ☐ Unk *If No, Skip the Laboratory Exposure section.*

If Yes, Date of exposure _____ Total number exposed _____: High Risk _____ Low Risk _____

Laboratory name and location. _____

Activities resulting in exposure. _____

Describe potential exposure. _____

Date post-exposure prophylaxis (PEP) was offered/discussed _____ Risk Status: ☐ High ☐ Low ☐ Unknown

Date PEP initiated _____ PEP regimen used _____

Time between first exposure and start of PEP: _____ Dosing: _____ Duration: _____

Were any side effects reported with the PEP? ☐ Yes ☐ No ☐ Unk

If Yes, Date of onset _____

Describe side effects. _____

Did side effects result in the termination of PEP? ☐ Yes ☐ No ☐ Unk If Yes, how many days was prophylaxis administered? _____

Did side effects result in a switch to another antimicrobial agent? ☐ Yes ☐ No ☐ Unk

If Yes, Specify antimicrobial agent. _____

Date started. _____

Are serial serum specimens being collected? ☐ Yes ☐ No ☐ Unk

If Yes, Collection date of "baseline" serum sample? _____

Time between first exposure and initial serum collection: _____ ☐ Days ☐ Weeks

Dates of serum collection: Week 1 _____ Week 2 _____ Week 4 _____ Week 6 _____

REMARKS

☐ CDPH notified: Contact name _____ Date notified _____ Method: ☐ Call ☐ Email