ENCLOSURE 4: UNSPECIFIED RESPIRATORY ILLNESS OUTBREAK

Case Investigation Form

ID NUMBER:_____

INTERVIEWER:_____

AGENCY:_____

DATE OFNTERVIEW:____/____/____

PERSON INTERVIEWED: □Patient □Other

If other, Name of person _____

Telephone contact ____- ____- _____

Describe relationship _____

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____

SEX: □ Male □ Female DATE OF BIRTH: ____/____/____ AGE____

RACE: □ White□ Black □ Asian □ Other, specify _____ □Unknown

ETHNICITY: □ Hispanic □ Non-Hispanic □ Unknown

HOME TELEPHONE: ( ) _____-_____

WORK/OTHER TELEPHONE: ( ) _____-_____

HOME ADDRESS STREET: _____

CITY:_____ STATE:_____ZIP:_____

EMPLOYED: □ Yes □ No □ Unknown

OCCUPATION:_____

WORKPLACE/SCHOOL NAME:_____

WORK/SCHOOL ADDRESS: STREET: _____ CITY: _____

STATE:_____ZIP:_____

HOW MANY PEOPLE RESIDE IN THE SAME HOUSEHOLD? _____

LIST NAME(S), AGE(S), AND RELATIONSHIPS (use additional pages if necessary):

Name					
Age					
Relationship					

CLINICAL INFORMATION (as documented in admission history of medical record or from case/proxy interview)

CHIEF COMPLAINT: _____

DATE OF ILLNESS ONSET: ____/____/____

Briefly summarize History of Present Illness: _____

_____

_____

SIGNS AND SYMPTOMS:

Cough	□Yes	□No	□Unknown
If yes, sputum production?	□Yes	□No	□Unknown
If yes, any blood?	□Yes	□No	□Unknown
Chest pain	□Yes	□No	□Unknown
Shortness of breath	□Yes	□No	□Unknown
Stridor/wheezing	□Yes	□No	□Unknown
Cyanosis	□Yes	□No	□Unknown
Conjunctivitis	□Yes	□No	□Unknown
Tender/enlarged glands	□Yes	□No	□Unknown
Fever	□ Yes	□ No	□ Unknown
If yes, maximum temperature _____	□ °F	□ °C	
Antipyretics taken:	□Yes	□No	□Unknown
Headache	□Yes	□No	□Unknown
Muscle aches	□Yes	□No	□Unknown
Fatigue	□Yes	□No	□Unknown
Joint pains	□Yes	□No	□Unknown
Stiff neck	□Yes	□No	□Unknown
Altered mental status	□Yes	□No	□Unknown
Unconscious/unresponsive	□Yes	□No	□Unknown
Nausea	□Yes	□No	□Unknown
Vomiting	□Yes	□No	□Unknown
Diarrhea	□Yes	□No	□Unknown
Abdominal pain	□Yes	□No	□Unknown
Rash	□Yes	□No	□Unknown

If yes, describe:_____

Other symptom/abnormality:_____

Did patient appear to improve and then relapse? □Yes □No □Unknown

PAST MEDICAL HISTORY:

Diabetes	□Yes	□No	□Unknown
Cardiac disease	□Yes	□No	□Unknown
Pulmonary disease	□Yes	□No	□Unknown

If yes,
describe:_____

Malignancy □Yes □No □Unknown
If yes, specify type: _____
Currently on treatment: □Yes □No □Unknown
Currently pregnant □Yes □No □Unknown
HIV infection □Yes □No □Unknown
Other immunocompromising condition (e.g., renal failure, cirrhosis, chronic steroid use)
□Yes □No □Unknown
If yes, specify disease or drug therapy:_____ _____
Other underlying condition(s): _____
Prescription Medications: _____
_____

SOCIAL HISTORY:

Current alcohol abuse □Yes □No □Unknown
Past alcohol abuse □Yes □No □Unknown
Current injection drug use □Yes □No □Unknown
Past injection drug use □Yes □No □Unknown
Current smoker □Yes □No □Unknown
Former smoker □Yes □No □Unknown
Other illicit drug use □Yes □No □Unknown
If yes,
specify:_____

HOSPITAL INFORMATION:

HOSPITALIZED □ Yes □ No
NAME OF HOSPITAL: _____
DATE OF ADMISSION ____/____/____ DATE OF DISCHARGE ____/____/____

NAME OF ATTENDING PHYSICIAN: Last _____ First _____
Office Telephone: ( )____- _____ Pager: ( ) ____-_____ Fax: ( ) ____-_____

MEDICAL RECORD ABSTRACTION:

MEDICAL RECORD NUMBER:_____
HOSPITAL NAME:_____
ROOM NUMBER:_____
ADMISSION DIAGNOSIS(ES): 1) _____
2_____
3) _____

PHYSICAL EXAM:

Admission Vital Signs:

Temp____ (□oral / □rectal__ □ °F / □ °C) Heart Rate___ B/P___/___

Resp. Rate___ %Oxygen saturation _____

Mental Status: □Normal □Abnormal □Not Noted

If abnormal, describe:_____

Respiratory status: □Normal spontaneous □Respiratory distress □Ventilatory support

If abnormal, check all that apply:

□ rales □ decreased or absent breath sounds □ wheezing/stridor

□ other (specify:_____)

Skin: □Normal □Abnormal □Not Noted

If abnormal, check all that apply:

□ edema □ chest wall edema □ cyanosis □ erythema

□ sloughing/necrosis □ rash □ petechiae □ purpura

If rash present, describe type and location:_____

Other abnormal physical findings (describe):_____

DIAGNOSTIC STUDIES:

Test	**Results of tests done on admission (___/___/___)**	**Abnormal test result at any time (specify date mm/dd/yy)**
Hemoglobin (Hb)		(____/____/____)
Hematocrit (HCT)		(____/____/____)
Platelet (plt)		(____/____/____)
Prothrombin time (PT)		(____/____/____)
Partial thromboplastin time (PTT)		(____/____/____)
Total white blood cell (WBC)		(____/____/____)
WBC differential:		

Test	Results of tests done on admission (___/___/___)	Abnormal test result at any time (specify date mm/dd/yy)
		(____/____/____)
% granulocytes (PMNs)		(____/____/____)
% bands		(____/____/____)
% lymphocytes		(____/____/____)
Renal function: BUN/Cr		(____/____/____)
Liver enzymes: AST/ALT		(____/____/____)
Blood cultures	□ positive (specify_____) □ negative □ pending □ not done	□ positive (specify_____) □ negative □ pending □ not done (____/____/____)
Respiratory secretions: specimen type	□ expectorated sputum □ induced sputum □ bronchial alveolar lavage (BAL) □ tracheal aspirate	□ expectorated sputum □ induced sputum □ bronchial alveolar lavage (BAL) □ tracheal aspirate (____/____/____)
Respiratory secretions: Gram stain (check all that apply)	□ PMNs □ epithelial cells □ gram positive cocci □ gram negative cocci □ gram positive rods □ gram negative coccobacilli □ gram negative bipolar staining/safety pin shaped rods □ gram negative rods □ other _____	□ PMNs □ epithelial cells □ gram positive cocci □ gram negative cocci □ gram positive rods □ gram negative coccobacilli □ gram negative bipolar staining/safety pin shaped rods □ gram negative rods □ other_____ (____/____/____)

Test	Results of tests done on admission (___/___/___)	Abnormal test result at any time (specify date mm/dd/yy)
Respiratory secretions: Bacterial culture	□ positive (specify_____) □ negative □ pending □ not done	□ positive (specify_____) □ negative □ pending □ not done (____/____/____)
Respiratory secretions: Viral culture	□ positive (specify_____) □ negative □ pending □ not done	□ positive (specify_____) □ negative □ pending □ not done (____/____/____)
Respiratory secretions: Influenza antigen	□ positive □ negative □ pending □ not done	□ positive □ negative □ pending □ not done (____/____/____)
Respiratory secretions: Other tests (DFA, PCR, etc.)		(____/____/____)
Chest radiograph	□ normal □ unilateral, lobar/consolidation □ bilateral, lobar/consolidation □ interstitial infiltrates □ widened mediastinum □ pleural effusion □ other _____	□ normal □ unilateral, lobar/consolidation □ bilateral, lobar/consolidation □ interstitial infiltrates □ widened mediastinum □ pleural effusion □ other _____ (____/____/____)
Legionella urine antigen	□ positive □ negative □ pending □ not done	□ positive □ negative □ pending □ not done (____/____/____)
Other pertinent study results (e.g., chest CT, pleural fluid)		(____/____/____)

Test	Results of tests done on admission (___/___/___)	Abnormal test result at any time (specify date mm/dd/yy)

INFECTIOUS DISEASE CONSULT: □Yes □No □Unknown

Date:___/___/___

Name of physician: Last _____ First _____

Telephone or beeper number ( ) _____ - _____

H0SPITAL TREATMENT:

a. antibiotics □Yes □No □Unknown

If yes, check all that apply:

□ Amoxicillin
□ Ampicillin
□ Ampicillin + sulbactam (Unasyn)
□ Augmentin (amoxicillin + clavulanate)
□ Azithromycin (Zithromax)
□ Cefazolin (Ancef, Kefzol)
□ Cefepime (Maxipime)
□ Cefixime (Suprax)
□ Cefotetan (Cefotan)
□ Cefotaxime (Claforan)
□ Cefoxitin (Mefoxin)
□ Ceftazidime (Fortaz, Tazicef, Tazidime)
□ Ceftizoxime (Cefizox)
□ Ceftriaxone (Rocephin)
□ Cefuroxime (Ceftin)
□ Cephalexin (Keflex, Keftab)
□ Ciprofloxacin (Cipro)
□ Clarithromycin (Biaxin)
□ Doxycycline (Doryx, Vibramycin)
□ Erythromycin (E-Mycin, Ery-Tab, Eryc
□ Gentamicin (Garamycin)
□ Levofloxacin (Levaquin)
□ Nafcillin
□ Ofloxacin (Floxin)
□ Streptomycin
□ Ticarcillin + clavulanate (Timentin)
□ Trimethaprim-sulfamethoxazole (Bactrim, Cotrim, TMP/SMX)
□ Vancomycin (Vancocin)
□ other_____

b. antivirals □Yes □No □Unknown

If yes, check all that apply:

□ Acyclovir (Zovirax)

□ Amantadine (Symmetrel)

□ Oseltamivir (Tamiflu)

□ Rimantidine (Flumadine)

□ Zanamivir (Relenza)

□ other _____

Did patient require intensive care? □Yes □No □Unknown

If patient was admitted to Intensive Care Unit:

a. Length of stay in ICU, in days:_____

b . Was patient on mechanical ventilation? □Yes □No □Unknown

WORKING OR DISCHARGE DIAGNOSIS(ES)

1) _____

2) _____

3) _____

OUTCOME:

□Recovered/discharged

□Died

□Still in hospital: a) improving □ b) worsening □

□ Comment_____ _____

ADDITIONAL COMMENTS: _____

_____

_____

Risk Exposure Questions

The following questions pertain to the 2 week period prior to the onset of your illness/symptoms:

Occupation (provide information for all jobs/ volunteer duties)

1. Please briefly describe your job/ volunteer duties:_____

2. Does your job involve contact with the public?
   Yes No
   If "Yes", specify_____

3. Does anyone else at your workplace have similar symptoms?
   Yes No Unk
   If "Yes", name and approximate date on onset (if known)_____

Knowledge of Other Ill Persons

4. Do you know of other people with similar symptoms? Y / N / Unk

(If Yes, please complete the following questions)

Name of ill person	Age	M/F	Address	Phone number (s)	Date of onset	Relation to you	Did they seek medical care? Where?	Were they diagnosed by a physician? Describe.

Travel*

*Travel is defined as staying overnight (or longer) at somewhere other than the usual residence

8. Have you traveled anywhere in the last two weeks? Y / N / Unk

Dates of Travel: ____/____/____ to ____/____/____
Method of Transportation for Travel: _____
Where Did You Stay? _____
Purpose of Travel? _____
Did You Do Any Sightseeing on your trip? Yes □ No □

If yes, specify: _____
Did Anyone Travel With You? Yes □ No □
If yes, specify: _____
Are they ill with similar symptoms? Yes □ No □ Unk □

Information for Additional Trips during the past two weeks:

_____
_____

Public Functions/Venues (during 2 weeks prior to symptom onset)

Category	**Yes/No/ Unknown (Y/N/U)**	**Description of Activity**	**Location of Activity**	**Date of Activity**	**Time of Activity** (start, end)	**Anyone else ill? (Y/N/U)**
9. Sporting Event						
10. Performing Arts (ie Concert, Theater, Opera)						
11. Movie Theater						
12. Religious Gatherings						
13. Picnics						
14. Political Events (including Marches and Rallies)						
15. Meetings or Conferences (for work or personal interests)						
16. Family Planning Clinics						
17. Government Office Building						
18. Airports						
19. Shopping Malls						
20. Gym/Workout Facilities						
21. Casinos						
22. Beaches						
23. Parks						
24. Parties (including Raves, Prom, etc)						
25. Bars/Clubs						
26. Tourist Attractions (ie Sea World, Zoo, Disneyland)						
27. Museums						
28. Street Fairs, Swap Meets, Flea Markets						
29. Carnivals/Circus						
30. Campgrounds						

Transportation

Have you used the following types of transportation in the 2 weeks prior to onset?

31. Bus Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Bus Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Bus#_____)
Company Providing Transportation: _____
Destination:_____

32. Train/Metro Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Route Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Route #_____)
Company Providing Transportation: _____
Destination:_____

33. Airplane Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Flight Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Flight #_____)
Company Providing Transportation: _____
Destination:_____

34. Boat/Ferry Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Ferry Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Ferry #_____)
Company Providing Transportation: _____
Destination:_____

35. Van Pool/Shuttle Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Route Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Route #_____)
Company Providing Transporation: _____
Destination:_____

Food & Beverage

36. During the 2 weeks before your illness, did you eat at any of the following ***food establishments or private gatherings with food or beverages***? (If "yes", circle establishment(s); describe below)

Restaurant, fast-food or deli	Y / N / Unk	Grocery store or salad-bar	Y / N / Unk
Cafeteria at school, hospital, other	Y / N / Unk	Plane, boat, train, other	Y / N / Unk
Concert, movie, other entertainment	Y / N / Unk	Gas station or 24-hr store	Y / N / Unk
Sporting event or snack bar	Y / N / Unk	Street-vended food	Y / N / Unk
Outdoor farmers market or swap meet	Y / N / Unk	Beach, park or outdoor event	Y / N / Unk
Dinner party, barbecue or potluck	Y / N / Unk	Other food establishment	Y / N / Unk
Birthday party or other celebration	Y / N / Unk	Other private gathering	Y / N / Unk

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain):_____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

37. During the 2 weeks before your illness, did you consume any free ***food samples*** from……..?

Grocery store	Y / N / Unk
Race/competition	Y / N / Unk
Public gathering?	Y / N / Unk
Private gathering?	Y / N / Unk

If "YES" for any in question #34, provide date, time, location and list of food items consumed:
Date/Time: _____ Location (Name and Address): _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #34, provide date, time, location and list of food items consumed:
Date/Time: _____ Location (Name and Address):_____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

38. During the 2 weeks before your illness, did you consume any of the following ***products***?

Vitamins	Y / N / Unk	Specify (Include Brand Name):_____
Herbal remedies	Y / N / Unk	Specify (Include Brand Name):_____
Diet Aids	Y / N / Unk	Specify (Include Brand Name):_____
Nutritional Supplements	Y / N / Unk	Specify (Include Brand Name):_____
Other Ingested non-food	Y / N / Unk	Specify (Include Brand Name):_____

39. During the 2 weeks before your illness, did you consume any unpasteurized products (ie milk, cheese, fruit juices)? Y/N/Unk If yes, specify name of item:_____
Date/Time: _____ Location (Name and Address):_____
Others also ill?: Y / N / Unk (explain): _____

40. During the 2 weeks before your illness, did you purchase food from any internet grocers? Y/N/Unk
If yes, specify date / time of delivery:_____ Store/Site:_____
Items purchased:_____

41. During the 2 weeks before your illness, did you purchase any mail order food? Y/N/Unk
If yes, specify date/time of delivery:_____ Store purchased from:_____
Items purchased:_____

42. Please check the routine sources for drinking water (check all that apply):
□ Community or Municipal □ Well (shared) □ Well (private family)
□ Bottled water (Specify Brand:_____) □ Other (Specify:_____)

Aerosolized water

43. During the 2 weeks prior to illness, did you consume water from any of the following sources (check all that apply):
□ Wells □ Lakes □ Streams □ Springs □ Ponds □ Creeks □ Rivers
□ Sewage-contaminated water
□ Street-vended beverages (Prepared with water and sold by street vendors)
□ Ice prepared w/ unfiltered water (Prepared with water that is not from a municipal water supply or that is not bottled or boiled)
□ Unpasteurized milk
□ Other (Specify:_____)

If "YES" for any in question #43, provide date, time, location and type of water consumed:
Date/Time: _____ Location (Name and Address):_____
Type of water consumed: _____
Others also ill?: Y / N / Unk (explain):_____

44. During the 2 weeks prior to illness, did you engage in any of the following recreational activities (check all that apply):

□ Swimming in public pools (e.g., community, municipal, hotel, motel, club, etc)
□ Swimming in kiddie/wading pools
□ Swimming in sewage-contaminated water
□ Swimming in fresh water, lakes, ponds, creeks, rivers, springs, sea, ocean, bay (please circle)
□ Wave pools □ Water parks □ Waterslides □ Surfing
□ Rafting □ Boating □ Hot tubs (non-private) □ Whirlpools (non-private)
□ Jacuzzis (non-private) □ Other (Specify:_____)

If "YES" for any in question #44, provide date, time, location and type of activity:
Date/Time: _____ Location (Name and Address):_____
Type of water consumed: _____
Others also ill?: Y / N / Unk (explain):_____

If "YES" for any in question #44, provide date, time, location and type of activity:
Date/Time: _____ Location (Name and Address):_____
Type of water consumed: _____
Others also ill?: Y / N / Unk (explain):_____

45. During the 2 weeks prior to illness, were you exposed to aerosolized water from any of the following sources (check all that apply):

□ Air conditioning at public places □ Respiratory devices* □ Vaporizers*
□ Humidifiers* □ Misters* □ Whirlpool spas* □ Hot tubs*
□ Spa baths* □ Creek and ponds □ Decorative fountains*
□ Other (please explain) _____
* Non-private (i.e., used at hospitals, spas, salons, etc.)

If "YES" for any in question #45, provide date, time, and location of exposure to aerosolized water:
Date/Time: _____ Location (Name and Address):_____
Explanation of aerosolized water: _____
Others also ill: Y / N / Unk (explain):_____

If "YES" for any in question #45, provide date, time, and location of exposure to aerosolized water:

Date/Time: _____ Location (Name and Address):_____
Explanation of aerosolized water: _____
Others also ill: Y / N / Unk (explain):_____

Recreation*

**Recreation is defined as non-work related activities*

46. In the past two weeks, did you participate in any outdoor activities? Y / N / Unk
(If "yes", list all and provide location)

_____
_____

47. Do you recall any insect or tick bites during these outdoor activities? Y / N / Unk
(If "yes", list all and provide location)

_____
_____

48. Did you participate in other indoor recreational activities (i.e. clubs, crafts, etc that do not occur in a private home)? Y / N / Unk
(List all and provide location)

_____
_____

Vectors

49. Do you recall any insect or tick bites in the last 2 weeks? Y / N / Unk
Date(s) of bite(s):_____ Bitten by □ Mosquito □ Tick □ Flea □ Fly □ Other:
Where were you when you were bitten? _____

50. Have you had any contact with wild or domestic animals, including pets? Y / N / Unk
Type of Animal: _____ Explain nature of contact:_____

Is / was the animal ill recently: Y / N / Unk Symptoms:_____
Date / Time of contact:_____ Location of contact:_____

51. To your knowledge, have you been exposed to rodents/rodent droppings in the last 2 weeks?
Y / N / Unk If yes, explain type of exposure:_____
Date/Time of exposure:_____
Location where exposure occurred:_____