



Enterovirus D68 Infection

County _____

LHJ Use ID _____
 Reported to DOH Date ___/___/___
 LHJ Classification Confirmed
 Probable
 Patient Under Investigation (Suspect)
 By: Lab Clinical
 Epi Link: _____

Outbreak-related
 LHJ Cluster# _____
 LHJ Cluster Name: _____
 PHL Lab # _____
 DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No DK Date of interview ___/___/___
 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: _____
 Zip code (school or occupation): _____ 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 Unk
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk
 Language: _____

CLINICAL INFORMATION

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

Signs and Symptoms

Y N DK NA
 Fever Highest measured temp (°F): _____
 Onset date ___/___/___
 Runny nose
 Sneezing
 Cough
 Shortness of breath or difficulty breathing
 New-onset asthma
 New-onset wheezing
 Skin rash
 Mouth blisters
 Body and muscle aches
 Other: _____

Clinical Findings

Y N DK NA
 Wheezing
 Hypoxemia
 Tachypnea
 Bronchiolitis
 Pneumonia
 Chest x-ray showing infiltrates
 Rhonchi
 Rales
 Other: _____

Hospitalization

Y N DK NA
 Healthcare visit prior to hospitalization
 Location _____ Date ___/___/___
 Location _____ Date ___/___/___
 Hospitalized at least overnight for this illness
 Hospital name _____
 Admit ___/___/___ Discharge ___/___/___
Y N DK NA
 Admitted to intensive care unit
 Mechanical ventilation
 Died from illness Death date ___/___/___
 Autopsy Specimens available: _____

Predisposing Conditions

Y N DK NA
 Any history of:
 Asthma/wheezing
 Chronic lung disease/recurrent resp infection
 Immunocompromised
 Chemotherapy
 Hemoglobinopathy
 Steroid therapy
 Cystic Fibrosis
 Hemodialysis
 Diabetes
 Obesity Ht:___(in) Wt:___(lbs)
 Leukemia
 Congestive heart failure
 Congenital genetic anomaly
 Other: _____
 Pregnant if yes, weeks: _____

Laboratory

P = Positive O = Other N = Negative
 NT = Not Tested I = Indeterminate

P N I O NT
 Enterovirus/rhinovirus RT-PCR
 Date: ___/___/___ Specimen type: _____
 Result: rhino/entero rhino entero
 Lab: Hospital/commercial lab CDC both
 CDC Enterovirus D-68 Test result
 Respiratory Panel Test type: _____ Lab: _____
 Result: flu parafu adeno HMP RSV
 Date: ___/___/___ Specimen type: _____

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Incubation period and period of communicability for EV-D68 are unknown.

Exposure period* Days from onset:

Contagious period Consider contagious until 10 days after onset or until respiratory symptoms absent or improving.

Calendar dates:

o
n
s
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t

EXPOSURE (only required for novel flu infections)

<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"/> Contact with person with similar symptoms: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologically linked to lab-confirmed case of EVD68</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Part of a defined cluster of respiratory illnesses</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Healthcare worker</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"/> Healthcare setting exposure <input type="checkbox"/> Hospital <input type="checkbox"/> ER <input type="checkbox"/> Outpatient <input type="checkbox"/> Long-term care <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> U.S. military</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Air flight crew</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congregate living or employment <input type="checkbox"/> Long term care <input type="checkbox"/> Barracks <input type="checkbox"/> Corrections <input type="checkbox"/> Dormitory <input type="checkbox"/> Boarding school <input type="checkbox"/> Camp <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____</p>
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Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

PUBLIC HEALTH ISSUES

Y N DK NA

Nosocomial infection suspected

Work/volunteer in healthcare setting during contagious period
Facility name: _____

Close contact works in healthcare setting

Resident of/staff in long-term care facility
Facility name: _____

Attends childcare or preschool
School name: _____

Attends K-12
School name: _____

PUBLIC HEALTH ACTIONS

Outbreak investigation

Healthcare facility notified

NOTES

OPTIONAL HOUSEHOLD WORKSHEET

#	Name	Relationship*	Age (yrs)	Ill (Y/N)	T>100F	Diff breathing	Onset
1							/ /
2							/ /
3							/ /
4							/ /
5							/ /
6							/ /
7							/ /

* 1=spouse, 2=mother, 3=father, 4=son, 5 = daughter, 6=sister, 7=brother, 8=cousin, 9=aunt, 10=uncle, 11=grandmother, 12=grandfather, 13=no relation, 19=other

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

Local health jurisdiction _____ Record complete date ___/___/___