



Rare Diseases of Public Health Significance

County: _____

LHJ Use ID _____
 Reported to DOH Date ____/____/____
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Epi Link: _____

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

REPORT SOURCE

LHJ notification date ____/____/____ Investigation start date ____/____/____
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other

Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

OK to talk to case? Yes No DK Date of interview ____/____/____

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

CLINICAL INFORMATION

Onset date: ____/____/____ Derived Diagnosis date: ____/____/____ Illness duration: ____ days

Signs and Symptoms (Note: not all questions apply for all diseases)

Rare disease being reported: _____

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Y | N | DK | NA | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever Highest measured temp: _____ °F |
| | | | | Type: <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures new with disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle aches or pain (myalgia) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rash |

Hospitalization

Y N DK NA
 Hospitalized at least overnight for this illness

Hospital name _____
 Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA
 Died from illness Death date ____/____/____
 Autopsy Place of death _____

Laboratory

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

P N I O NT
 Specimens collected for lab testing
 Date: ____/____/____
 Specimen type: _____
 Results: _____

 Date: ____/____/____
 Specimen type: _____
 Results: _____

 Date: ____/____/____
 Specimen type: _____
 Results: _____

Clinical Findings

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

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| Y | N | DK | NA | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| | | | | X-ray result: <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> O <input type="checkbox"/> NT |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac involvement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Meningitis or encephalitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Altered mental status |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis or weakness |
| | | | | <input type="checkbox"/> Acute flaccid paralysis <input type="checkbox"/> Asymmetric |
| | | | | <input type="checkbox"/> Symmetric <input type="checkbox"/> Ascending <input type="checkbox"/> Descending |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neurologic abnormalities: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone or organ infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin lesion or skin abscess |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rash observed by health care provider |
| | | | | Describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhage |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sepsis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Complications, specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppressive therapy/disease: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Admitted to intensive care unit |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Preliminary diagnosis established |
| | | | | Diagnosis: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Final diagnosis established |
| | | | | Diagnosis: _____ |

(Rare disease being reported should be specified under "LHJ species/organism" field in PHIMS.)

(Positive results from lab tests should be entered in the notes field. Fields above are for optional use during investigations.)

EXPOSURES

Y N DK NA

- Travel out of the state, out of the country, or outside of usual routine
Out of: County State Country
Dates/Locations: _____
- Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____
- Contact with recent foreign arrival
Specify country: _____
- Epidemiologic link to a confirmed human case**
- Case knows anyone with similar symptoms
- Congregate living
 - Barracks Corrections Long term care
 - Dormitory Boarding school Camp
 - Shelter Other: _____

Y N DK NA

- Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
- Unusual rodent, bird, or other animal exposure
Specify: _____
- Insect or tick bite
 - Deer fly Flea Mosquito Tick
 - Louse Other: _____ Unk
 Location of insect or tick exposure
 WA county Other state Other country
 Multiple exposures Unk
 Date of exposure: __/__/__
- Occupational exposure
 - Lab worker Y N DK NA
 - Other: _____
 Occupation: _____
 Date of exposure: __/__/__
- Blood, organ or tissue transplant recipient
Date of receipt: __/__/__

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

Exposure details: _____

- No risk factors or exposures could be identified
- Patient could not be interviewed

PUBLIC HEALTH ISSUES

Y N DK NA

- 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: _____
- Suspected person to person transmission
- Bioterrorism related

PUBLIC HEALTH ACTIONS

- Isolation precautions
- Prophylaxis of appropriate contacts recommended:
 - Household members Roommates
 - Child care contacts Playmates Other children
 - Other patients Medical personnel EMTs
 - Co-workers Teammates Carpools
 - Other close contacts: _____
- Notify blood or tissue bank
- Other, specify: _____

NOTES

Investigator _____ Phone/email: _____

Investigation complete date __/__/__

Local health jurisdiction _____

Record complete date __/__/__