



LHJ Use ID _____

By: Lab Clinical
 Epi Link: _____

Rash Illness with Fever

Disease:

County

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 Unk
 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

Y N DK NA

- Rash** Onset date ___/___/___ Duration ___ days
(See back of sheet for rash details)
- Fever** Highest measured temp: _____ °F
Type: Oral Rectal Other: _____ Unk
Fever onset date: ___/___/___ Duration ___ days
- Conjunctivitis Onset date ___/___/___
- Breathing difficulty or shortness of breath
Onset date ___/___/___
- Cough Cough onset date ___/___/___
- Runny nose (coryza) Onset date ___/___/___
- Sore throat Onset date ___/___/___
- Swollen lymph nodes Onset date ___/___/___
- Headache Onset date ___/___/___
- Muscle aches or pain (myalgia)
Onset date ___/___/___

Y N DK NA

- Rash observed by health care provider**
Rash distribution: _____
 Generalized Localized On palms and soles
 Petechial Macular Papular
 Pustular Vesicular Bullous
 Other: _____ (See back of sheet for rash details)
- Regional lymphadenitis
- Respiratory infection
 Upper Lower Both Unknown
- Koplik spots
- Admitted to intensive care unit

Predisposing Factors

Y N DK NA

- Allergies Specify: _____
- Any medication Specify: _____
Start/change date(s): _____
- Any recent vaccinations Specify: _____
- Current chickenpox (varicella) infection
- Immunosuppressive therapy or disease

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 _____

Vaccination

Y N DK NA

- Measles or rubella vaccine received Total #: _____
Dose 1 Type: _____ Date received: ___/___/___
Dose 2 Type: _____ Date received: ___/___/___
- Varicella vaccine received Total # received: _____
Dose 1 Type: _____ Date received: ___/___/___
Dose 2 Type: _____ Date received: ___/___/___

Clinical Findings

Y N DK NA

- Altered mental status
- Complications, specify: _____
- Gastrointestinal symptoms
- Mechanical ventilation or intubation required
- Photophobia

Laboratory

Specimen type _____ Specimen type _____
Collection date ___/___/___ Collection date ___/___/___

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: _____

- Any contact with animals at home or elsewhere
- Any recent changes to personal products (e.g. shampoo, moisturizer, laundry detergent)
Specify: _____
- Attended social gatherings or crowded setting
- Congregate living
 Barracks Corrections Long term care
 Dormitory Boarding school Camp
 Shelter Other: _____
- Contact with persons recently vaccinated for smallpox or varicella

Y N DK NA

- Contact with recent foreign arrival
 Casual Household Sexual
 Needle use Other: _____
Specify country: _____
- Case knows anyone with similar symptoms
- Human saliva (e.g. water bottle, cigarettes, lipstick, eating utensils)
- If infant, birth mother had febrile illness
- 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: __/__/__
- Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
- Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)

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

- Attends child care or preschool
- Employed as health care worker
- Employed in child care or preschool
- Household member or close contact in sensitive occupation or setting (HCW, child care, food)
- Potential bioterrorism exposure

PUBLIC HEALTH ACTIONS

NOTES

RASH DESCRIPTION (location, progression, etc.)

Where did it first appear? _____
 Where did it spread? _____
 Where was it most intense? _____
 What does the rash look like?
 Flat spots__ Raised spots__ Both__
 Blisters/Pustules__ Blotchy__ Color__
 When pressure applied, does rash fade and then return when pressure is removed? Yes__ No__
 Is the skin peeling? Yes__ No__
 Does the rash itch? Yes__ No__



RASH NOTES:

Investigator _____ Phone/email: _____

Investigation complete date __/__/__

Local health jurisdiction _____

Record complete date __/__/__