



Cryptococcus gattii infection

County _____

LHJ Use ID _____
 Reported to DOH Date ___/___/___
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Other: _____
 Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____
 Date Received ___/___/___
 DOH Classification
 Confirmed
 Probable
 No count; reason: _____

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) _____ Birth date ___/___/___ Age _____
 Address _____ Homeless Gender F M Other Unk
 City/State/Zip _____ Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____
 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 | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asymptomatic |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever Highest measured temp (°F): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chills |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Night sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weight loss |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <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"/> | Neck stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain |

Predisposing Conditions

- | Y | N | DK | NA | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Preexisting medical condition which may have contributed to current illness or death |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Previously healthy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV positive |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppressive therapy or disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Organ or stem cell transplant |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic lung disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, solid tumors, or hematologic malignancies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Connective tissue disorder, specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Taking oral steroids (e.g. cortisone, prednisone) in the year before onset |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Current tobacco smoker |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Former tobacco smoker |

Clinical Findings

- | Y | N | DK | NA | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Encephalitis or encephalomyelitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Meningitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brain cryptococcoma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | X-ray confirmed: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lung cryptococcoma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin abscess |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Hospitalization

- | Y | N | DK | NA | |
|---|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hospitalized at least overnight for this illness |
| Hospital name _____ | | | | |
| Admit date ___/___/___ Discharge date ___/___/___ | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Died from illness Death date ___/___/___ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autopsy Place of death _____ |

Laboratory

- | | | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|--|
| Collection date ___/___/___ | Source: _____ | | | |
| Collection date ___/___/___ | Source: _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Positive serology Titer: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cryptococcus identified from fungal culture |
| How was it identified? _____ | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cryptococcus identified from cytology |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cryptococcus identified from histopathology or immunohistochemistry |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | C. gattii identified by PCR |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | C. gattii identified by MALDI-TOF |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Species identified |
| Result _____ | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Variant identified (e.g. VGIIa) |
| Result _____ | | | | |

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

Exposure period

Months

from onset:

-13	-2
-----	----

Calendar dates:

--	--	--

o
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t

EXPOSURE (13 months before onset)

Location/Travel (past 2 years)

Y N DK NA

- Travel out of the county, state, or country**
 Out of: County State Country

City	Month/Year

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

Location of Residence (past 13 months)

Y N DK NA

- Live less than a mile from wooded area
 Live less than a mile from animal farm
 If yes, what type of farm? _____
 Live less than a mile from a crop farm
 Live less than a mile from a soil disturbance
 (excavation, construction, pipe laying, etc)

Location of Residence (continued)

Y N DK NA

- Live less than a mile from logging or vegetation clearing
 Changed residence during past 13 months
 Explain: _____

Activities (past 13 months)- specify locations in spaces provided

Y N DK NA

- Camping or hiking: _____
 Handle wood on a regular basis (sawing, chopping, stacking, etc)
 Type of wood: _____
 Moving or digging earth: _____
 Construction using lumber: _____
 Yard landscaping (more than maintenance)
 Home Professionally (location: _____)
 Spreading bark mulch/mood chips: _____
 Cutting individual trees: _____
 Type of trees: _____
 Logging/clearing of lots
 Were any of these activities done in neighborhood
 Was wood (e.g. for burning) or other vegetation brought into the home?
 Were any of your pets diagnosed with cryptococcal infection?

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

- Treatment prescribed for this illness
- Amphotericin (conventional): oral IV
 - Amphotericin (lipid): IV only
 - Fluconazole / 5-fluorocytosine: oral IV
 - Itraconazole: oral IV
 - Voriconazole: oral IV
 - Posaconazole: oral IV
 - Corticosteroids: oral IV
 - Gamma IFN
 - Other: _____ oral IV

PUBLIC HEALTH ACTIONS

- Any public health action, specify: _____

NOTES

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

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

Note: This form is not available through PHIMS. Cryptococcal disease due to *C. gattii* should be reported through PHIMS as a "Rare Disease of Public Health Significance." Fax this form to DOH upon completion: 206-418-5515.