**ADMINTISTRATIVE**

**Investigator**

LHJ Case ID (optional)  

**LHJ notification date** __/__/__

**Classification**
- Classification pending  
- Confirmed  
- Not reportable  
- Probable  
- Ruled out  
- Suspect

**Investigation status**
- In progress  
- Complete  
- Complete – not reportable to DOH  
- Unable to complete  
- Reason ____________________________

**Investigation start date** __/__/__

**Investigation complete date** __/__/__

**Case complete date** __/__/__

**Outbreak related**
- Yes  
- No  

**LHJ Cluster ID** __________  
**Cluster Name** __________

**REPORT SOURCE**

**Initial report source**

LHJ  

**Reporter organization**

**Reporter name**

**Reporter phone**

**All reporting sources (list all that apply)**

**COMMUNICATIONS**

**Primary HCP name**

**Phone**

**OK to talk to patient (If Later, provide date)**
- Yes  
- Later __/__/__  
- Never

**Date of interview attempt** __/__/__

**Patient could not be interviewed**

**Alternate contact**
- Parent/Guardian  
- Spouse/Partner  
- Friend  
- Other ____________________________

**Contact name**

**Contact phone**

**CLINICAL INFORMATION**

**Complainant ill**
- Yes  
- No  
- Unk

**Symptom Onset** __/__/__

**Illness duration** ___________  
- Days  
- Weeks  
- Months  
- Years  
- Illness is still ongoing

**Clinical Features**

<table>
<thead>
<tr>
<th>Any fever, subjective or measured</th>
<th>Temp measured?</th>
<th>Yes</th>
<th>No</th>
<th>Highest measured temp ___________ºF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Night sweats</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspnea (shortness of breath)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Diagnosed by</td>
<td>X-Ray</td>
<td>CT</td>
<td>MRI</td>
</tr>
<tr>
<td>Result</td>
<td>Positive</td>
<td>Yes</td>
<td>No</td>
<td>Negative</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>Not tested</td>
<td>Yes</td>
<td>No</td>
<td>Other ____________________________</td>
</tr>
<tr>
<td>Other pulmonary lesion diagnosed by imaging</td>
<td>Describe ____________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Case Name ___________________________________**  
**LHJ Case ID ___________________________________**

Coccidioidomycosis required variables are in **bold**. Answers are: Yes, No, Unknown to case

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### Symptoms

- **Arthralgia (joint pain)**  
  - **Y**  
  - **N**  
  - **Unk**

- **Erythema nodosum or erythema multiforme rash**  
  - **Y**  
  - **N**  
  - **Unk**

- **Rash observed by healthcare provider**  
  - **Y**  
  - **N**  
  - **Unk**

- **Nuchal rigidity (stiff neck)**  
  - **Y**  
  - **N**  
  - **Unk**

- **Meningitis**  
  - **Y**  
  - **N**  
  - **Unk**

- **Disseminated to other site**  
  - **Y**  
  - **N**  
  - **Unk**

- **Site(s) (select all that apply)**  
  - **Bone**  
  - **Joint**  
  - **Lymph node**  
  - **Skin**  
  - **Other _________________________**

- **Weight loss with illness**  
  - **Y**  
  - **N**  
  - **Unk**

### Predisposing Conditions

- **Cardiovascular disease**  
  - **Y**  
  - **N**  
  - **Unk**

- **Chronic lung disease (e.g., COPD, emphysema)**  
  - **Y**  
  - **N**  
  - **Unk**

- **Liver disease**  
  - **Y**  
  - **N**  
  - **Unk**

- **Chronic kidney disease**  
  - **Y**  
  - **N**  
  - **Unk**

- **Malignancy**  
  - **Type ___________________________________**

- **Immunosuppressive therapy before illness onset**
  - **Chemotherapy**
  - **Corticosteroids (e.g., prednisone, cortisone)**
  - **TNF-a inhibitors**
  - **Other _________________________**

- **Organ or stem cell transplant recipient**  
  - **Organ transplanted _________________________**  
  - **Year ______**

- **HIV positive/AIDS**  
  - **Y**  
  - **N**  
  - **Unk**

- **Diabetes mellitus**  
  - **Y**  
  - **N**  
  - **Unk**

- **Other underlying medical conditions**  
  - **Specify ___________________________________**

### Pregnancy

- **Pregnancy status at time of symptom onset**
  - **Pregnant**  
    - *(Estimated) delivery date ___/___/___**  
    - **Weeks pregnant at any symptom onset ______**
    - **OB name, phone, address ___________________________________________________________________**
    - **Outcome of pregnancy**  
      - **Still pregnant**  
      - **Fetal death (miscarriage or stillbirth)**  
      - **Abortion**
      - **Delivered – full term**  
      - **Delivered – preemie**  
      - **Delivered – Unk**
      - **Delivery method**  
        - **Vaginal**  
        - **C-section**  
        - **Unk**
    - **OB name, phone, address ___________________________________________________________________**
    - **Outcome of pregnancy**  
      - **Fetal death (miscarriage or stillbirth)**  
      - **Abortion**
      - **Delivered – full term**  
      - **Delivered – preemie**  
      - **Delivered – Unk**
      - **Delivery method**  
        - **Vaginal**  
        - **C-section**  
        - **Unk**
    - **OB name, phone, address ___________________________________________________________________**
    - **Outcome of pregnancy**  
      - **Still pregnant**  
      - **Fetal death (miscarriage or stillbirth)**  
      - **Abortion**
      - **Delivered – full term**  
      - **Delivered – preemie**  
      - **Delivered – Unk**
      - **Delivery method**  
        - **Vaginal**  
        - **C-section**  
        - **Unk**
  - **Postpartum**  
    - *(Estimated) delivery date ___/___/___**
    - **OB name, phone, address ___________________________________________________________________**
    - **Outcome of pregnancy**  
      - **Fetal death (miscarriage or stillbirth)**  
      - **Abortion**
      - **Delivered – full term**  
      - **Delivered – preemie**  
      - **Delivered – Unk**
      - **Delivery method**  
        - **Vaginal**  
        - **C-section**  
        - **Unk**
    - **OB name, phone, address ___________________________________________________________________**
    - **Outcome of pregnancy**  
      - **Fetal death (miscarriage or stillbirth)**  
      - **Abortion**
      - **Delivered – full term**  
      - **Delivered – preemie**  
      - **Delivered – Unk**
      - **Delivery method**  
        - **Vaginal**  
        - **C-section**  
        - **Unk**
    - **OB name, phone, address ___________________________________________________________________**
  - **Neither pregnant nor postpartum**  
    - **Unk**

### Healthcare and Hospitalization

- **Presented to ER for this illness**  
  - **Date ___/___/___**  
  - **Facility name ___________________________________**

- **Hospitalized at least overnight for this illness**  
  - **Facility name ___________________________________**

  - **Hospital admission date ___/___/___**  
    - **Discharge ___/___/___**  
    - **HRN _____________________**

  - **Disposition**  
    - **Another acute care hospital**  
      - **Facility name ___________________________________**
      - **HRN _____________________**
    - **Died in hospital**
    - **Long term acute care facility**  
      - **Facility name ___________________________________**
      - **HRN _____________________**
    - **Long term care facility**
    - **Non-healthcare (home)**  
      - **Unk**  
      - **Other _________________________**
    - **Admitted to ICU**  
      - **Date admitted to ICU ___/___/___**  
      - **Date discharged from ICU ___/___/___**

  - **Mechanical ventilation or intubation required**  
    - **Y**  
    - **N**  
    - **Unk**

### Risk and Response

- **Died of this illness**  
  - **Death date ___/___/___**  
  - **Please fill in the death date information on the Person Screen**

  - **Autopsy performed**

  - **Death certificate lists disease as a cause of death or a significant contributing condition**

  - **Location of death**  
    - **Outside of hospital (e.g., home or in transit to the hospital)**  
    - **Emergency department (ED)**  
    - **Inpatient ward**  
    - **ICU**  
    - **Other _________________________**

### Travel

- **Ever (lifetime) traveled to southwestern US, Mexico, Central/South America**  
  - **Destination _________________________**  
  - **Start date ___/___/___**  
  - **End date ___/___/___**

  - **Comments ___________________________________**
For travel 3 weeks prior to onset

<table>
<thead>
<tr>
<th></th>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Travel out of:</strong></td>
<td>□ County/City</td>
<td>□ County/City</td>
<td>□ County/City</td>
</tr>
<tr>
<td></td>
<td>□ State</td>
<td>□ State</td>
<td>□ State</td>
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<tr>
<td></td>
<td>□ Country</td>
<td>□ Country</td>
<td>□ Country</td>
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<tr>
<td></td>
<td>□ Other</td>
<td>□ Other</td>
<td>□ Other</td>
</tr>
<tr>
<td><strong>Destination name</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Start and end dates</strong></td>
<td>□/□ to □/□</td>
<td>□/□ to □/□</td>
<td>□/□ to □/□</td>
</tr>
</tbody>
</table>

**Risk and Exposure Information**

Y  N  Unk

- Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Yes
- Exposed to dust/wind storm, earthquake, or substantial soil disturbance Yes
- Location(s) of soil disturbance exposure: Home, Less than 1 mile from home, Work, Other
- Date: □/□/□
- Source: Wind/dust storm/earthquake, Construction, Excavation, Landscaping (large scale), Other
- Moving or digging in soil (e.g., gardening): Location: □/□/□
- Participate in dust generating recreational activity: Location: □/□/□
- Date: □/□/□
- Type: 4-wheeling/ATV riding, Horseback riding, Soccer/other sports, Mountain biking, Other
- Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work): Location: □/□/□
- Activity: Outdoor recreation, Cabin, Hunting, Lawn mowing, Other
- Habitat: Wooded/brushy, Grassy, Other
- Where: At home property, Elsewhere
- Date: □/□/□
- (Potential) Occupational exposure: Specify
- If in-state exposure site identified, environmental sampling conducted
- Were any of your pets diagnosed with coccidioidomycosis? Yes
- Pet(s) (enter all that apply): Dog, Cat, Unk, Other

**Exposure and Transmission Summary**

- Likely geographic region of exposure: In Washington – county, Other state
- Not in US - country, Unk
- International travel related: During entire exposure period, During part of exposure period, No international travel

- Suspected exposure setting: School (not college), Home, Work, College, Military, Correctional facility, Laboratory, Long term care facility, Homeless/shelter, International travel, Out of state travel, Other

- Describe

**Exposure summary**

**Public Health Interventions/Actions**

Y  N  Unk

- Letter sent: Date □/□/□
- Batch date □/□/□

**TREATMENT**

Y  N  Unk

- Did patient receive prophylaxis/treatment: Yes, No, Why not
- Specify medication: Antibiotic, Fungal/Parasitic, Other
- Number of days actually taken: □
- Treatment start date: □/□/□
- Treatment end date: □/□/□
- Prescribed dose: □ g, □ mg, □ ml
- Frequency: □
- Duration: □ Days, □ Weeks, □ Months
- Did patient take medication as prescribed: Yes, No
- Prescribing provider: □

Coccidioidomycosis required variables are in **bold**. Answers are: Yes, No, Unknown to case
<table>
<thead>
<tr>
<th>NOTES</th>
</tr>
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</table>

<table>
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<tr>
<th>LAB RESULTS</th>
</tr>
</thead>
</table>

**Lab report information**

**Lab report reviewed – LHJ**

WDRS user-entered lab report note

**Submitter**

Performing lab for entire report

Referring lab

**Specimen**

**Specimen identifier/accession number** ____________________________________

Specimen collection date ___/___/___ Specimen received date ___/___/___

**WDRS specimen type** ____________________________________

WDRS specimen source site ____________________________________

WDRS specimen reject reason ____________________________________

**Test performed and result**

**WDRS test performed** ____________________________________

**WDRS test result, coded** ____________________________________

WDRS test result, comparator

**WDRS result, numeric only** (enter only if given, including as necessary **Comparator** and **Unit of measure**) _______

WDRS unit of measure _______

Test method ____________________________________

WDRS interpretation code ____________________________________

**Test result – Other, specify**

**WDRS result summary**

- Positive
- Negative
- Indeterminate
- Equivocal
- Test not performed
- Pending

Test result status

- Final results: Can only be changed with a corrected result
- Preliminary results
- Record coming over is a correction and thus replaces a final result
- Results cannot be obtained for this observation
- Specimen in lab; results pending

Result date ___/___/___

**Upload document**

**Ordering Provider**

WDRS ordering provider ____________________________________

**Ordering facility**

WDRS ordering facility name ____________________________________