

Tularemia Case Investigation Report

Date of report:

Case ID #: _____

Reporting and Basic Contact Information

Person reporting the case: _____	Person taking the report: _____
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Agency/affiliation: _____	Agency/affiliation: _____
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Phone number/Email: _____	Phone number/Email: _____
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Has the local health department been notified? **If yes, provide name, phone number and/or email of contact person:**
 Yes No _____

Treating Physician(s) _____	Phone number and/or email of contact person: _____
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Hospital: _____	City/State: _____	Phone: _____
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Patient Demographics

Age: _____	Sex: Female Male Unknown	Patient Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown	Patient race: (select all that apply) American Indian/Alaska Native Asian Black or African American	Native Hawaiian or Pacific Islander White Unknown
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Residence: State: _____ County: _____ Zip: _____

Occupation: _____ **Works primarily:** Indoors Outdoors Both Unknown

Medical History and Current Illness

Any underlying medical conditions? Yes No Unknown	If yes, please indicate all conditions that apply: Cancer Cardiovascular Disease For females - pregnant Other (specify): _____	Diabetes Mellitus Immunocompromised	Pulmonary Disease Renal Disease
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Date of initial symptom onset: ____ / ____ / ____ mm dd yyyy	Location where first seen: Emergency Department Urgent Care Center Hospital Unknown Outpatient clinic/office Other: _____
Date first seen by medical person: ____ / ____ / ____ mm dd yyyy	

Symptoms at initial presentation: Yes No Unknown	Yes No Unknown
Fever	Skin lesions (e.g. papules, ulcer)
Sweats/chills/rigors	Swollen/tender lymph nodes
Headache	Conjunctival irritation/discharge
Cough	Sore throat
Myalgias	Weakness/lethargy/malaise
Chest pain	Nausea, vomiting, and/or diarrhea
Shortness of breath	Abdominal pain
Other(s): _____	

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Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).

Medical History and Current Illness (continued)

If known, vital signs at initial presentation: (if unknown, check here) Date: ____/____/____

Temperature: _____ Blood pressure: ____/____ Heart rate: _____ Respiratory rate: _____
mm dd yyyy

Physical findings: Yes No Unk Description (e.g. location, size, tenderness, erythema, etc...):

Skin ulcer _____

Adenopathy _____

Pharyngitis/tonsillitis _____

Conjunctivitis _____

Other: _____

Radiographic and Laboratory Findings

Chest X-ray:

Yes (date: ____/____/____)

No mm dd yyyy

Unknown

Results:

Clear/normal

Hilar adenopathy

Infiltrates, unilateral

Infiltrates, bilateral

Interstitial changes

Pleural effusion

Pulmonary abscess

Pulmonary nodules

Unknown

Initial blood tests: (date: ____/____/____)

WBC (x 10³): _____ Differential (indicate %) Segs: _____ Bands: _____ Lymphs: _____
mm dd yyyy

Hgb (mg/dl) or Hct: _____ Platelets (x 10³): _____ BUN (U/dl): _____ Creatinine (mg/dl): _____

Tularemia testing: Yes No Unk Date specimen collected Test(s) performed - Results

(mm / dd / yyyy)

(e.g. culture - positive, DFA - positive, PCR - negative)

Blood culture (1) _____

Blood culture (2) _____

Ulcer/wound swab _____

Lymph node aspirate _____

Sputum sample _____

Serology: S1: Date drawn ____/____/____ Titer: _____ S2: Date drawn ____/____/____ Titer: _____
mm dd yyyy

Francisella tularensis subspecies identified: Type A (i.e. *tularensis*) Type B (i.e. *holartica*)
 Other (specify: _____) Unknown

Clinical Course and Treatment

Was the patient hospitalized? Yes No Unknown Admit date: ____/____/____ Discharge date: ____/____/____
mm / (dd) mm / dd

Was the patient isolated? No Respiratory Contact Unknown Date isolated: ____/____/____
mm / dd

Did the patient receive antibiotics? Yes No Unknown
 If yes, please list all antibiotics: Date started Date stopped Dosage and schedule

1. _____ /____/____ /____/____ _____

2. _____ /____/____ /____/____ _____

3. _____ /____/____ /____/____ _____
mm / dd mm / dd

