UAC Respiratory Disease Cluster Case Investigation Form

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

State: _____ Date reported to health department: ___/___/_____ (MM/DD/YYYY) Date interview completed: ___/___/_____ (MM/DD/YYYY)

Alien Number:_____ CDC Lab ID: _____

Demographic Information

1. Date of birth: _____/_____/_____ (MM/DD/YYYY)
2. Country of origin: _____ Region: _____ City/town: _____
3. Estimated travel time from country of origin to US border: _____ ☐days ☐weeks ☐months
4. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
5. Sex: ☐ Male ☐ Female

Symptoms and Care Seeking

6. What date did symptoms associated with this illness start? _____/_____/_____ (MM/DD/YYYY)
7. Were symptoms present at the CBP Processing Center? ☐ Yes ☐ No ☐ Unknown
8. Were symptoms present at a CBP facility before transfer to the processing center? ☐ Yes, which facility? _____ ☐No ☐Unknown
9. During this illness, did the patient experience any of the following?

Symptom	Symptom Present?	Symptom	Symptom Present?
Fever (highest temp _____ °F)	☐ Yes ☐ No ☐ Unk	Shortness of breath	☐ Yes ☐ No ☐ Unk
If fever present, date of onset ___/___/____ (MM/DD/YYYY)		Vomiting	☐ Yes ☐ No ☐ Unk
Felt feverish	☐ Yes ☐ No ☐ Unk	Diarrhea	☐ Yes ☐ No ☐ Unk
If felt feverish, date of onset ___/___/____ (MM/DD/YYYY)		Eye infection/redness	☐ Yes ☐ No ☐ Unk
Cough	☐ Yes ☐ No ☐ Unk	Rash	☐ Yes ☐ No ☐ Unk
Sore Throat	☐ Yes ☐ No ☐ Unk	Fatigue	☐ Yes ☐ No ☐ Unk
Muscle aches	☐ Yes ☐ No ☐ Unk	Seizures	☐ Yes ☐ No ☐ Unk
Headache	☐ Yes ☐ No ☐ Unk	Back pain	☐ Yes ☐ No ☐ Unk
Abdominal pain	☐ Yes ☐ No ☐ Unk	Other, specify	☐ Yes ☐ No ☐ Unk

10. Does the patient still have symptoms?
    ☐ Yes (skip to Q.12) ☐ No ☐ Unknown (skip to Q.12)
11. When did the patient feel back to normal? _____/_____/_____ (MM/DD/YYYY)
12. Did the patient receive any medical care for the illness?
    ☐ Yes ☐ No (skip to Q.14) ☐ Unknown (skip to Q.14)
13. Where and on what date did the patient seek care (check all that apply)?
    ☐ CBP Processing Center **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Shelter medical service **date**:_____/_____/_____ (MM/DD/YYYY)
    ☐ Urgent care **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Emergency room **date**:_____/_____/_____ (MM/DD/YYYY)
    ☐ Other _____ **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Unknown
14. Did the patient experience any other complications as a result of this illness? ☐ Yes (please describe below) ☐ No ☐ Unknown
    _____
15. Does the patient have any preexisting medical conditions (e.g. problems with heart, lung)? ☐ Yes (please describe below) ☐ No ☐ Unknown
    _____

Risk Factors

16. In the 7 days prior to illness onset, please list the locations/CPB facilities the patient has been (including international).
    Location 1: Dates: _____/_____/_____ to _____/_____/_____ Country _____ State _____ City/CPB facility_____
    Location 2: Dates: _____/_____/_____ to _____/_____/_____ Country _____ State _____ City/CPB facility_____
    Location 3: Dates: _____/_____/_____ to _____/_____/_____ Country _____ State _____ City/CPB facility_____
17. Which dormitory was the patient in when symptomatic? _____ (dormitory 101-110)
18. Which bed number was the patient in when symptomatic? _____
19. Does the patient know anyone who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **in the 7 days BEFORE** the case patient's illness onset?
    ☐ Yes (**please list those ill before the case patient in the table below**) ☐ No ☐ Unknown

Contact name	Sex (M/F)	Age	Date of illness onset	Comments

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20. Any additional comments or notes?

_____

_____

_____

_____

_____

_____

Please review the patient's medical record, patient testing results, and facility records to obtain the answers for the remainder of the form.

Clinical Course, Treatment, and Outcome

21. Date of identification by CBP: _____/_____/_____ (MM/DD/YYYY)
22. Date of arrival to CBP Processing Center: _____/_____/_____ (MM/DD/YYYY) ☐ Nogales, AZ or ☐ McAllen, TX ☐ Other: _____
23. Date of arrival to Baytown Shelter: _____/_____/_____ (MM/DD/YYYY)
24. Approximately how many children were in the patient's dormitory at the shelter on the date of symptom onset? _____
25. Were other persons in the same dormitory symptomatic in the 7 days prior to the illness onset in this patient?
    ☐ Yes ☐ No (skip to Q.27) ☐ Unknown (skip to Q.27)
26. How many persons were ill? _____
27. Was the patient hospitalized for the illness?
    ☐ Yes ☐ No (skip to Q.36) ☐ Unknown (skip to Q.36)
28. Date(s) of hospital admission? **First admission date:**___/___/____ (MM/DD/YYYY) **Second admission date:**___/___/____ (MM/DD/YYYY)
29. Was the patient admitted to an intensive care unit (ICU)?
    ☐ Yes ☐ No (skip to Q.31) ☐ Unknown (skip to Q.31)
30. Date of **ICU admission:** _____/_____/_____ (MM/DD/YYYY) Date of **ICU discharge:** _____/_____/_____ (MM/DD/YYYY)
31. Did the patient receive mechanical ventilation / have a breathing tube?
    ☐ Yes ☐ No (skip to Q.33) ☐ Unknown (skip to Q.33)
32. For how many days did the patient receive mechanical ventilation or have a breathing tube? _____ days
33. Was the patient discharged?
    ☐ Yes ☐ No (skip to Q.36) ☐ Unknown (skip to Q.36)
34. Date(s) of hospital discharge? **First discharge date:**___/___/____ (MM/DD/YYYY) **Second discharge date:**___/___/____ (MM/DD/YYYY)
35. Where was the patient discharged?
    ☐ NBVC Shelter ☐ Family member ☐ Permanent shelter ☐ Other _____ ☐ Unknown
36. Did the patient have a new abnormality on chest x-ray or CAT scan?
    ☐ No, x-ray or scan was normal ☐ Yes, x-ray or scan detected new abnormality ☐ No, chest x-ray or CAT scan not performed ☐ Unknown
37. Did the patient receive a diagnosis of pneumonia?
    ☐ Yes ☐ No ☐ Unknown
38. Did the patient receive a diagnosis of ARDS?
    ☐ Yes ☐ No ☐ Unknown
39. Did the patient receive antimicrobials prior to becoming ill (within 2 weeks) or after becoming ill?
    ☐ Yes, (please complete table below) ☐ No ☐ Unknown

Drug	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antivirals	Dosage (if known)
Oseltamivir (Tamiflu)				mg
Zanamivir (Relenza)				mg
Azithromycin				mg
Levofloxacin				mg
Augmentin				mg
Penicillin				mg
Other antimicrobial_____				mg
Other antimicrobial_____				mg
Other antimicrobial_____				mg

40. Did the patient die as a result of this illness?
    ☐ Yes, **Date of death**:_____/_____/_____ (MM/DD/YYYY) ☐ No ☐ Unknown

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Medical History -- Past Medical History and Vaccination Status

41. Were any of the following chronic medical conditions noted during patient interview or recorded on the patient's medical record? Please specify **ALL** conditions noted.

a.	Asthma/reactive airway disease	☐ Yes	☐ No	☐ Unknown	
b.	Tuberculosis	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
c.	Other chronic lung disease	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
d.	Chronic heart or circulatory disease	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
e.	Diabetes mellitus	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
f.	Kidney or renal disease	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
g.	Non-cancer immunosuppressive condition	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
h.	Cancer chemotherapy in past 12 months	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
i.	Neurologic/neurodevelopmental disorder	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
j.	Cerebrospinal fluid leaks	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
k.	Chronic liver disease	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
l.	Sickle cell/other hemaglobinopathies	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
m.	Congenital or acquired asplenia	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
n.	Malnutrition	☐ Yes	☐ No	☐ Unknown	(If YES, specify weight/height) _____
o.	Other chronic diseases	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____

42. Was patient pregnant or ≤6 weeks postpartum at illness onset?
☐ Yes, pregnant (weeks pregnant at onset)_____ ☐Yes, postpartum (delivery date) ___/___/____ (MM/DD/YYYY) ☐ No ☐ Unknown
43. Does the patient currently smoke?
☐ Yes ☐ No ☐ Unknown
44. Was the patient vaccinated against influenza in the past year?
☐ Yes ☐ No (skip to Q.47) ☐ Unknown (skip to Q.47)
45. Month and year of influenza vaccination? **Vaccination date 1:**____/_____ (MM/YYYY) **Vaccination date 2:**____/_____ (MM/YYYY)
46. Type of influenza vaccine (check all that apply): ☐ Inactivated (injection) ☐ Live attenuated (nasal spray) ☐ Unknown
47. Did the patient ever receive the pneumococcal vaccine?
☐ Yes ☐ No (skip to Q.49) ☐ Unknown (skip to Q.49)
48. Month and year of pneumococcal vaccination? **Vaccination date 1:**____/_____ (MM/YYYY)

Specimen Testing Results

49. Was the patient tested for any pathogens? ☐ Yes (please complete table below) ☐ No ☐ Unknown

	Positive	Negative	Not Tested/Unknown	Collection Date	CT Value
a. Influenza	☐	☐	☐	____/____/_____	_____
If influenza positive, specify subtype	☐ H1N1pdm09 ☐ H3N2 ☐ A,subtype unknown ☐ Influenza B ☐ Other_____ ☐ Unknown				
b. Pneumococcus	☐	☐	☐	____/____/_____	_____
c. Respiratory syncytial virus/RSV	☐	☐	☐	____/____/_____	_____
d. Adenovirus	☐	☐	☐	____/____/_____	_____
e. Parainfluenza 1	☐	☐	☐	____/____/_____	_____
f. Parainfluenza 2	☐	☐	☐	____/____/_____	_____
g. Parainfluenza 3	☐	☐	☐	____/____/_____	_____
h. Human metapneumovirus	☐	☐	☐	____/____/_____	_____
i. Rhinovirus	☐	☐	☐	____/____/_____	_____
j. Coronavirus	☐	☐	☐	____/____/_____	_____
k. Other, specify: _____	☐	☐	☐	____/____/_____	_____
l. Other, specify: _____	☐	☐	☐	____/____/_____	_____
m. Other, specify: _____	☐	☐	☐	____/____/_____	_____

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Estado: _TX_ Fecha de reporte al Departamento de Salud: ___/___/___ (MM/DD/AAAA) Fecha de la entrevista: ___/___/_____ (MM/DD/AAAA)

Número de extranjería:_____ CDC Lab ID: _____

Información Demográfica

1. Fecha de nacimiento: _____/_____/_____ (MM/DD/AAAA)
2. País de origen: _____Region:_____Ciudad/Pueblo:_____
3. Tiempo de viaje estimado de país de origen a la frontera con EEUU: _____ ☐días ☐semanas ☐meses
4. Etnia: ☐ Hispano ó Latino ☐ No Hispano ó Latino
5. Sexo: ☐ Masculino ☐ Femenino

Síntomas, Curso Clínico de la enfermedad, Tratamiento, Análisis de las muestras y Resultados

6. En qué fecha comenzaron los síntomas asociados con la enfermedad? _____/_____/_____ (MM/DD/AAAA) (VER CALENDARIO)
7. Los síntomas estaban presentes al llegar a la Base de la Patrulla de Frontera de los EEUU? ☐ Si ☐ No ☐ No sabe
8. Los síntomas estaban presentes antes de llegar a la Base de la Patrulla de Frontera de los EEUU? ☐ Si ☐ No ☐ No sabe, si dijo si Cual?_____
9. Durante el curso de la enfermedad, el paciente manifestó alguno de los siguientes síntomas?

Síntoma	**Presentó?**	**Síntoma**	**Presentó?**
Fiebre (Temperatura más alta __ °F)	☐ Si ☐ No ☐ No sabe	Dificultad para respirar	☐ Si ☐ No ☐ No sabe
Si presentó fiebre, fecha de inicio __/__/___(MM/DD/AAAA)		Vómitos	☐ Si ☐ No ☐ No sabe
Se sintió afiebrado	☐ Si ☐ No ☐ No sabe	Diarrea	☐ Si ☐ No ☐ No sabe
Si se sintió afiebrado, fecha de inicio__/__/__(MM/DD/AAAA)		Infección en los ojos/Ojos rojos	☐ Si ☐ No ☐ No sabe
Tos	☐ Si ☐ No ☐ No sabe	Salpullido	☐ Si ☐ No ☐ No sabe
Dolor de garganta	☐ Si ☐ No ☐ No sabe	Fatiga	☐ Si ☐ No ☐ No sabe
Dolor muscular ó de cuerpo	☐ Si ☐ No ☐ No sabe	Convulsiones	☐ Si ☐ No ☐ No sabe
Dolor de cabeza	☐ Si ☐ No ☐ No sabe	Dolor de espalda	☐ Si ☐ No ☐ No sabe
Dolor abdominal	☐ Si ☐ No ☐ No sabe	Otro, especificar	☐ Si ☐ No ☐ No sabe

10. El paciente todavía tiene síntomas?

☐ Si (Pasar a la pregunta Q.12) ☐ No ☐ No sabe (Pasar a la pregunta Q.12)

11. En qué fecha es que el paciente se siente sano nuevamente? _____/_____/_____ (MM/DD/AAAA)
12. Recibió el paciente la atención médica adecuada para tratar la enfermedad?

☐ Si ☐ No (Pasar a la pregunta Q.14) ☐ No sabe (Pasar a la pregunta Q.14)

13. Dónde y en qué fecha es que el paciente solicita atención médica (marcar todas las que apliquen)?

☐ Base de la Patrulla de Frontera de los EEUU **fecha**:_____/_____/_____ (MM/DD/AAAA)
☐ Clínica de CASA HOGAR **fecha**:_____/_____/_____ (MM/DD/AAAA)
☐ Clínica de urgencia **fecha**:_____/_____/_____ (MM/DD/AAAA)
☐ Sala de emergencia **fecha**:_____/_____/_____ (MM/DD/AAAA)
☐ Otro, especificar _____ **fecha**:_____/_____/_____ (MM/DD/AAAA) ☐ No sabe

14. El paciente desarrolló alguna complicación como resultado de la enfermedad? ☐ Si (por favor describir/especificar) ☐ No ☐ No sabe

_____

15. El paciente tenía alguna condición médica preexistente (por ejemplo condición crónica pulmonar) ☐ Si (por favor describir/especificar) ☐ No ☐ No sabe

_____

Factores de Riesgo

16. En los 7 días previos al inicio de síntomas, liste la ubicación del paciente (incluyendo zona internacional)

Ubicación 1: Fecha: De_____/____/_____a _____/_____/____ País _____Estado _____Ciudad/Base Patrulla Fronteriza_____
Ubicación 2: Fecha: De_____/____/____ a _____/_____/____ País _____ Estado _____ Ciudad/Base Patrulla Fronteriza_____
Ubicación 3: Fecha: De_____/____/____ a _____/_____/____ País _____ Estado _____ Ciudad/Base Patrulla Fronteriza_____
Ubicación 4: Fecha: De_____/____/_____a _____/_____/____ País _____Estado _____ Ciudad/Base Patrulla Fronteriza_____

17. En qué numero de dormitorio se encontraba el paciente cuando tuvo los síntomas? _____ (dormitorio 101-110)
18. En qué numero de cama se encontraba el paciente cuando tuvo los síntomas? _____

19. El paciente conoció a alguien que tuvo fiebre, síntomas respiratorio como tos o dolor de garganta u otro síntoma respiratorio como neumonía **7 días ANTES** del inicio de síntomas en el paciente?

☐ Si (**liste todos los que estuvieron enfermos antes que el paciente**) ☐ No ☐ No sabe

Nombre	Sexo (M/F)	Edad	Fecha de inicio de síntomas	Comentarios

20. Algún comentario o nota adicional?

_____

_____

_____

_____

_____

_____