Zika Virus Disease Case Investigation Form

Arboviral Diseases Branch
Version 3.1

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

FOR CDC USE ONLY	
CDC R-number_____	ZIKVID:_____
CDC staff initial:_____	Date form completed:_____/_____/_____
CDC investigating group:_____	

Reporting Jurisdiction	
Jurisdiction (state/territory):_____	Agency:_____
Contact Name:_____ Contact Position:_____ Alternate Contact Name:_____	Contact Phone:_____ Contact Email:_____ Alternate Contact Phone:_____

Demographic Information

State of residence:_____ State patient ID number:_____

Patient last name: _____ Patient first name: _____

Age: _____ ☐ Years ☐ Months ☐ Days Sex: ☐ Male ☐ Female

Travel History

Dates of travel: _____

Country(s) visited:_____

Vaccination History

Previously vaccinated for: ☐ Yellow Fever ☐ Japanese Encephalitis ☐ Tick-borne Encephalitis

Cases of Special Interest

Please indicate if patient meets any of the following criteria:

Local vector-borne transmission	☐ Yes ☐ No ☐ Suspect
Pregnant	☐ Yes ☐ No ☐ Unknown If yes: Current gestational week:_____ Gestational week at illness onset (if applicable): _____
Fetal loss	☐ Yes ☐ No If yes: Gestational week at time of fetal loss:_____
Microcephaly	☐ Yes ☐ No ☐ Suspect
Guillain-Barre syndrome/acute flaccid paralysis	☐ Yes ☐ No ☐ Suspect
Sexual transmission	☐ Yes ☐ No ☐ Suspect
Blood/blood product transfusion transmission	☐ Yes ☐ No ☐ Suspect
Organ/tissue transplant transmission	☐ Yes ☐ No ☐ Suspect
Breastfeeding transmission	☐ Yes ☐ No ☐ Suspect

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Illness Information			
Illness onset date: _____/_____/_____ ☐ Hospitalized ☐ Died			
Fever	☐ Yes ☐ No		
	If yes: ☐ Subjective fever ☐ Measured fever (Maximum measured temperature: _____)		
Rash	☐ Yes ☐ No		
	If yes:	Type: ☐ Maculopapular ☐ Petechial ☐ Purpuric ☐ Other Pruritic: ☐ Yes ☐ No Distribution:_____	
☐ Arthralgia		☐ Myalgia	☐ Oral ulcers
☐ Conjunctivitis		☐ Vomiting	☐ Hematospermia (for males)
☐ Headache		☐ Diarrhea	☐ Peripheral edema

Specimen Information	
Specimen 1 collected: _____/_____/_____	Type: ☐ Serum ☐ CSF ☐ Amniotic fluid ☐ Tissue ☐ Saliva ☐ Urine ☐ Semen
Specimen 2 collected: _____/_____/_____	Type: ☐ Serum ☐ CSF ☐ Amniotic fluid ☐ Tissue ☐ Saliva ☐ Urine ☐ Semen
Specimen 3 collected: _____/_____/_____	Type: ☐ Serum ☐ CSF ☐ Amniotic fluid ☐ Tissue ☐ Saliva ☐ Urine ☐ Semen
Specimen 4 collected: _____/_____/_____	Type: ☐ Serum ☐ CSF ☐ Amniotic fluid ☐ Tissue ☐ Saliva ☐ Urine ☐ Semen
Specimen 5 collected: _____/_____/_____	Type: ☐ Serum ☐ CSF ☐ Amniotic fluid ☐ Tissue ☐ Saliva ☐ Urine ☐ Semen
Specimen 6 collected: _____/_____/_____	Type: ☐ Serum ☐ CSF ☐ Amniotic fluid ☐ Tissue ☐ Saliva ☐ Urine ☐ Semen
Specimen 7 collected: _____/_____/_____	Type: ☐ Serum ☐ CSF ☐ Amniotic fluid ☐ Tissue ☐ Saliva ☐ Urine ☐ Semen

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ANEXO H: EXTRAÇÃO DE PRONTUÁRIO PARA BEBÊS CASOS

Equipe: Identificação do bebê caso: Data da extração:

Nome da unidade da saúde:

Estado: Município:

HISTÓRICO DO BEBÊ

DT Nasc Bebe Data de nascimento mãe Peso ao nascer:

Comprimento: PC: Data das medições: Hora das medições:

PROBLEMAS DE SAÚDE DURANTE O INTERNAMENTO

☐ Problemas de audição ☐ Cegueira ☐ Convulsões ☐ Dificuldade na deglutição ☐ Desconforto respiratório

☐ Sepse ☐ Nenhum problema ☐ Outro: Especifique

RESULTADOS DA IMAGIOLOGIA E EXAMES PARA O BEBÊ

Tomografia computadorizada: Se sim, data:

☐ Normal ☐ Calcificações ☐ Lisencefalia ☐ Atrofia cerebral ☐ Ventriculomegalia ☐ Suturas calcificadas ☐ Outras

Outras,especificar:

Ultrassonografia transfontanelar: Se sim, data:

☐ Normal ☐ Calcificações ☐ Lisencefalia ☐ Atrofia cerebral ☐ Ventriculomegalia ☐ Suturas calcificadas ☐ Outras

Outras, especificar:

Ressonância magnética: Se sim,data:

☐ Normal ☐ Calcificações ☐ Lisencefalia ☐ Atrofia cerebral ☐ Ventriculomegalia ☐ Suturas calcificadas ☐ Outras

Outras, especificar:

Ecocardiograma: Se sim, data:

Se sim: Se alterado (resultado):

USG abdominal: Se sim, data:

Se sim: Se alterado (resultado):

EXAMES E HISTÓRICO PRÉ-NATAL

Ultrassonografia pré-natal: Resultado Se for anormal, data:

Se anormal, especifique:

Amostragem vilo corial: Resultado:

Descrever

Amniocentese Resultado:

Descrever:

Complicações durante a gestação?

Se sim, quais:

- [ ] ITU
- [ ] Anemia
- [ ] DM gestacional
- [ ] HAS gestacional
- [ ] Pré eclampsia
- [ ] Placenta prévia
- [ ] Oligodramnio
- [ ] Polidramnio
- [ ] Insuficiência colo uterino
- [ ] Hiperemese gravidica
- [ ] Anomalias anatômicas no útero
- [ ] Descolamento de placenta
- [ ] Crescimento intraútero restrito
- [ ] Incisura
- [ ] Outras

Se outras, especificar:

Medicamentos da mãe durante a gravidez:

Medicamento 1

Medicamento1
- [ ] 30 dias anteriores da gravidez
- [ ] 1º Tri
- [ ] 2º Tri
- [ ] 3º Tri

Medicamento 2:

Medicamento2
- [ ] 30 dias anteriores da gravidez
- [ ] 1º Tri
- [ ] 2º Tri
- [ ] 3º Tri

Medicamento 3:

Medicamento 3:
- [ ] 30 dias anteriores da gravidez
- [ ] 1º Tri
- [ ] 2º Tri
- [ ] 3º Tri

Medicamento 4:

Medicamento 4:
- [ ] 30 dias anteriores da gravidez
- [ ] 1 Tri
- [ ] 2º Tri
- [ ] 3º Tri

Medicamento 5:

Medicamento 5:
- [ ] 30 dias anteriores da gravidez
- [ ] 1º Tri
- [ ] 2º Tri
- [ ] 3º Tri

Exames de doenças infecciosas para o bebê:

VDRL		Resultado					
CMV		IgM		IgG		PCR	
HSV 1		IgM		IgG		PCR	
HSV 2		IgM		IgG		PCR	
Rubéola		IgM		IgG			
Toxo		IgM		IgG			
Dengue		IgM		IgG		PCR	
Zika		IgM		IgG		PCR	
Chikungunya		IgM		IgG		PCR	

Outros1

Resultados Outros1:

Outros 2:

Resultados Outros2:

Exames de doenças infecciosas durante a gravidez

VDRL | Resultado

CMV | IgM | IgG | PCR

HSV 1 | IgM | IgG | PCR

HSV 2 | IgM | IgG | PCR

Rubéola | IgM | IgG

Toxo | IgM | IgG

Dengue | IgM | IgG | PCR

Zika | IgM | IgG | PCR

Chikungunya | IgM | IgG | PCR

Outros1 | Resultados Outros1:

Outros 2 | Resultados Outros2:

O bebê fez exame de vista? | Resultado de exame de vista do bebê:

Caso anormal, descrever:

Outras anomalias/defeitos do bebê

Presença de malformações no RN:

Se sim, especificar:

- [ ] Aparelho circulatório
- [ ] Aparelho digestivo
- [ ] Aparelho respiratório
- [ ] Órgãos genitais
- [ ] Aparelho osteomuscular
- [ ] Outras

Descreva a malformação encontrada:

Descrever resultados de exames ou defeitos específicos de forma mais detalhada

Questionário da pesquisa - Microcefalia

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Equipe:
1 2 3 4 5 6 7 8

Número de identificação

Número de pareamento:

Entrevistador

Data da entrevista:

Endereço

Latitude

Longitude

Gerar coordenadas

Data Visita 1

Turno: Manhã Tarde Noite

Situação 1: Participante Recusou-se Indisponível

Data Visita 2

Turno: Manhã Tarde Noite

Situação 2: Participante Recusou-se Indisponível

Visita 3

Turno: Manhã Tarde Noite

Situação 3: Participante Recusou-se Indisponível

A.- Introdução

Nesta entrevista, faremos perguntas sobre sua gravidez, sua saúde, a saúde de seu bebê e algumas exposições que você pode ter tido durante a gravidez. Essas perguntas abrangem muitos temas, e esperamos que nos ajudem a compreender melhor por que alguns bebês têm microcefalia e outros não.

1. Idade atual da mãe (anos) :

2. Idade atual do bebê:

Idade em: semanas meses

3. Sexo do bebê:

5. Localização da residência:

B. Residência e histórico de deslocamentos da mãe

1. Há quanto tempo você mora na Paraíba?

Anos Meses Não sei

2. Há quanto tempo você mora em seu endereço atual?

3. Durante a gravidez, você morou...

4. Durante a gravidez, você passou 3 noites consecutivas ou mais fora de casa, onde o trajeto foi superior a 3 horas?

Nota: Se a mãe estiver morando no local há menos de 8 meses (mais a idade do bebê), talvez não atenda aos critérios de elegibilidade para o estudo; verificar os critérios de inclusão

5. Liste as datas e destinos dos deslocamentos:

Data Locais: Dias:

Data Locais Dias:

Data Locais: Dias

C. Informações sobre a gravidez

1. Data da útima mestruação: ☐ Não sei

2. Qual foi a data provável do parto informada pelo médico? ☐ Não sei

3. Tipo de gravidez Se gemelar, número de bebês: 4. Os outros bebês nasceram vivos?

Se sim, teve alguma malformação: Especificar

5. Tipo de parto:

6. Quantas vezes você engravidou antes desta gravidez, incluindo gestações que podem ter terminado em abortos naturais, bebê nascido morto ou outros resultados?

Número de gestações: Número de nascidos vivos

Número de abortos: Número de nascidos mortos:

7. Há alguma (outra) criança ou adulto da sua família que nasceu com microcefalia?

Se sim, especifique (grau de parentesco em relação ao bebê e o momento do diagnóstico):

8. Você e o paí da criança têm algum grau de parentesco? Se sim, qual?

9. Qual é a data de nascimento deste bebê?

D. Doenças durante a gravidez

Agora, vou fazer algumas perguntas sobre doenças que você pode ter tido durante a gravidez.

1. No período de 30 DIAS ANTES do início da gravidez, você teve alguma doença com algum dos seguintes sintomas:

Manchas vermelhas no corpo: Quando — Semanas ou meses: ◯ Semanas ◯ Meses ◯ Não sei

Febre: Quando — Semanas ou meses: ◯ Semanas ◯ Meses ◯ Não sei

Coceira: Quando — Semanas ou meses: ◯ Semanas ◯ Meses ◯ Não sei

Dores articulações: Quando — Semanas ou meses: ◯ Semanas ◯ Meses ◯ Não sei

Olhos vermelhos: Quando — Semanas ou meses: ◯ Semanas ◯ Meses ◯ Não sei

2. Durante o PRIMEIRO TRIMESTRE de gravidez (até 13 semanas), você teve alguma doença com algum dos seguintes sintomas?

Manchas vermelhas no corpo: Quando

Semanas ou meses
Semanas Meses Não sei

Febre: Quando

Semanas ou meses
Semanas Meses Não sei

Coceira: Quando

Semanas ou meses
Semanas Meses Naõ sei

Dores articulações: Quando

Semanas ou meses
Semanas Meses Não sei

Olhos vermelhos: Quando

Semanas ou meses
Semanas Meses Não sei

3. Durante o SEGUNDO TRIMESTRE de gravidez (14 a 26 semana), você teve alguma doença com algum dos seguintes sintomas?

Manchas vermelhas no corpo: Quando

Semanas ou meses
Semanas Meses Não sei

Febre: Quando

Semanas ou meses
Semanas Meses Não sei

Coceira: Quando

Semanas ou meses
Semanas Meses Não sei

Dores articulações: Quando

Semanas ou meses
Semanas Meses Não sei

Olhos vermelhos: Quando

Semanas ou meses
Semanas Meses Não sei

4. Durante o TERCEIRO TRIMESTRE de gravidez (27 a 42 semanas), você teve alguma doença com algum dos seguintes sintomas?

Manchas vermelhas no corpo: Quando

Semanas ou meses
Semanas Meses Não sei

Febre: Quando

Semanas ou meses
Semanas Meses Não sei

Coceira: Quando

Semanas ou meses
Semanas Meses Não sei

Dores articulações: Quando

Semanas ou meses
Semanas Meses Não sei

Olhos vermelhos: Quando

Semanas ou meses
Semanas Meses Não sei

5. Entre o mês anterior à gravidez e o final da gravidez, você teve alguma das seguintes doenças ou infecções? [Em caso afirmativo, registrar a semana de gravidez, se possível, e o(s) mês(es) de gravidez, caso a semana seja desconhecida]

Infecção urinária

-30 Infecção dos rins, bexiga ou trato urinário Quando

Semanas ou meses
Semanas Meses Não sei

1º Tri Infecção dos rins, bexiga ou trato urinário Quando

Semanas ou meses
Semanas Meses Não sei

2º Infecção dos rins, bexiga ou trato urinário Quando

Semanas ou meses
Semanas Meses Não sei

3º Tri Infecção dos rins, bexiga ou trato urinário Quando

Semanas ou meses
Semanas Meses Não sei

Infecções por fungos

-30 Infecção por fungos Quando

Semanas ou meses
Semanas Meses Não sei

1º Tri Infecção por fungos Quando

Semanas ou meses
Semanas Meses Não sei

2º Tri Infecção por fungos Quando

Semanas ou meses
Semanas Meses Não sei

3º Tri Infecção por fungos Quando

Semanas ou meses
Semanas Meses Não sei

Toxoplasmose | Quando | Semanas ou meses: Semanas / Meses / Não sei

Citomegalovírus (CMV) | Quando | Semanas ou meses: Semanas / Meses / Não sei

Rubéola | Quando | Semanas ou meses: Semanas / Meses / Não sei

Herpes | Quando | Semanas ou meses: Semanas / Meses / Não sei

Sífilis | Quando | Semanas ou meses: Semanas / Meses / Não sei

Catapora | Quando | Semanas ou meses: Semanas / Meses / Não sei

LCMV (coriomeningite linfocitária) | Quando | Semanas ou meses: Semanas / Meses / Não sei

3. Entre o mês anterior à gravidez e o final da gravidez, você teve alguma outra infecção que não citamos?

[Em caso afirmativo, registrar a semana de gravidez, se possível, e o(s) mês(es) de gravidez, caso a semana seja desconhecida]

Especifique: | Quando | Semanas ou meses: Semanas / Meses

4. Você já foi diagnosticada com algum dos seguintes problemas de saúde?

- Pressão alta
- Diabetes (fora do período da gravidez)
- Diabetes durante a gravidez
- Doenças respiratórias
- Doenças neurológicas
- Doenças cardíacas
- Outro problema de saúde crônico
- Nenhum dos anteriores
- Não sei

Se outra doença especificar?

Se marcou alguma das doenças acima (respiratória, neurológica e cardíaca), especifique

E. Medicamentos

Agora, vou fazer perguntas sobre medicamentos que você pode ter tomado durante a gravidez.

1. Entre o mês anterior à gravidez e o final da gravidez, você tomou algum medicamento com ou sem prescrição?

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

2. Entre o mês anterior à gravidez e o final da gravidez, você tomou algum medicamento tradicional ou medicamento homeopático?

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

Medicamento

Período: 30 dias antes | 1º Tri | 2º Tri | 3º Tri

3. Entre o mês anterior à gravidez e o final da gravidez, você tomou alguma multivitamina, vitamina pré-natal ou suplemento de ácido fólico?

Sulfato ferroso: | Quando iniciou o uso | Semanas ou meses: Anterior | Semanas | Meses

Ácido fólico: | Quando inicou o uso | Semanas ou meses: Anterior | Semanas | Meses

Outros polivitamínicos: | Quando inicou o uso | Semanas ou meses: Anterior | Semanas | Meses

F. Exposições ao tabaco e álcool

As próximas perguntas tratam do consumo de cigarros e álcool.

1. Entre o mês anterior à gravidez e o final da gravidez, você...

Fumou cigarros? Por quanto tempo: Anterior Periodo Quantos por dia:

2. Entre o mês anterior à gravidez e o final da gravidez, você conviveu com alguém que ...

Fumou cigarros? Dentro de casa Quanto: Anterior Periodo

Quantos por dia:

2A. Fumou narguilê ou algo semelhante Dentro de casa: Quanto:

Anterior Semanas ou meses Quantas horas por dia:

3. Entre o mês anterior à gravidez e o final da gravidez, você bebeu vinho, cerveja, bebidas destiladas, como cachaça, ou coquetéis de bebidas?

Quanto: Anterior Semanas ou meses Frequência:

G. Exposições ambientais

Agora, vamos fazer perguntas sobre outras exposições que você pode ter tido durante a gravidez.

1. Qual foi sua principal fonte de água para beber durante a gravidez?

- Torneira
- Poço
- Rio ou lagoa
- Outra fonte Especificar
- Aqueduto rural
- Agua mineral/agua filtrada
- Cisterna ou tanque
- Não sei

2. Você faz alguma coisa para filtrar ou purificar a água que você bebe? O que?

3. Você fez consumo de peixes e/ou frutos do mar durante a gestação?

4. Quanto tempo você ficou ao ar livre por dia durante a gravidez?

5. Você mantinha janelas e portas abertas durante o dia e noite quando estava grávida?

6. Suas janelas e portas tinham telas protetoras?

7. Você usou repelente contra insetos quando estava ao ar livre durante a gravidez?

7. Durante a gravidez, você teve exposição a... [Em caso afirmativo, registrar a semana de gravidez, se possível, e o(s) mês(es) de gravidez, caso a semana seja desconhecida]:

Pesticidas | Especifique o(s) pesticida(s):

Quando | Periodo: Semanas / Meses / Não sei | Frequência:

Inseticida | Especifique o(s) inseticida(s):

Quando | Periodo: Semanas / Meses / Não sei | Frequência:

Raticidas | Especifique o(s) raticida(s):

Quando | Semanas ou meses: Semanas / Meses / Não sei | Frequência:

Fertilizantes | Especifique o(s) fertilizante(s):

Quando | Semanas ou meses: Semanas / Meses / Não sei | Frequência:

Fumigação | Especifique o(s) produto(s):

Quando | Semanas ou meses: Semanas / Meses / Não sei | Frequência:

H. Avaliação do bebê

Agora, vou fazer algumas perguntas sobre a saúde do seu bebê.

1. Em geral, como você classificaria a saúde do seu bebê?

Caso seja regular ou ruim, explique:

2. Desde que seu bebê nasceu, ele(a) apresentou algum dos seguintes problemas?

Convulsões | Febre | Problemas de audição

Problemas de visão | Outro problema de saúde | Especifique:

I. Outras características demográficas e da residência

Agora, gostaria apenas de fazer as últimas perguntas sobre você e sua família.

1. Como você classificaria sua raça? | Se outra, especifique:

2. Qual era a sua escolaridade quando o bebê nasceu? (considerar o maior nível completo)

3. Durante os 9 meses de gravidez, qual era a renda mensal de sua família?

4. Quantas pessoas eram sustentadas por essa renda, inclusive adultos e crianças?

J. Medidas antropométricas no momento da entrevista:

PC(cm)

Estatura (cm)

Há alguma observação sobre o procedimento:

K. Observações finais e coleta das amostras

Para concluir, gostaríamos de agradecer muito pela sua atenção em responder às nossas perguntas e nos fornecer um pouco de sangue para ver se você ou o seu bebê foram infectados pelo vírus Zika. Sua contribuição para este estudo nos ajudará muito em nossos esforços para compreender melhor a razão para tantos bebês estarem nascendo com microcefalia no Brasil. Obrigado.

- [ ] 1. Uma amostra de sangue foi colhida da mãe?
- [ ] 2. Uma amostra de sangue foi colhida do bebê?
- [ ] 3. O bebê foi fotografado?

Observações finais

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Appendix 1: Case Investigation Form

Form Approved
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Elizabethkingia Spp.
Interview Form:

CDCID_____

This form is intended to interview patients with:

- Isolates of any Elizabethkingia spp from any body site with PFGE matching outbreak pattern; AND
- The specimen was collected on or after November 1, 2015

When initiating an interview, please use the script appropriate to a participant. Please fill out completely, if patient or proxy does not know the information, then please check 'unknown' or note that question was asked and information is not available.

Was consent given: ☐ Yes ☐ No (DO NOT PROCEED)

Contact Information

Patient contact information	Proxy contact information (if applicable):
(gather at least State and Zip Code, even if proxy was interviewed):	Name: _____
Name: _____	Relation to patient: ☐ Relative: _____
Address: _____	☐ Clinician ☐ Other: _____
City, State, Zip: _____	Address: ☐ Same as patient
Phone: ( ) _____	_____
Name of residence, if applicable (i.e. nursing home, assisted living)_____	City, State, Zip: _____
	Phone: ( ) _____

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____

Zip code of residence: _____

State Epi ID (state use only):_____

Interview Information

Date first culture collected: __/__/_____(MM/DD/YYYY)

First date of 30-day exposure period (date of culture collection – 30 days): __/__/_____(MM/DD/YYYY)

First date of 7-day exposure period (date of culture collection – 7 days): __/__/_____(MM/DD/YYYY)

Date interview completed: __/__/_____(MM/DD/YYYY) ☐ Not applicable. Why? _____

Interviewer: Name: _____

Affiliation (state health dept. or CDC): _____

Linelist patient ID _____

For interviewer use only:

Information on this report was collected through (check all that apply): ☐ Patient/proxy interview (specify: _____) ☐ Medical Record Review

☐ Review of health department notes ☐ Other: _____

Must be filled BEFORE faxing to DPH:

Does this patient have laboratory-confirmation of Elizabethkingia spp infection? ☐ Yes ☐ No (STOP interview)

Hello, I am (name, affiliation).

Thank you for taking the time to talk to me today. Understanding healthcare and community exposures you had before you got sick with Elizabethkingia is critical for identifying the source of these illnesses and stopping more people from getting sick. During this interview I will ask you about your health, healthcare, and activities in the 30 days before you tested positive for Elizabethkingia. This is the period from (first date of exposure period) to (date of culture collection) [if conducting in person interview, show a calendar]. To answer these questions, it might be helpful for you to gather information that will help you remember what you did in the month before you became ill, such as an appointment diary, calendar, statements from healthcare providers, and receipts from restaurants or travel. This is a standardized interview form we are using for all the patients affected, to see if we can find some things in common that may have led to people becoming sick with this bacteria. We are still not sure the source of this outbreak. This bacteria is very rare and relatively newly discovered, so there are a lot of things we don't know about it. What we do know is that it likes to live in water and when it has infected people in the past that has typically been people who are already sick in the hospital. For that reason many of these questions will focus on prior healthcare exposures in the month before you became sick. I'll also be asking about home exposures, including water and soil exposures. Then we'll also talk about food exposures.

InstructionstotheInterviewer-IfthecaseisstillonlyPossibleandnotConfirmed,besuretostate:

"The state health department is automatically receiving any samples of this bacteria from hospital labs, and so we have been informed that you grew this bacteria on __(date)__ from __(body location)__. We still need to check the DNA fingerprint of the sample we received and see if it matches the same fingerprint of the other patients in this outbreak, and so we cannot confirm at this time that you are actually a part of the outbreak. Nevertheless, we are trying to get ahead of things and start contacting anyone we think MIGHT be affected by the outbreak to ask some questions."

Please remember that all of your responses are confidential. This interview will take up to an hour.

Are you ready to begin?

Patient Provider (Patient interview or Medical Record Review)

1. Primary care provider name: _____
2. Location and phone number of Primary care provider: _____

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____

Zip code of residence: _____

State Epi ID (state use only):_____

Demographic Information (Medical Record Review and Patient Interview)

I will start by asking some questions about your background and where you live.

3. Date of birth: ____/____/_____(MM/DD/YYYY)
4. In the time period from (first date of exposure period) to (date of culture collection) did you stay at least one night in an institutional setting?
   ☐ Yes ☐ No ☐ Unk
   a. If yes, select all that apply: ☐ Nursing home or rehabilitation facility ☐ Assisted living facility ☐ Acute care facility ☐ Other, specify: _____
5. What is your race: (check all that apply) ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐ Unk
6. What is your ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
7. What is your sex: ☐ Male ☐ Female ☐ Unk
8. Are you employed ☐ Yes ☐ No ☐ Unk If yes, place of employment, location (city) of employment?

_____

Healthcare Exposure (Patient Interview)

I am now going to ask you about your healthcare exposures that occurred in the 30 days before you became ill, the period from (first date of exposure period) to (date of culture collection). I will refer to this period as the month before you became ill.

9. In the month before you became ill, did you receive home health services (including wound checks, dressing changes, baths)? ☐Yes ☐ No ☐ Unk
   Please tell me about each of these home health visits, starting with the most recent.
   a. If yes, please list:

Date	Agency Name and Contact Information	Reason for Visit

10. In the month before you became ill, did you have any outpatient visits at a clinic with healthcare providers (this does not include outpatient visits for dialysis)? Examples of healthcare providers are primary care providers, specialists such as cardiologists or oncologists, eye doctors, and dentists.

    ☐ Yes ☐ No ☐ Unk
    a. If yes, please list your appointments:

Date	Clinic Name (phone number and address, if known) and Specialty Type	Reason for Visit

11. In the month before you became ill, were you receiving outpatient dialysis? ☐ Yes ☐ No ☐ Unk
    a. If yes, what type of dialysis: ☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Unk
    b. Name and contact information for dialysis facility: _____
    c. If hemodialysis please specify access type: ☐ fistula ☐ graft ☐ central venous catheter ☐ other ☐ Unk
    d. What days do you receive dialysis ☐ MWF ☐ T TH S ☐ Other ☐ Unk
    e. Last dialysis session before symptoms onset. Date: _____ ☐ do not know

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____
Zip code of residence: _____
State Epi ID (state use only):_____

12. In the month before you became ill, did you go to the emergency room for any reason? ☐ Yes ☐ No ☐ Unk
    a. If yes, please tell us more:

Date	Hospital Name and Contact Information	Reason for ER Visit	How did you get to the hospital?
			☐ EMS ☐ POV ☐ Other
			☐ EMS ☐ POV ☐ Other
			☐ EMS ☐ POV ☐ Other
			☐ EMS ☐ POV ☐ Other
			☐ EMS ☐ POV ☐ Other

13. Have you been to an Urgent Care in the month prior to illness onset? ☐ Yes ☐ No ☐ Unk
    a. If yes, please tell us more:

Date	Urgent Care Name and Contact Information	Reason for Urgent Care Visit

14. In the month before you became ill, did you have an overnight stay at a nursing home? This does not include assisted living facilities?
    ☐ Yes ☐ No ☐ Unk

15. In the month before you became ill, were you hospitalized overnight? ☐ Yes ☐ No ☐ Unk
    a. Please tell me all long term care facilities and hospitals where you were a patient overnight in the month before you became ill (including multiple stays or admissions).

Name and Type of Facility (nursing home, hospital)	Location (Address and phone number)	Indication	Admission date (MM/DD/YYYY)	Discharge date (MM/DD/YYYY)

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____

Zip code of residence: _____

State Epi ID (state use only):_____

16. Have you received care from any of the following in the month prior to illness onset?

Exposure	Yes	No	Unk	Location	Were any procedures beyond a routine examination performed? If yes, describe.	Date(s) (MM/DD/YYYY)
Dentist						.
Podiatrist						
Chiropractor						
Massage Therapist						
Naturopath						

17. In the month before you became ill did you use any of the following medications, check all that apply

a. Inhalers ☐ Yes ☐ No ☐ Unk
b. Nebulizers ☐ Yes ☐ No ☐ Unk
c. Nasal sprays ☐ Yes ☐ No ☐ Unk
d. Eye drops ☐ Yes ☐ No ☐ Unk
e. Oxygen ☐ Yes ☐ No ☐ Unk
f. Over the counter supplements, including vitamins, probiotics, powders added to a drink or smoothie (e.g., protein powder)
☐ Yes ☐ No ☐ Unk
If yes, specify type and brand _____
g. Thickened juice, food, or shakes? ☐ Yes | No ☐ Unk
i. If yes, which brand of thickener? | Thick-It® | ReadyCare 2.0™ | Hormel Thick & Easy® | Simply Thick | Oth
specify:_____ ☐ Unknown
ii. If yes, specify type of thickener:_____ ☐ Unknown
h. Proton pump inhibitors (PPI). Examples of PPI are Prilosec, Prevacid, and Nexium. ☐ Yes ☐ No ☐ Unk
i. H2 blockers. Examples of H2 blockers are Zantac and Tagamet. ☐ Yes ☐ No ☐ Unk
j. Antibiotics ☐ Yes ☐ No ☐ Unk
i. If yes, check all those that were received:

☐ Amikacin	☐ Cefprozil	☐ Doxycycline	☐ Penicillin
☐ Amoxicillin	☐ Ceftazidime	☐ Ertapenem	☐ Piperacillin-Tazobactam
☐ Amoxicillin/Clavulanic Acid	☐ Ceftizoxime	☐ Fosfomycin	☐ Polymyxin B
☐ Ampicillin/sulbactam	☐ Ceftriaxone	☐ Gentamicin	☐ Rifampin
☐ Azithromycin	☐ Cefuroxime	☐ Imipenem	☐ Tetracycline
☐ Aztreonam	☐ Cephalexin	☐ Levofloxacin	☐ Ticarcillin/Clavulanic Acid
☐ Cefaclor	☐ Ciprofloxacin	☐ Linezolid	☐ Tigecycline
☐ Cefazolin	☐ Clarithromycin	☐ Meropenem	☐ Tobramycin
☐ Cefdinir	☐ Clindamycin	☐ Metronidazole	☐ Trimethoprim-Sulfamethoxazole
☐ Cefepime	☐ Colistin	☐ Moxifloxacin	☐ Vancomycin
☐ Cefotaxime	☐ Daptomycin	☐ Nitrofurantoin	☐ Other (specify):_____
☐ Cefpodoxime	☐ Doripenem	☐ Ofloxacin	☐ Other (specify): _____

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____
Zip code of residence: _____
State Epi ID (state use only):_____

18. In the month before you became ill, did you experience any of the following:

Sign/Symptom	Present	If Yes, Date of Symptom Onset (MM/DD/YYYY) Write UNK if unknown	Notes (describe circumstances)	Treatment (include description of products used)
Open wounds, sores, or skin injury (i.e. ulcers, burns, cuts, or scrapes)	☐ Yes ☐ No ☐ Unk			

19. In the month before you became ill, did you receive any medication or immunization injections (i.e., intramuscular (IM), subcutaneous (SQ), intradermal (ID) shot, not through a catheter or during dialysis. Does not include IV infusions)? ☐ Yes ☐ No ☐ Unk
    a. If yes, please tell us more:

Medication	How frequent are the injections?	Date of last injection?

20. In the month before you became ill, did you receive any intravenous infusions (infusions into the vein) for saline, medicines, or vitamins?
☐ Yes ☐ No ☐ Unk
    a. If yes, please tell us more:

Medication/Vitamin or Substance (including saline or heparin	Facility or Location (Address/Phone number)	Date(s) (MM/DD/YYYY)

21. In the month before you became ill, were any central, peripheral lines or other IV catheters present? (for example, intravenous line, dialysis line not including a dialysis graft or fistula)
**NOTE FOR INTERVIEWER: THIS LINE COULD HAVE BEEN INSERTED PRIOR TO 30 DAYS, BUT MUST HAVE BEEN PRESENT IN THE MONTH PRIOR TO ILLNESS.
☐ Yes ☐ No ☐ Unk
a. If yes, please tell us more:

Type of intravenous catheter	Date of Insertion (MM/DD/YYYY)

22. In the month before you became ill, did you have any implanted medical devices (includes any device regardless of time placed)? (joint replacements, bone plates, cardiac defibrillator/pacer, heart valves, vascular stents, urinary catheter, etc.). Note: This does not include central or peripheral venous catheters which should be captured above

☐ Yes ☐ No ☐ Unk

a. If yes, please tell us more:

Device Type	Device Location (note Left/Right if applicable)	Year Implanted

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____
Zip code of residence: _____
State Epi ID (state use only):_____

Home Exposures (Patient Interview)

Thank you for providing that information. Now I am going to ask you questions about potential exposures at home and in the community.

23. How long before you became ill did you live in your current home? _____months/years ☐ Unk

24. In the month before you became ill, did you make any changes to your plumbing, heating, or cooling systems? ☐ Yes ☐ No ☐ Unk
    a. If yes, please explain: _____

25. In the three months before you became ill, were your plumbing, heating, or cooling systems serviced? ☐ Yes ☐ No ☐ Unk
    a. If yes, please explain: _____

26. Describe the water supply used in the month prior to becoming ill? ☐ Private Well ☐ City or Municipal water (Specify municipality_____) ☐ Other, specify _____ ☐ Unk

27. Does your home water use a de-chlorinator ☐ Yes ☐ No ☐ Unk
    a. If yes, when was the filter last replaced prior to illness onset? _____ ☐ Unk
    b. Type of filter? _____ ☐ Unk

28. Does your home water use a softener ☐ Yes ☐ No ☐ Unk

29. Where did you get your drinking water in the month before you became ill, check all that apply?

    ☐ Home Tap ☐ Point of Use Filter ☐ Bottled ☐ Other, specify _____ ☐ Unk

30. In the month before you became ill, did you consume commercially bought ice? ☐ Yes ☐ No ☐ Unk
    a. If yes, specify brand and location: _____

31. In the month before you became ill, did you use a humidifier in your home? ☐ Yes ☐ No ☐ Unk

32. In the month before you became ill, did you use a Neti-Pot or performed nasal rinsing? ☐ Yes ☐ No ☐ Unk
    a. If yes, what is the water source used? _____ ☐ Unk

33. In the month before you became ill, did you have an aquarium in your home? ☐ Yes ☐ No ☐ Unk

34. In the month before you became ill, did you have any pets at home? ☐ Yes, specify_____ ☐ No ☐ Unk

35. Did you have any exposure to animals in the 2 weeks before you became ill? ☐ Yes, specify_____ ☐ No ☐ Unk

36. Did you have any plants in your home in the month before you became ill? ☐ Yes, specify_____ ☐ No ☐ Unk

37. In the month before you became ill, did you have any contact with cut flowers? ☐ Yes ☐ No ☐ Unk

38. In the month before you became ill, did you come in to contact with any soil such as during gardening, farming, sports, or other outdoor activities?
    ☐ Yes ☐ No ☐ Unk
    a. If yes, please describe:_____

39. How do you bathe, check all that apply?
    ☐ Bath ☐ Shower ☐ Sponge bath ☐ Whirlpool ☐ Other, please specify _____ ☐ Unk

40. Do you have dentures? ☐ Yes ☐ No ☐ Unk

41. What brand of toothpaste did you use in the month before you became ill? _____ ☐ Unk

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____
Zip code of residence: _____
State Epi ID (state use only):_____

42. Did you use mouthwash in the month before you became ill? ☐ Yes ☐ No
    a. If yes, which brand? _____ ☐ Unk
43. In the month before you became ill, did you use any topical products (e.g., lotions, creams, liniments, or ointments)? ☐ Yes ☐ No ☐ Unk
    a. If yes: Please tell me all of the products you used during this period. _____
    _____
    _____
44. In the month before you became ill, did you use any peri-anal creams, pads, or medications? ☐ Yes ☐ No ☐ Unk
    a. If yes: Please tell me all of the peri-anal creams, pads or medications you used during this period.
    _____
45. In the month before you became ill, did you use any soaps or bodywashes? ☐ Yes ☐ No ☐ Unk
    a. If yes: Please tell me all of the soaps and body washes you used during this period. _____
    _____
46. In the month before you became ill, did you use any shampoos? ☐ Yes ☐ No ☐ Unk
    a. If yes: Please tell me all of the shampoos you used during this period. _____
    _____
47. Where did you purchase the personal care products that you used in the month before you became ill (e.g., soap, shampoo, creams and lotions, toothpaste, deodorant)? Check all that apply and specify location:

    ☐ Drug Store ☐ Grocery Store ☐ On-line ☐ Other

Name	Location

48. Now I would like to ask about a topic that might be sensitive to you. Please remember that your responses are confidential.
    In the month before you became ill, did you use marijuana, also called cannabis, in any form?
    ☐ Yes ☐ No ☐ Refuse to answer ☐ Unk
    a. If yes, specify route (check all that apply): ☐ Smoked ☐ Ate ☐ Topical (oils) ☐ Other (specify)
49. Do you know of anyone else in your home or community that has experienced a similar illness? ☐ Yes ☐ No ☐ Unk
    a. If yes, who: _____
50. Were you been bitten by any insect in the month before you became ill? ☐ Yes ☐ No ☐ Unk
    a. If so which? _____
51. In the month before you became ill, have any pets in your home had insect infestations (i.e., fleas)? ☐ Yes ☐ No ☐ Unk
52. In the month before you became ill, did anyone live (stay overnight) with you in your home? ☐ Yes ☐ No
    If yes: Please tell me more about all the people who live with you:

Name	Phone Number	Relationship	Occupation	Place of Employment	Check if surveillance cultures were obtained
					☐
					☐
					☐

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____
Zip code of residence: _____
State Epi ID (state use only):_____

53. In the 7 days before you became ill, did you have any visitors to your home? ☐ Yes ☐ No ☐ Unk
If yes: Please tell me more about all the people who visited you:

Name	Phone Number	Relationship	County of Residence	Occupation	Place of Employment

Outside Exposure (Patient Interview)

54. In the month before you became ill did you attend any of the following check all that apply: ☐ Religious service ☐ Support Group ☐ Exercise gym/group ☐ Club ☐ Social gathering ☐ None
55. If yes to any of the above, please specify when and where _____

NotetoInterviewer:Ifyouwillbeconductingthefullfoodexposurequestionnairewiththispatientthenskipquestions56-58andproceedtoquestion 59.

I am now going to ask you some questions about food you have eaten which will focus only on the 7 days before you became ill, which is the period from (7 days prior to date of culture) to (date of culture collection).

56. In the 7 days before you became ill, where did your food come from that was prepared at home
    a. Grocery store ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____
    b. Farmers market/food purchased directly from farm ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____
    c. Health food store ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____
    d. Ethnic specialty market ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____
    e. Fish or meat shop (e.g., butcher's) ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____
    f. Hunting or fishing ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____
    g. Locally grown fresh foods, e.g., hydroponic greens ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____
    ☐ Not applicable (my food is prepared and controlled by my residence facility)
57. In the 7 days before you became ill, did family or friends bring you food from outside the facility? ☐ Yes ☐ No ☐ Unk
    If yes, please describe: _____
58. In 7 days before you became ill, did you eat food prepared outside the home, such as from a restaurant, meal delivery service, or at a school, or hospital? This includes foods that you ate outside the home, brought home, or had delivered ☐ Yes ☐ No ☐ Unk
    a. Restaurants (including deliveries such as pizza) ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____
    b. Meal delivery service, such as meals on wheels ☐ Yes ☐ No ☐ Unk_
        i. If yes, specify 1. _____ 2._____ 3._____
    c. Institution, such as hospital or school ☐ Yes ☐ No ☐ Unk
        i. If yes, specify 1. _____ 2._____ 3._____

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____
Zip code of residence: _____
State Epi ID (state use only):_____

59. In the 7 days before you became ill, did you use any consumables (lotions, balms, salves) prepared outside the U.S.? ☐ Yes ☐ No ☐ Unk
60. In the 7 days before you became ill, did you consume any foods from outside the U.S.? ☐ Yes ☐ No ☐ Unk

Thank you. Now I am going to ask you a few more questions about your activities. These questions will refer to the full 30 day period from (first date of exposure period) to (date of culture collection).

61. In the month before you became ill, did you do any of the following activities?

Exposure	Yes	No	Unk	Location	Date(s) (MM/DD/YYYY)
Swimming, hot tub					
Water aerobics					
Water park					
Fishing					
Steam room, or wet sauna					
Hot tub or whirlpool/spa					
Other:					

62. In the month before you became ill, did you travel anywhere outside your home town, even for part of a day? Please include any towns that you visited where you ate a meal or bathed, showered, or swam. ☐ Yes ☐ No ☐ Unk
    a. If yes, please list the places you visited.

Location	Date(s) (MM/DD/YYYY)

63. Any additional comments or notes (e.g. travel details, additional visits to healthcare providers, other diagnostic testing, and information)?

Elizabethkingia Spp. Interview Form:

Date of interview: __/ __ / _____

Zip code of residence: _____

State Epi ID (state use only):_____

InterviewerInstructions:IfyouwillbeconductingthefullfoodexposurequestionnaireproceedtoitatthispointIfyouwillnotbeconductingthefull foodexposurequestionnairethentheinterviewiscompleted.

This is the end of the interview. Thank you very much for your time and willingness to provide this valuable information.

If you have any questions please feel free to contact Wisconsin Division of Public Health at 608-267-9003.

If necessary, would it be okay to contact you again in the future with any follow-up questions?

Thank you, and take care.

Interviewer: Please fax completed forms to 608-261-4976

Form Approved
OMB# 0929-1011
Expires 03/31/2017

Appendix 3: Case Series Form

Patient CDCID: _____

Wisconsin Clinical Course Abstraction Form

SECTION A

Section A Instructions: Abstract Section A using all medical records relevant to Elizabethkingia infection. This includes the medical record from the outpatient encounter, ER, or hospitalization where the positive culture was collected and follow-up care (hospitalization for EK, care at AL for EK, or outpatient treatment for the positive culture). If a patient was transferred during their EK hospitalization, abstract medical records for EK hospitalization from both facilities.

Obtain list of ICU locations from hospital prior to abstraction to ensure that all ICU stays are captured in item 21.

Patient CDCID:

Abstractor Name:

Date of Abstraction:

Specify name of facilities included in abstraction for Section A:

1. Age: _____

2. Sex: ☐ Male ☐ Female ☐ Unk

3. Race (check all that apply): ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black
   ☐ Native Hawaiian/Other Pacific Islander ☐ Unk

4. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

5. County of residence: _____

6. Date of collection of first specimen positive for E. anophelis: ___/___/_____(MM/DD/YYYY)

7. Time of collection of first specimen positive for E. anophelis: (HOURS/MINUTES; 24 HOUR CLOCK)

8. Where was the first specimen positive for E. anophelis collected (select one)?

   ☐ Inpatient
   ☐ Emergency Room
   ☐ Observational unit/Clinical Decision Unit
   ☐ Outpatient
   ☐ Assisted Living
   ☐ LTCF/SNF
   ☐ LTACH
   ☐ Dialysis clinic
   ☐ Other (specify): _____
   ☐ Unknown

Patient CDCID: _____

9. Was patient hospitalized at the time of or during the 7 days after the first specimen positive for E. anophelis was collected? ☐ Yes ☐ No ☐ Unk

   a. If yes, specify date of admission: ___/___/_____(MM/DD/YYYY) (If patient was hospitalized and transferred, specify first date of admission) ☐ Unk

   b. Was patient transported to the hospital by EMS/ambulance (this is only intended to capture emergency transports by EMS not planned transfers via private ambulance)? ☐ Yes ☐ No ☐ Unk

   c. Was patient transferred to a different short stay acute care hospital at any point after the first specimen positive for E. anophelis was collected? ☐ Yes ☐ No ☐ Unk

      If yes, specify date(s) of transfer: ___/___/_____(MM/DD/YYYY)

   d. List all admission diagnoses on H&P:

_____
_____
_____
_____
_____
_____
_____

10. Where was the patient admitted from? (select one)

☐ Private residence
☐ Acute care hospital inpatient
☐ Homeless
☐ Assisted living
☐ LTCF/SNF
☐ LTACH
☐ Other (specify): _____
☐ Unknown

11. History of present illness at the time of hospital admission (please briefly summarize details from the H&P):

_____
_____
_____
_____
_____
_____
_____

_____

Patient CDCID: _____

12. Past Medical History known at time first positive specimen was collected (check all that apply)

☐None ☐Unknown

☐AIDS	☐Failure to thrive
☐Atrial Fibrillation	☐Hemiplegia
☐History of alcohol abuse	☐HIV without AIDS
☐Asplenia	☐Inflammatory bowel disease (Ulcerative Colitis/Crohns)
☐Asthma	☐Ischemic heart disease
☐Autoimmune disease	☐History of IVDU
☐Cerebrovascular disease/stroke (except hemiplegia)	☐Kidney stones/nephrolithiasis
☐Cerebral palsy	☐Leukemia
☐Chronic cognitive deficit	☐Lymphoma or multiple myeloma
☐Chronic kidney disease (not on dialysis)	☐MRSA colonization or infection history (prior to admission)
☐Chronic kidney disease (on dialysis)	☐Myocardial infarction
☐Chronic liver disease without cirrhosis	☐Neutropenia (absolute neutrophil count <500 cells/μL)
☐Cirrhosis	☐Peptic ulcer disease
☐Chronic obstructive pulmonary disease (COPD)/emphysema	☐Peripheral vascular disease
	☐Postpartum (30 days or less)
☐Chronic lung disease (other than COPD/emphysema, asthma)	☐Pregnancy (current)
	☐Pulmonary hypertension
☐Chronic steroid or other immunosuppressive therapy	☐Recurrent cystitis or urinary tract infection
☐Chronic ventilation/tracheostomy	☐Sickle cell disease
☐Congenital heart disease	☐Solid tumor malignancy, metastatic
☐Congestive heart failure	☐Solid tumor malignancy, not metastatic
☐Connective tissue disease	☐Spinal cord injury or paraplegia or quadriplegia
☐Cystic fibrosis	☐Transplant, hematopoietic stem cell or bone marrow
☐Dementia	☐Transplant, solid organ
☐Diabetes mellitus with complications	☐Other _____
☐Diabetes mellitus without complications	☐Other _____
☐Eczema	☐Other _____

a. Summarize other past history not captured above:

_____

_____

_____

13. Did the patient have any of the following exposures at time of hospital admission?

a. Current smoking: ☐ Yes ☐ No ☐ Unk , if yes, specify pack years:_____ ☐ Unk

b. Current alcohol use: ☐ Yes ☐ No ☐ Unk , if yes, specify drinks per week: _____ ☐ Unk

c. Current illicit drug use: ☐ Yes ☐ No ☐ Unk , if yes, specify drugs and frequency:

Drug_____Frequency_____ ☐ Unk

Drug_____Frequency_____ ☐ Unk

Drug_____Frequency_____ ☐ Unk

Patient CDCID: _____

14. Did the patient have any medication allergies? : ☐ Yes ☐ No ☐ Unk

    If yes, specify all: _____

15. Specify all symptoms reported by patient on the date the first positive specimen was collected and the onset date reported by the patient (if known). Check No only if the records indicate the patient denied the symptom was present; otherwise specify unknown.

Symptom	Symptom Present?	If Yes, Date of Symptom Onset (MM/DD/YYYY) Write UNK if unknown
Weakness	☐ Yes ☐ No ☐ Unk	
Headache	☐ Yes ☐ No ☐ Unk	
Lightheadedness, Dizziness	☐ Yes ☐ No ☐ Unk	
Blurry vision	☐ Yes ☐ No ☐ Unk	
Documented Fever (T >100.3)	☐ Yes ☐ No ☐ Unk if yes, temp _____ °F	
Subjective fever	☐ Yes ☐ No ☐ Unk	
Night sweats	☐ Yes ☐ No ☐ Unk	
Chills	☐ Yes ☐ No ☐ Unk	
Cough	☐ Yes ☐ No ☐ Unk	
Wheezing	☐ Yes ☐ No ☐ Unk	
Sore throat / difficulty swallowing	☐ Yes ☐ No ☐ Unk	
Muscle aches	☐ Yes ☐ No ☐ Unk	
Chest pain	☐ Yes ☐ No ☐ Unk	
Shortness of breath	☐ Yes ☐ No ☐ Unk	
Vomiting	☐ Yes ☐ No ☐ Unk	
Nausea	☐ Yes ☐ No ☐ Unk	
Diarrhea	☐ Yes ☐ No ☐ Unk	
Abdominal pain	☐ Yes ☐ No ☐ Unk	
Joint pain	☐ Yes ☐ No ☐ Unk	
Bleeding gums	☐ Yes ☐ No ☐ Unk	
Mouth sores	☐ Yes ☐ No ☐ Unk	
Skin wound	☐ Yes ☐ No ☐ Unk	
Rashes	☐ Yes ☐ No ☐ Unk	
Skin warmth	☐ Yes ☐ No ☐ Unk	
Skin redness	☐ Yes ☐ No ☐ Unk	
Skin pain	☐ Yes ☐ No ☐ Unk	
Altered mental status	☐ Yes ☐ No ☐ Unk	
Other specify_____	☐ Yes ☐ No ☐ Unk	
Other specify_____	☐ Yes ☐ No ☐ Unk	
Other specify_____	☐ Yes ☐ No ☐ Unk	

Patient CDCID: _____

16. Specify all physical exam findings documented by the clinical team on the date the first positive specimen was collected. Check No only if the records indicate the finding was not present (e.g., if team documents skin exam was normal then would check No for skin signs); otherwise specify unknown.

Sign	Sign Present?
Altered mental status	☐ Yes ☐ No ☐ Unk
Rash	☐ Yes ☐ No ☐ Unk
Skin redness	☐ Yes ☐ No ☐ Unk
Skin tenderness	☐ Yes ☐ No ☐ Unk
Skin warmth	☐ Yes ☐ No ☐ Unk
Skin wound (including decubitus ulcer)	☐ Yes ☐ No ☐ Unk
Cellulitis specifically documented	☐ Yes ☐ No ☐ Unk
Other specify_____	☐ Yes ☐ No ☐ Unk
Other specify_____	☐ Yes ☐ No ☐ Unk
Other specify_____	☐ Yes ☐ No ☐ Unk
Other specify_____	☐ Yes ☐ No ☐ Unk
Other specify_____	☐ Yes ☐ No ☐ Unk
Other specify_____	☐ Yes ☐ No ☐ Unk
Other specify_____	☐ Yes ☐ No ☐ Unk

17. Vital signs documented closest to time of collection of first positive specimen

☐ None ☐ Unknown

Date_/__/____(MM/DD/YYYY) ☐ Unk

Time: (HOURS/MINUTES; 24 HOUR CLOCK) ☐ Unk

Parameter (include units)	Result
Systolic Blood pressure (mmHg)	
Diastolic Blood pressure (mmHg)	
Pulse (beats per minute)	
Respiratory rate (breaths per minute)	
Temperature (degrees F)	
Pulse Ox (percent)	Percent saturation_____ On O_2 ☐ Yes ☐ No ☐ Unk If Yes, mode of delivery: ☐ Nasal cannula ☐ Intubated ☐ Other (specify): _____ If yes, FiO2:_____ or L/Min: _____(if FiO2 not documented) ☐ Unk

Patient CDCID: _____

18. Record each for the 3 days beginning with the day of collection of first positive specimen. If only 1 value was documented (e.g., only 1 wbc value recorded for a given day) record the value as both the highest and the lowest.

	Day 1 (Day culture was performed) Date: ____/____/____	Day 2 Date: ____/____/____	Day 3 Date: ____/____/____
Highest systolic blood pressure			
Lowest systolic blood pressure			
Highest heart rate			
Lowest heart rate			
Highest respiratory rate			
Lowest respiratory rate			
Highest WBC			
Lowest WBC			
Highest proportion bands			
Altered mental status present (Yes/No/Unknown)			

19. Complete supplementary Table 1. For each day of the patient's hospital admission, record vitals documented closest to 6am and 6pm in the medical record. If the patient was already hospitalized at the time their first positive specimen was collected, document vitals starting 7 days prior to specimen collection date through the duration of their hospitalization.

Patient CDCID: _____

20. Record laboratories documented as specified below.

Parameter (include units)	Results on day patient was admitted to hospital (if multiple results, select first collected) Date: _/__/___	Results on day first positive specimen was collected (select results closest to specimen collection) Date: _/__/__	Results of highest value obtained during hospitalization Specify date for each value	Results of lowest value obtained during hospitalization Specify date for each value	Results on day discharged from hospital or died Date: _/__/__
WBC					
Percent neutrophils (corresponds to WBC count above)					
Percent bands (corresponds to WBC count above)					
Platelets					
Hematocrit					
BUN					
Creatinine					
Lactate					
AST					
ALT					
INR					
Alkaline phosphatase					
Bilirubin					
Glucose					
CRP					
Anion Gap: Sodium – (Chloride + Bicarbonate)					

21. Was the patient admitted to an intensive care unit during his/her stay? ☐ Yes ☐ No ☐ Unk

If yes, specify dates of admission to ICU:

	Date of ICU Admit	Date of ICU Discharge
1	___/_____/_____ ☐Unk	___/_____/_____ ☐Unk
2	___/_____/_____ ☐Unk	___/_____/_____ ☐Unk
3	___/_____/_____ ☐Unk	___/_____/_____ ☐Unk
4	___/_____/_____ ☐Unk	___/_____/_____ ☐Unk

Patient CDCID: _____

22. Specify if any of the following procedures were performed or provided during the patient's hospitalization:

Procedure	Performed?	Date of Procedure Indicate Start Date for those procedures where number of days is documented	If yes, describe indication for procedure	Number of Days (do not fill if box is greyed)
Placement of Chest tube	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Placement of other drain Specify_____	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Acute hemodialysis	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Mechanical ventilation	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Noninvasive ventilation (CPAP or BiPAP)	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Placement of Central Venous Catheter	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Bronchoscopy	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Endoscopy Specify_____	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Surgery Specify_____	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Other Specify_____	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Other Specify_____	☐ Yes ☐ No ☐ Unk	___/_____/_____		
Other Specify_____	☐ Yes ☐ No ☐ Unk	___/_____/_____		

Patient CDCID: __________

23. Did the patient require vasopressors? ☐ Yes ☐ No ☐ Unk If yes, specify which ones and all start and stop dates:

List all vasopressors that were started at any point during the hospitalization. Each row is an event. If a vasopressor was stopped and then restarted on a different date, the restart should be documented as a separate entry.

Examples: Dopamine, Dobutamine, Epinephrine, Norepinephrine, Neosynephrine, Vasopressin, Other (specify)

Vasopressor	Start date	Stop date
	___/_____/_______	___/_____/_______
	___/_____/_______	___/_____/_______
	___/_____/_______	___/_____/_______
	___/_____/_______	___/_____/_______
	___/_____/_______	___/_____/_______
	___/_____/_______	___/_____/_______

24. Using the medical administration record for inpatient hospitalization, specify all antibiotics received during hospitalization. Complete one row for each antibiotic course. If four or more days between stop and start then assume new antibiotic course and start new row.

Antimicrobial	Route (IV, IM, PO, Topical, Inhaled)	Start date	Stop date
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____ /_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____/_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____/_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____/_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____/_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____/_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____/_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____/_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	_____/_______ /☐ Unk
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	___/_____/_______ ☐ Unk	___/____/_______ ☐ Unk

Patient CDCID: _____

25. Were antibiotics prescribed for patient at discharge? ☐ Yes ☐ No ☐ Unk

a. If yes, specify:

Antimicrobial	Route (IV, IM, PO, Topical)	Prescribed Duration in Days (specify unknown if not documented)
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	
	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	

Imaging

26. List all imaging studies and results

Note: Do not include results from X-Rays except Chest X-Ray as described in item 27

Performed	Location	Impression	Date
☐ CT ☐ MRI Ultrasound ☐ Nuclear Medicine ☐ Other (specify): ☐ _____	☐ Head ☐ Abdomen ☐ Chest ☐ Extremity (specify): _____ ☐ Other (specify): _____		___/_____/_____
☐ CT ☐ MRI Ultrasound ☐ Nuclear Medicine ☐ Other (specify): ☐ _____	☐ Head ☐ Abdomen ☐ Chest ☐ Extremity (specify): _____ ☐ Other (specify): _____		___/_____/_____
☐ CT ☐ MRI Ultrasound ☐ Nuclear Medicine ☐ Other (specify): ☐ _____	☐ Head ☐ Abdomen ☐ Chest ☐ Extremity (specify): _____ ☐ Other (specify):		___/_____/_____
☐ CT MRI ☐ Ultrasound ☐ Nuclear Medicine ☐ Other (specify): ☐ _____	☐ Head ☐ Abdomen ☐ Chest ☐ Extremity (specify): _____ ☐ Other (specify): _____		___/_____/_____

Patient CDCID: __________

☐ CT ☐ MRI Ultrasound ☐ Nuclear Medicine ☐ Other (specify): ☐ ____________________	☐ Head ☐ Abdomen ☐ Chest ☐ Extremity (specify): ____________________ ☐ Other (specify): ____________________		___/_____/______
☐ CT ☐ MRI Ultrasound ☐ Nuclear Medicine ☐ Other (specify): ☐ ____________________	☐ Head ☐ Abdomen ☐ Chest ☐ Extremity (specify): ____________________ ☐ Other (specify): ____________________		___/_____/______
☐ CT ☐ MRI Ultrasound ☐ Nuclear Medicine ☐ Other (specify): ☐ ____________________	☐ Head ☐ Abdomen ☐ Chest ☐ Extremity (specify): ____________________ ☐ Other (specify): ____________________		___/_____/______
☐ CT ☐ MRI Ultrasound ☐ Nuclear Medicine ☐ Other (specify): ☐ ____________________	☐ Head ☐ Abdomen ☐ Chest ☐ Extremity (specify): ____________________ ☐ Other (specify): ____________________		___/_____/______

27. Chest X-Ray (Document findings from the X-ray that was performed most proximal to the time the first positive specimen was collected; only Chest X-rays on day of positive culture or the 2 days following)

☐ Yes ☐ No ☐ Unk

If yes, specify date of Chest XRay: ___/_____/______ ☐ Unk

Record impression:

____

____

____

Were any of the following noted (check all that apply; only check items that were explicitly documented by the radiologist. Please also document their full written impression above)?

☐ Pleural effusion ☐ Infiltrate ☐ Consolidation ☐ Bronchopneumonia/pneumonia

☐ No evidence of pneumonia ☐ Cannot rule out pnemonia

Patient CDCID: _____

Procedures

28. Did patient have a lumbar puncture? ☐ Yes ☐ No ☐ Unk

If yes, record results for each lumbar puncture performed (include units)

Date: ___/_____/_____ ☐ Unk

Parameter	First tube	Subsequent tube	
WBC count			List differential
RBC count			
Protein			
Glucose			
Opening pressure			
Gram stain			

Date: ___/_____/_____ ☐ Unk

Parameter	First tube	Subsequent tube	
WBC count			List differential
RBC count			
Protein			
Glucose			
Opening pressure			
Gram stain			

29. Did patient have paracentesis? ☐ Yes ☐ No ☐ Unk

If yes, record results for each paracentesis performed (include units)

Date: ___/_____/_____ ☐ Unk

Parameter	First tube	
WBC		Differential:
RBC		
LDH		
Protein		
Gram stain		

Date: ___/_____/_____ ☐ Unk

Parameter	First tube	
WBC		Differential:
RBC		
LDH		
Protein		
Gram stain		

Patient CDCID: _____

30. Did patient have thoracentesis? ☐ Yes ☐ No ☐ Unk

If yes, record results for each thoracentesis performed (include units)

Date: ___/_____/_____ ☐ Unk

Parameter	First tube	
WBC		Differential:
RBC		
LDH		
Protein		
pH		
Gram stain		

Date: ___/_____/_____ ☐ Unk

Parameter	First tube	
WBC		Differential:
RBC		
LDH		
Protein		
pH		
Gram stain		

31. Did patient have joint aspiration? ☐ Yes ☐ No ☐ Unk

If yes, record results for each joint aspiration performed (include units)

Date: ___/_____/_____ ☐ Unk

Parameter	First tube	
WBC		Differential:
RBC		
LDH		
Protein		
Gram stain		

Date: ___/_____/_____ ☐ Unk

Parameter	First tube	
WBC		Differential:
RBC		
LDH		
Protein		
Gram stain		

Patient CDCID: _____

32. List all cultures (positive and negative) during the hospital course (Note: each set is one row)

Culture source (specimen type)	Date	Result	If blood culture is a "set" of cultures specify total number of bottles and the number positive
	___/_____/_____ ☐ Unk	☐ No growth ☐ Organism specify__	☐ Unk
	___/_____/_____ ☐ Unk	☐ No growth ☐ Organism specify__	☐ Unk
	___/_____/_____ ☐ Unk	☐ No growth ☐ Organism specify__	☐ Unk
	___/_____/_____ ☐ Unk	☐ No growth ☐ Organism specify__	☐ Unk
	___/_____/_____ ☐ Unk	☐ No growth ☐ Organism specify__	☐ Unk
	___/_____/_____ ☐ Unk	☐ No growth ☐ Organism specify__	☐ Unk

33. For E. anophelis isolates specify MIC or zone diameter and interpretation (if available) listed in the medical record for first isolate

Isolate collection date	Date	MIC	Zone Diameter	Interpretation
Piperacillin/tazobactam	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Trimethoprim/sulfamethoxazole	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Levofloxacin	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Ciprofloxacin	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Moxifloxacin	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Rifampin	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Vancomycin	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Minocycline	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Doxycycline	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None

Patient CDCID: _____

Other (specify): _____	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Other (specify): _____	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Other (specify): _____	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None
Other (specify): _____	___/___/_____ ☐ Unk			☐ S ☐ I ☐ R ☐ None

a. What method was used? : ☐ ATI ☐ Disc Diffusion/Kirby Bauer ☐ Other (specify)
b. How was organism reported? Genus_____ Species _____

Outcomes (at end of discharge from last short-stay acute care hospital):

34. Patient disposition: ☐ Died ☐ Discharged ☐ Still inpatient at time of record review ☐ Unknown ☐ Other (specify): _____
   a. Date of discharge : ___/___/_____
   b. Date of death if not discharged: ___/___/_____ ☐ Unk
   c. Did patient die in the 30 days after discharge from the hospital (complete using information from state vital records)? ☐ Yes ☐ No ☐ Unk
      a. If yes, specify

      Date of death: ___/___/_____ ☐ Unk

      Cause(s) of death listed on death certificate in the order they are listed:

      _____

      _____

35. If discharged specify location of discharge:

☐ Home ☐ Long-term care facility ☐ Long-term acute care hospital ☐ Assisted living ☐ Unk

☐ Other, specify _____

36. Specify all discharge diagnoses in the order listed in the medical record:

_____

_____

_____

37. Was patient readmitted to acute care hospital within 30 days from discharge from the hospital?

☐ Yes ☐ No ☐ Unk

a. If yes, date of readmission _____
b. If yes, indication for readmission _____

Patient CDCID: _____

SECTION B

Compete Section B using all available records from the 30 days prior to the collection date of the first culture positive specimen to complete the following section.

Did the patient receive any of the following medications in the 30 days prior to collection of the first positive specimen?

38. H2 blocker: ☐ Yes ☐ No ☐ Unk

If yes, were H2 blockers listed as outpatient medication in the HPI from the time of first positive culture collection? ☐ Yes ☐ No ☐ Unk

39. Proton pump inhibitor: ☐ Yes ☐ No ☐ Unk

If yes, was the PPI listed as outpatient medication in the HPI from the time of first positive culture collection? ☐ Yes ☐ No ☐ Unk

40. Were antibiotics administered during the 30 days prior to collection of positive culture, based on provider notes
☐ Yes ☐ No ☐ Unk

Do not include those already documented in item 24 above.

If yes, specify:

Antimicrobial	Route	Start date	Stop date
☐ Amikacin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Amoxicillin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Amoxicillin/Clavulanic Acid	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Ampicillin/sulbactam	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Azithromycin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Aztreonam	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cefaclor	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cefazolin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cefdinir	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cefepime	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cefotaxime	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cefpodoxime	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cefprozil	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Ceftazidime	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Ceftizoxime	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Ceftriaxone	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cefuroxime	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Cephalexin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Ciprofloxacin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Clarithromycin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Clindamycin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Colistin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Daptomycin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Doripenem	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Doxycycline	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Ertapenem	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk
☐ Fosfomycin	☐ IV ☐ IM ☐ PO ☐ Topical ☐ Inhaled	____/____/____ ☐ Unk	____/____/____ ☐ Unk

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☐ Gentamicin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Imipenem	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Levofloxacin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Linezolid	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Meropenem	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Metronidazole	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Moxifloxacin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Nitrofurantoin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Ofloxacin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Penicillin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Piperacillin-Tazobactam	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Polymyxin B	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Rifampin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Tetracycline	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Ticarcillin/Clavulanic Acid	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Tigecycline	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Tobramycin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Trimethoprim-Sulfamethoxazole	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Vancomycin	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Other (specify):____________	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Other (specify):____________	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Other (specify):____________	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk
☐ Other (specify):____________	☐ IV ☐ IM ☐ PO ☐ Topical ☐nhaled	_____/_____/_____ ☐ Unk	_____/_____/_____ ☐ Unk

Form Approved
OMB# 0929-1011
Expires 03/31/2017

Appendix 2: Medical Abstraction Form

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

This form is intended to be used for abstraction of medical records for patients in Wisconsin with:

- Isolates of *Elizabethkingia* spp cultured from sterile sites,
  AND
- collected on or after November 1, 2015

Patient NAME: _____

Patient DOB: ___/___/_____ (MM/DD/YYYY)

MRN: _____

Abstraction Information

Date medical record abstraction completed: ___/___/_____ (MM/DD/YYYY)

Abstractor: Name: _____
Affiliation (state health dept. or CDC): _____
Date_____

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

SECTION 1: Case Background Information. Complete this section using the Case Report Form

1. Date positive culture collected: ___/___/_____ (MM/DD/YYYY) Time positive culture collected (24 hour): HH:MM
2. First date of 30-day exposure period (date of culture collection – 30 days): ___/___/_____ (MM/DD/YYYY)
3. First date of 7-day exposure period (date of culture collection – 7 days): ___/___/_____ (MM/DD/YYYY)
4. Name of facility where first positive culture was collected: _____

LOCATION OF CULTURE COLLECTION:

- ☐ Inpatient
- ☐ Emergency Room
- ☐ Observational unit/Clinical Decision Unit
- ☐ Outpatient
- ☐ Assisted Living
- ☐ LTCF/SNF
- ☐ LTACH
- ☐ Dialysis clinic
- ☐ Unknown

5. Was this collected more than 3 calendar days after admission: ☐ Yes ☐ No
6. Where was patient **residing** at time of culture collection:

- ☐ Private residence
- ☐ Acute care hospital inpatient
- ☐ Homeless
- ☐ Assisted living
- ☐ LTCF/SNF
- ☐ LTACH
- ☐ Other
- ☐ Unknown

7. Was the patient hospitalized for *Elizabethkingia* infection? ☐ Yes ☐ No
8. **If yes to 5**: Admission date: ___/___/_____ (MM/DD/YYYY) Admission time(24 hour): _____HH:MM
9. If culture was not collected in a hospital facility, what was the reason for culture? _____

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

10. Please list all known medical encounters in **30 days prior**. Medical records should be requested from each of the listed facilities.

HC Encounter #	Date of Health Care Encounter	Encounter location	Type of encounter	Record or interview included, Yes or No
1		☐ outpatient clinic ☐ home health ☐ EMS ☐ emergency room (no admy to ACH) ☐ ACH (admission) ☐ Assisted living ☐ LTCF ☐ LTACH ☐ Dialysis ☐ Dental ☐ Other If admitted: Dates __/__/____- __/__/____		
2		☐ outpatient clinic ☐ home health ☐ EMS ☐ emergency room (no admy to ACH) ☐ ACH (admission) ☐ Assisted living ☐ LTCF ☐ LTACH ☐ Dialysis ☐ Dental ☐ Other If admitted: Dates __/__/____- __/__/____		
3		☐ outpatient clinic ☐ home health ☐ EMS ☐ emergency room (no admy to ACH) ☐ ACH (admission) ☐ Assisted living ☐ LTCF ☐ LTACH ☐ Dialysis ☐ Dental ☐ Other If admitted: Dates __/__/____- __/__/____		
4		☐ outpatient clinic ☐ home health ☐ EMS ☐ emergency room (no admy to ACH) ☐ ACH (admission) ☐ Assisted living ☐ LTCF ☐ LTACH ☐ Dialysis ☐ Dental ☐ Other If admitted: Dates __/__/____- __/__/____		
5		☐ outpatient clinic ☐ home health ☐ EMS ☐ emergency room (no admy to ACH) ☐ ACH (admission) ☐ Assisted living ☐ LTCF ☐ LTACH ☐ Dialysis ☐ Dental ☐ Other If admitted: Dates __/__/____- __/__/____		

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

SECTION 2: Overall Medical History. Complete this section using <u>all available</u> medical records

Medical History

11. ***Females only:*** Were you pregnant or ≤6 weeks postpartum at the time of first positive EK culture?
    ☐ Yes, pregnant (weeks pregnant at onset)_____ ☐Yes, postpartum (delivery date) ___/___/____ ☐ No ☐ Unk
12. Height (use record closest to EK positive culture) _____ft _____in _____cm
13. Weight (use record closest to EK positive culture) _____lb _____kg
14. BMI _____
15. Did the patient have any of the following medical conditions? ***Specify <u>ALL</u> conditions that are present.***

☐ Coronary artery disease	☐ Connective Tissue Disease
☐ Atrial Fibrillation	☐ Malignant Lymphoma
☐ Congestive Heart Failure	☐ Solid Tumor
☐ Peripheral Vascular Disease	☐ Mild Liver Disease
☐ Cerebrovascular Disease	☐ HIV without AIDS
☐ Dementia	☐ AIDS
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ History of decubitus ulcers
☐ Pulmonary Hypertension	☐ Cellulitis
☐ Peptic Ulcer Disease	☐ Pancreatitis
☐ Diabetes Mellitus without complications	☐ Current alcohol dependence
☐ moderate or severe renal disease	☐ Inflammatory bowel disease(Ulcerative Colitis/Crohns)
☐ Hemiplegia	☐ Smoking (previous year)
☐ Hematologic Malignancy	☐ Solid organ transplant
☐ Moderate or severe liver disease	☐ Asthma
☐ Diabetes mellitus with end organ damage	Other _____

Dialysis

16. Did the patient get dialysis in the **30 days** prior to positive EKM culture? ☐ Yes ☐ No ☐ Unknown
    a. What type of dialysis was performed? ☐ Hemodialysis ☐ Peritoneal ☐ Unknown
    b. Does the patient have permanent vascular access? ☐ Yes ☐ No ☐ Unknown
    c. What type of vascular access was used? ☐ AV fistula/graft ☐ CVC ☐ Unknown
    d. Did the patient get this type of dialysis in the **7 days** prior to positive EKM culture? ☐ Yes ☐ No ☐ Unk
        i. Date of most recent dialysis _____
        ii. Location ☐ Dialysis Center (Name_____)
        ☐ Emergency Department (Name_____)
        ☐ Home *note: peritoneal dialysis is usually done at home
        ☐ Other: _____

17. Did the patient have CRRT in the **30 days** prior to positive EK culture? ☐ Yes ☐ NO
    e. Date _____
    f. Name of facility: _____

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

18. Did the patient receive any IV or IM **medications** in the 30 days to 2 hours prior to positive culture? ☐ Yes ☐ No
    If yes, complete the table below:

Medication Name	Facility Name	Route (IV, IM)	Most Recent Date Prior to Positive Cx (MM/DD?YYY)	Approximate start date	Comments

19. Did the patient have surgery in the 30 days prior to positive EK culture? ☐ Yes ☐ No

Type of Surgery	Date (MM/DD/YYY)	Facility Name

20. Did patient have a wound in the thirty days prior to positive culture: Yes or No
    a. Wound type (description and location) _____
    b. Topical treatments received: _____

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

21. Did patient have any indwelling devices **present in the 30 days prior** ☐ Yes ☐ No

Device	Present at EK Cx?	Details	Placed in last 30 days?
Cardiac Pacemaker/ICD	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Cardiac Defibrillator	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Prosthetic Cardiac Valve	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Vascular Stent	☐ Yes ☐ No ☐ Unk	☐ cardiac ☐ peripheral ☐ other_____	☐ Yes ☐ No ☐ Unk
Vascular grafts	☐ Yes ☐ No ☐ Unk	☐ cardiac ☐ aortic ☐ other_____	☐ Yes ☐ No ☐ Unk
Indwelling vascular catheter	☐ Yes ☐ No ☐ Unk	☐ Port ☐ Picc ☐ HD permcath ☐ other _____	☐ Yes ☐ No ☐ Unk
Urinary Catheter	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Prosthetic joint	☐ Yes ☐ No ☐ Unk	Location: _____	☐ Yes ☐ No ☐ Unk
Orthopedic implants (plates/screws)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Other Implant1	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Other Implant2	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk

22. Has patient used any immunosuppressant medications in the last 30 days: ☐ Yes ☐ No

Immunosuppressant	In 30 days prior to Cx?	Medication name	Date of most recent administration
Corticosteroid (e.g. Predisone >20mg daily)	☐ Yes ☐ No		
Biologics	☐ Yes ☐ No		
Chemotherapy	☐ Yes ☐ No		
Radiation	☐ Yes ☐ No		
Other1	☐ Yes ☐ No		
Other2	☐ Yes ☐ No		

*examples of common biologics include Humira (adalimumab), Remicade (infliximab), Rituxan (rituximab), Enbrel (etanercept), or other medications ending in –mab or –cept

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

23.Culture Data: Complete for <u>all cultures</u> collected 7 days prior to positive EK culture (<u>EXCEPT EK POSTIVE CULTURES</u>)

Culture No.	Specimen		Collect date (mm/dd/yy) Time (HH:MM)	Pathogens identified
1	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
2	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
3	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
4	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
5	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
6	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
7	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
8	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
9	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____
10	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	☐CX is Neg Path1 _____ Path2 _____ Path3 _____

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

24.Culture Data: Complete for all *positive EK cultures*

Culture No.	Specimen		Collect date (mm/dd/yy) Time (HH:MM)	Comments
1	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐Sputum	____ / ___ / ___ ___:___	
2	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	
3	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	
4	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	
5	☐Blood ☐Urine ☐BAL ☐CSF ☐Ascites	☐Pleural fluid ☐Synovial fluid ☐Wound ☐Stool ☐ Sputum	____ / ___ / ___ ___:___	

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

Section III: Visit with the positive culture.

Location of visit: ☐ acute care hospital ☐ LTACH ☐ Dialysis Center ☐ Outpatient Clinic ☐ Assisted living ☐ Skilled Nursing Facility ☐ Urgent Care ☐ Other _____

Date of symptom onset (for positive culture): _____

25. Chief Complaint (i.e. what were the patient's symptoms) at time of positive culture:

		Approximate Start Date (MM/DD/YYY)
Abdominal Pain	☐	
Altered Mental Status	☐	
Chest Pain	☐	
Cough	☐	
Diarrhea	☐	
Dysuria	☐	
Facial Droop	☐	
Fever	☐	
Hyperglycemia	☐	
Rash/Redness	☐	
Tachypnea/Dyspnea/Shortness of Breath	☐	
Swelling	☐	
Vomiting/Nausea	☐	
Weakness	☐	
None, Asymptomatic	☐	
Other1_____	☐	
Other2_____	☐	

a. If patient asymptomatic did the patient develop signs of infection later? ☐ Yes ☐ No ☐ Unk
   i. If yes, what were the symptom(s)_____?
   ii. What day did symptoms develop? _____(MM/DD/YYY)

26. Patient Labs & Vitals within 2 hours of culture collection

	Value	Date: _____MMDDYY	Time:____:_____
Temperature			
Heart Rate			
Blood Pressure			
Respiratory Rate			
Pulse Ox			
Lactate			
WBC			

27. Diagnosis for the visit when the positive culture was collected:

☐ Acute Respiratory Failure	☐ Pleural Effusion
☐ Atrial Fibrillation	☐ Pneumothorax
☐ Bacteremia	☐ Renal Failure
☐ Cellulitis	☐ Sepsis
☐ DKA	☐ Stroke
☐ Heart Failure	☐ UTI
☐ Hyperglycemia	☐ Other1: _____
☐ Myocardial Infarction	☐ Other2:_____

28. Was Patient Admitted in response to the positive culture? ☐ Yes ☐ No

29. Did the patient have evidence of soft tissue infection at time of positive culture: Yes or No
   a. If yes, describe: _____

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

30. Did the patient have diagnosed pulmonary infection at time of positive culture? Yes or No
    a. If yes, describe: _____
31. Did the patient have any other infections at time of positive culture? Yes or No?
    a. If yes, describe: _____
32. What was patient's disposition from hospitalization in which EK positive culture was collected?
33. ☐ Death ☐ Home ☐ Inpatient rehab ☐ LTCF/SNF ☐ Hospice ☐ Other: _____
34. If the patient Died : Date of death____/____/_____ (MM/DD/YYYY)
35. Location of death: ☐ home ☐ Inpatient rehab ☐ LTCF/SNF ☐ hospice ☐ Other: _____
36. Diagnosis at time of death? _____

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

Section IV: Complete one Healthcare Facility form for EACH healthcare facility the patient visited in the 30 days prior to positive EK culture

Name of Facility/Clinic_____

Facility type: ☐ acute care Hospital ☐ University Hospital ☐ Dialysis Center ☐ Outpatient Clinic ☐ Dental Office ☐ Skilled Nursing Facility ☐ Urgent Care ☐ Other _____

Date(s) of visit to healthcare facility: ____/____/_____ (MM/DD/YYYY)

Inpatient or outpatient: _____

If inpatient, date of admission: ____/____/_____ (MM/DD/YYYY)

If inpatient, date of discharge: ____/____/_____ (MM/DD/YYYY)

Reason for visit or chief complaint: _____

Percutaneous Exposures		Date (MM/DD/YYYY)	Notes	Specify products used
1. IV infusion	☐ Yes ☐ No			Infusate: Antiseptic:
2. IM injection	☐ Yes ☐ No			Infusate: Antiseptic:
3. Thoracentesis	☐ Yes ☐ No			Specify antiseptic
4. Paracentesis	☐ Yes ☐ No			Specify antiseptic
5. Peripheral IV insertion	☐ Yes ☐ No			Specify antiseptic
6. Central line placement. 7. Type 1:	☐ Yes ☐ No			Specify antiseptic
8. Central line placement. 9. Type 2:	☐ Yes ☐ No			
10. Interventional Radiology	☐ Yes ☐ No			Infusate: Antiseptic:
11. Radiology with contrast	☐ Yes ☐ No			Infusate: Antiseptic:
12. Labs Drawn	☐ Yes ☐ No		Specify:	Specify antiseptic
13. Bedside tests (e.g. Blood glucose, lactate)	☐ Yes ☐ No		Specify:	Specify antiseptic
14. Other 1(specify)_____	☐ Yes ☐ No			
15. Other 2 (specify)_____	☐ Yes ☐ No			
16. Other 3 (specify)_____	☐ Yes ☐ No			

Line list patient ID (CDCID) _____ Wisconsin State Laboratory of Hygiene ID _____ Abstractor Initials_____

Respiratory Exposures				
17. Oxygen Administered (e.g face mask, nasal cannula)	☐ Yes ☐ No			
18. Intubation	☐ Yes ☐ No			
19. Nebulizer	☐ Yes ☐ No			Specify agent
20. Metered Dose Inhaler (MDI)	☐ Yes ☐ No			Specify agent
21. Other(specify)_____	☐ Yes ☐ No			
Topical Exposures				
22. Podiatry care	☐ Yes ☐ No			Specify any topical treatments
23. Whirlpool therapy	☐ Yes ☐ No			
24. Any topical treatments	☐ Yes ☐ No			
Other exposures:				
25. Endoscopy	☐ Yes ☐ No		Specify:	
26. Other exposure 1	☐ Yes ☐ No			

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

2016 Urgent Assessment of Blood Collection and Use in Puerto Rico in Response to the Zika Virus Outbreak

¡Hola!

Please fill out the following sections that pertain to your institution as completely as possible. The arrows will help you progress through the survey. In general, Section 2 corresponds to Blood Collections and Section 3 corresponds to Blood Transfusions.

Please complete and return to the below email by February 19, 2016

Amber Vasquez, MD, MPH
Zika Blood Safety Team
email: amber.vasquez@salud.pr.gov
cell: 937-269-3169

Please do not hesitate to call or email with questions.

Contact Information

orgid: 101

Primary person responsible for completing this section	
Prefix	
First name	
Last name	
Title/Position	
Name of Institution	
Address of Institution	
Telephone	
Email	

Facility included in the survey	
Facility name	
Address	

General Information

Which of the following best describes your institution?	Select one (with "X")
A local or regional blood center (non-hospital) that collects blood from donors and supplies blood and components to other institutions, but does not perform transfusion services	
A hospital-based blood bank and transfusion service that collects blood from donors (may be only autologous or directed) and provides blood and components for transfusion primarily to your own institution	
A transfusion service that provides blood and components for transfusion, but does not collect blood from donors	
A local or regional blood center that collects blood from donors and supplies blood, components, and cross matched blood products to participating facilities (e.g., centralized transfusion services). In this category, the service is not limited to reference laboratory work, but includes routine transfusion service work	

	Yes/No
Does your institution collect blood from donors? (Even if you collect autologous units only, enter "Yes.")	

Section 2 Blood collections

From Jan 1, 2015 through Dec 31, 2015, how many collections were successfully completed by your institution in each of the following categories? (*indicates required fields)	Number of Collection Procedures*	Number of Units
Whole Blood		
Allogeneic (non-directed donations)*		
Autologous*		
Directed*		
Total*		
Red Blood Cells		
Apheresis		
Allogeneic*		
Autologous*		
Directed*		
Concurrent red cells (from apheresis platelets)		
Total Apheresis Red Blood Cells*		
Whole-blood-derived		
Allogeneic*		
Autologous*		
Directed*		
Total WBD Red Blood Cells*		
Platelets		
Apheresis		
Single-donor		
Directed single-donor		
Single collection		
Double collection[1]		
Triple collection[1]		
Total Apheresis Platelets*		
Total apheresis platelet units subjected to pathogen reduction technology		
Whole-blood-derived		
Individual*[2]		
Total whole blood-derived individual units subjected to pathogen reduction technology		
Plasma		
Apheresis		
FFP		
PF24		
PF24RT24		
Jumbo FFP (>400 mL)		
Total Apheresis Plasma*		
Total Apheresis plasma units subjected to pathogen reduction technology		
Whole-blood-derived		
FFP		
PF24		
Cryoprecipitate reduced		
Liquid		
Total WBD Plasma*		
Total WBD plasma units subjected to pathogen reduction technology		
Cryoprecipitate		
Individual*[3]		
Total Granulocytes*		

[1] Count double collections as two units and triple collections as three units

[2] Enter the number of individual platelet units prepared from whole blood collections

[3] Enter the number of individual cryoprecipitate units prepared from whole blood collections

2.3 Blood collections

2.3. From Jan 1, 2015 through Dec 31, 2015, from how many of the following types of donors did your institution successfully collect blood?	Number of Donors
First-time allogeneic donors	
Repeat allogeneic donors (Count multiple donations from a single repeat donor only once)	
Directed donors	
Autologous donors	
Total number of donors	

2.4 Blood collections

From Jan 1, 2015 through Dec 31, 2015, how many units of each product were imported, distributed, and outdated by your institution? (* indicate required fields)	Total Units Imported	Total Units Distributed (including imported units)[1]	Total Units Outdated
Whole Blood for distribution as Whole Blood			
Allogeneic (non-directed donations)			
Autologous			
Directed			
Total*			
Red Blood Cells			
Apheresis			
Allogeneic			
Autologous			
Directed			
Concurrent red cells (from			
Total Apheresis Red Blood Cells*			
Whole-blood-derived			
Allogeneic			
Autologous			
Directed			
Total WBD Red Blood Cells*			
Platelets			
Apheresis			
Single-donor			
Directed single-donor			
Single collection			
Double collection[2]			
Triple collection[2]			
Total Apheresis Platelets*			
Whole-blood-derived			
Individual*			
Pooled[3]			
Plasma			
Apheresis			
FFP			
PF24			
PF24RT24			
Jumbo FFP (>400 mL)			
Total Apheresis Plasma*			
Whole-blood-derived			
FFP			
PF24			
Cryoprecipitate reduced			
Liquid			
Total WBD Plasma*			
Cryoprecipitate			
Individual*			
Pooled[4]			
Total Granulocytes*			

[1] Units returned and distributed more than once should be counted only once
[2] Count double collections as two units and triple collections as three units
[3] Total number of platelet pools prepared from whole blood collections
[4] Total number of cryoprecipitate pools prepared from whole blood collections

2.5-2.6 Blood collections

2.5 What was the average whole dollar amount your institution was reimbursed (by hospital or clinical facility) per unit in 2015 for the following components? (Include discounts in your calculations. If you do not use a particular component, select "Not Applicable". CPT/HCPCS codes are in in parenthesis.)	Average Amount Paid Per Unit ($)
Plasma, single donor, frozen with 8 hours of phlebotomy (P9017)	
Plasma, frozen between 8 and 24 hours of phlebotomy (P9059)	
Red cells, leuko-reduced (P9016)	
Red cells, non-leuko-reduced (P9021)	
WBD platelets, each unit, not leuko-reduced, not irradiated (P9019)	
Apheresis platelets, leuko-reduced (P9035)	
Cryoprecipitate, each unit (P9012)	

2.6. If your facility does not use pathogen reduction technology for apheresis platelet or plasma collections...	Cost
What is the estimated total cost of implementation (this includes equipment, capital investment, training, etc)?	
What is the estimated additional cost per each unit type below if your facility adopted pathogen reduction technology?	

Section 3 - Blood utilization

	Yes/No
Is your institution directly involved in the transfusion of blood to patients?	

3.3 Blood utilization

3.3. From Jan 1, 2015 through Dec 31, 2015, how many units of allogeneic whole blood and red blood cells did your institution transfuse? (Leave the field blank if you do not know the answer).	Total Number of Units Transfused	Total number of Recipients	Total outdated units
Allogeneic Whole Blood			
Allogeneic Red Blood Cells (include all blood groups)			
Allogeneic Group O Positive RBCs			
Allogeneic Group O Negative RBCs			
Allogeneic Group A Positive RBCs			
Allogeneic Group A Negative RBCs			
Allogeneic Group B Positive RBCs			
Allogeneic Group B Negative RBCs			
Allogeneic Group AB Positive RBCs			
Allogeneic Group AB Negative RBCs			

3.4 Blood utilization

3.4. Indicate the disposition of directed and autologous units in 2015	Total Number of Units Transfused to Intended Recipient	Total Number of Recipients	Outdated Units
Directed Whole Blood Units			
Directed RBC Units			
Autologous Whole Blood Units			
Autologous RBC Units			

3.5 Blood utilization

3.5. From Jan 1, 2015 through Dec 31, 2015, how many units of each of the following components did your institution transfuse and how many units were outdated while on your shelf (include units transfused to pediatric patients)? (* indicates required fields)	**Total Number of Units Transfused**	**Total Number of Units Outdated**
WBD Platelets (individual concentrates and pools expressed as individual concentrate equivalents)*		
Apheresis Platelet units – Full dose*		
Directed Platelets to intended recipients		
Total Plasma*		
Fresh Frozen Plasma (FFP)		
FFP, pediatric size (≤100 mL)		
Plasma, Frozen within 24 hours (PF24)		
PF24RT24		
Jumbo FFP (>400 mL)		
Liquid plasma		
Directed plasma to intended recipients		
Thawed plasma		
Plasma, cryoprecipitate reduced		
Group AB plasma		
Granulocytes*		
Platelets with pathogen reduction technology		
Plasma with pathogen reduction technology		

3.6 Blood utilization

3.6. Indicate the total number of units transfused to pediatric populations in 2015	Number of Adult Equivalent Units in Whole or in Part for Pediatric Patients[1]	Total Number of Pediatric Recipients
Whole Blood		
RBCs		
Plasma		
Platelets		

[1] This should be a subset of data reported in question 4 and 5 if your hospital transfuses non-pediatric patients.

3.7 Blood utilization

3.7. Indicate how many irradiated, leuko-reduced, and leuko-filtered units for each of the following components your institution transfused in 2015. For pediatrics, use the number of adult equivalent units used in whole or part. For components that are irradiated and leuko-reduced, include these in the count for both columns.	**Components Irradiated**	**Components Leuko-reduced Before or After Storage (not at bedside)**	**Components Leuko-filtered at the Bedside**
a. Whole Blood			
b. RBCs			
c. Apheresis platelets (single donor platelets)			
d. WBD platelets			
Total components (if the number for a-d is 'unknown', enter the total number of components for the modification)			

3.8-3.9 Blood utilization

	Yes/No
3.8. Does your institution have a policy to transfuse only leuko-reduced (LR) components?	

3.9a. In 2015, how many total units of RBCs transfused were…	**Number of Units**
1 – 35 day(s) old	
36 – 42 days old	

3.9b. In 2015, how many total units of WBD platelets transfused were…	**Number of Units**
1 – 3 day(s) old	
4 – 5 days old	

3.9c. In 2015, how many total units of Apheresis platelets transfused were…	**Number of Units**
1 – 3 day(s) old	
4 – 5 days old	

3.10-3.11 Blood utilization

	Number of platelet units
3.10. In your institution, on average, how many individual platelet units were included in a pooled WBD platelet dose in 2015?	

3.11. Indicate the number of units that were transfused in inpatient or outpatient settings.	**Number of RBC Units**	**Number of Platelet Units**	**Total**	**Don't Know**
All Surgery (including transplant)				
Inpatient Medicine (including hematology/oncology)				
Emergency Department				
Obstetrics/Gynecology				
Pregnant females				
Pediatrics				
Neonates				
Outpatient and non-acute inpatient settings[1]				

[1] E.g., outpatient dialysis, rehabilitation, long term care, etc.

3.12 Blood utilization

3.12. What was the average whole dollar amount your institution paid per unit in 2015 for the following components? (Include discounts in your calculations. If you do not use a particular component, select "Not Applicable". CPT/HCPCS codes are in in parenthesis.)	Average Amount Paid Per Unit ($)
Plasma, single donor, frozen with 8 hours of phlebotomy (P9017)	
Plasma, frozen between 8 and 24 hours of phlebotomy (P9059)	
Red cells, leuko-reduced (P9016)	
Red cells, non-leuko-reduced (P9021)	
WBD platelets, each unit, not leuko-reduced, not irradiated (P9019)	
Apheresis platelets, leuko-reduced (P9035)	
Cryoprecipitate, each unit (P9012)	

3.13 Blood utilization

	Yes/No
3.13a. Were any elective surgeries postponed due to blood inventory shortages in 2015?	

	Number of days
3.13b. How many days were elective surgeries postponed?	

	Number of surgeries
3.13c. How many elective surgeries were postponed in 2015?	

3.16 - 3.17 Blood utilization

16. In 2015, how many days was your institution's order incomplete for the following components?	Number of days
Whole Blood	
RBCs	
Plasma	
Apheresis platelets	
WBD platelets	

	Number of days
17. In 2015, how many days were you unable to meet other non-surgical blood requests (e.g., red cells, platelets)?	

3.18-3.20 Blood utilization

	Number of units
18. At your institution, how many units of Group O red cells are on your shelf on an average weekday?	

	Number of units
19. At what number of Group O positive and Group O negative RBC units in uncrossmatched inventory do you consider your inventory to be "critically low"?	

	Yes/No
20. Does your facility have an electronic system for tracking transfusion-related adverse events (e.g., unplanned, unexpected, and undesired occurrences)?	

3.21 Blood utilization

	Number of units
3.21a. How many total red blood cell units did you buy from a non-American Red Cross blood center in 2015?	

	Number of units
3.21b. How many total red blood cell units did you buy from an American Red Cross blood center in 2015?	

Survey Completed!

Thank you for taking the time to complete this survey.

Please return to the below email by February 19, 2016

Amber Vasquez, MD, MPH
Zika Blood Safety Team
email: amber.vasquez@salud.pr.gov
cell: 937-269-3169

Please do not hesitate to call or email with questions.

Survey Glossary

Autologous: Self-directed donations.

Centralized transfusion service: A hospital or blood center that collects blood from donors and supplies blood, components, medical services and/or crossmatched blood products to multiple transfusing facilities.

Collected: Successful whole blood or apheresis collections placed into production (not QNS, or other removals).

Deferrals: The number of donors deferred for specific reasons:

a) Donors deferred for low hemoglobin do not meet the current FDA blood hemoglobin level requirements for blood donation.

b) Deferrals for other medical reasons may include the use of medications on the medication deferral list, growth hormone from human pituitary glands, insulin from cows (bovine, or beef, insulin), Hepatitis B Immune Globulin (HBIG), unlicensed vaccines, or presenting with physical conditions or symptoms that do not qualify a person to be a blood donor.

c) High-risk behavior deferrals include deferrals intended to reduce the risk of transmission of infectious diseases including HIV and hepatitis viruses. Examples of questions intended to identify these risks are sexual contact (e.g., men who have sex with men (MSM)) and non-medical injection drug use questions.

d) Travel deferrals are deferrals for travel to a specific region of the world.

Directed: Allogeneic donations intended for a specific patient.

Donation: The collection of a unit of blood or blood component from a volunteer donor.

Dose/Dosage: a quantity administered at one time, such as a specified volume of platelet concentrates.

First-time allogeneic donor: A donor who is donating for the first time at your center.

Imported: Units not collected by your institution, but obtained by your institution from another institution for distribution to a transfusion facility.

Modify: Procedures applied by a blood center, hospital blood bank, or transfusion service that may affect the quality or quantity of the final product (e.g., irradiation, leukofiltration, or production of aliquots of lesser volume).

Outdated: Units that expire on your shelf.

Plasma:

a) **Plasma, frozen within 24 hours of phlebotomy (PF24):** plasma separated from the blood of an individual donor and placed at -18 C or colder within 24 hours of collection from the donor.

b) **Fresh frozen plasma (FFP):** Plasma frozen within 8 hours of collection.

c) **Plasma, Jumbo:** FFP having a volume greater than 400 mL.

d) **Plasma frozen within 24 hours of phlebotomy and held at room temperature up to 24 hours after phlebotomy (PF24RT24):** Plasma held at room temperature for up to 24 hours after collection and then frozen at -18 C or colder.

Recipient: A unique individual patient receiving a transfusion one or more times in a calendar year.

Distributed: units that have fulfilled all processing requirements and have been made available for transfer to customers.

Repeat allogeneic donor: A donor who has previously donated a blood component.

Severe Donor-Related Adverse Events: adverse events occurring in donors attributed to the donation process that include, for example, major allergic reaction, arterial puncture, loss of consciousness of a minute or more, loss of consciousness with injury, nerve irritation, etc.

Transfusion Related Adverse Reactions: An undesirable response or effect in a patient temporally associated with the administration of blood or blood components. For a list of adverse reaction types and case definitions, visit http://www.cdc.gov/nhsn/PDFs/Biovigilance/BV-HV-protocol-current.pdf.

Transfusion Service: a facility that performs, or is responsible for the performance of, the storage, selection, and issuance of blood and blood components to intended recipients.

Study ID #: _CHÿÿÿ

Appendix 1. Invasive GAS in Long Term Care Facility 2016

Employee Survey

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

Date Completed: ____/____/____

□ **Check box if documented case**

A. Employee Background	1. Name: 2. Age:
3. Sex: ÿ Male ÿ Female	4. Employed at Facility since: ______/______/______

5. List occupation: ÿ Activity aid ÿ Administrative ÿ CNA ÿ Dietary ÿ Food service
ÿ Housekeeping ÿ Laundry ÿ PT/OT ÿ Pharmacist ÿ Physician
ÿ Maintenance ÿ RNA ÿ RN/LPN ÿ Social service ÿ Van driver
ÿ Wound care team ÿ Other ___________________________

6. Since Thanksgiving to present, have you worked in any other patient-care facility? ÿ Yes ÿ No *(If no, skip to Section B)*

Name & city of facility	Dates of employment	Have you been in contact with a patient infected with group A strep?	What was the patient's diagnosis?
	Start: ____ / _____ / _______ End: ____ / _____ / _______	ÿ Yes ÿ No If yes, date of contact: ____ / _____ / _______	ÿ Strep throat ÿ Impetigo ÿ Cellulitis ÿ Bacteremia/Sepsis ÿ Other, specify: _________________
	Start: ____ / _____ / _______ End: ____ / _____ / _______	ÿ Yes ÿ No If yes, date of contact: ____ / _____ / _______	ÿ Strep throat ÿ Impetigo ÿ Cellulitis ÿ Bacteremia/Sepsis ÿ Other, specify: _________________
	Start: ____ / _____ / _______ End: ____ / _____ / _______	ÿ Yes ÿ No If yes, date of contact: ____ / _____ / _______	ÿ Strep throat ÿ Impetigo ÿ Cellulitis ÿ Bacteremia/Sepsis ÿ Other, specify: _________________

7. a. Since the outbreak, have you had a screening culture for group A Streptococcus? ÿ Yes ÿ No *(If no, skip to # 8)*
b. If yes, when? ______ / _______ / _______
c. Where was the culture obtained from? ÿ Throat ÿ Rectal ÿ Vaginal ÿ Skin/wound ÿ Other
d. What were the results? ÿ Positive ÿ Negative

B. Job Description at Facility A	8. As part of your job, do you have physical contact with patients? ÿ Yes ÿ No *(If no, skip to Section D)*

9. Areas usually worked: ÿ Patient rooms ÿ Nurses' station ÿ Cafeteria ÿ Rehab floor ÿ Other _____________________
10. Shifts usually worked: ÿ Day ÿ Evening ÿ Night ÿ Other________________________
11. Patient units usually worked: ÿ 1 ÿ 2 ÿ 3 ÿ 4 ÿ 5 ÿ 6 ÿ 7 ÿ 8 ÿ Do not work in patient units ÿ All patient units
12. Which days do you usually work *(circle ALL that apply)*:

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Public reporting burden of this collection of information is estimated to average 15 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 (0920-1011)

13. What kind of patient contact do you have? *(check ALL that apply)*

ÿ Give oral medications	ÿ Feeding resident	ÿ Respiratory therapy	ÿ Tracheostomy care
ÿ Change dressings/wound care	ÿ Gastrostomy care	ÿ Handle urinary catheter	ÿ Bathe resident
ÿ Assist with patient transfer	ÿ Clean room	ÿ Handle soiled linens/bedding	ÿ Handle soiled diapers/bedpans
ÿ Deliver meal trays	ÿ Take vital signs	ÿ Bedside incision and debridement aspiration/drainage	
ÿ Provide PT/OT	ÿ Other beside surgical procedures		

C. Work Practice

14. Do you use soap and water to clean your hands? ÿ Yes ÿ No

15. Do you use alcohol-based hand sanitizer to clean your hands? ÿ Yes ÿ No

16. Please answer the following questions *(circle answer)*

		Never				Always	
a.	Do you perform hand hygiene BEFORE physical contact with patients?	1	2	3	4	5	N/A
b.	Do you perform hand hygiene BEFORE physical contact with each patient's environment or belongings (e.g. bedside table, refrigerator, rolling walker, etc.)?	1	2	3	4	5	N/A
c.	Do you perform hand hygiene AFTER physical contact with patients?	1	2	3	4	5	N/A
d.	Do you perform hand hygiene AFTER physical contact with each patient's environment or belongings (e.g. bedside table, refrigerator, rolling walker, etc.)?	1	2	3	4	5	N/A
e.	Do you perform hand hygiene BETWEEN contact with patients?	1	2	3	4	5	N/A
f.	Do you use the sink or alcohol-based sanitizer in the patient's room or outside patient's room?	1	2	3	4	5	N/A
g.	Do you use the sink or alcohol-based sanitizer at the nurse's station?	1	2	3	4	5	N/A
h.	Do you use gloves when changing bandages/dressing wounds?	1	2	3	4	5	N/A
i.	If yes, do you change gloves between patients/patient rooms?	1	2	3	4	5	N/A
j.	If yes, do you perform hand hygiene before donning gloves?	1	2	3	4	5	N/A
k.	If yes, do you perform hand hygiene after removing gloves?	1	2	3	4	5	N/A
l.	Do you use gloves when cleaning soiled patients or linens?	1	2	3	4	5	N/A
m.	If yes, do you change gloves between patients/patient rooms?	1	2	3	4	5	N/A
n.	If yes, do you perform hand hygiene before donning gloves?	1	2	3	4	5	N/A
o.	If yes, do you perform hand hygiene after removing gloves?	1	2	3	4	5	N/A
p.	Do you use person protective equipment (PPE) when bathing patients?	1	2	3	4	5	N/A
q.	If yes, please specify type of PPE: _____						

D. Your Health

17. Do you have paid "Sick Leave"? ÿ Yes ÿ No

18. Did you receive prophylaxis for group A streptococcal infection? ÿ Yes ÿ No When? ___ / ___ / ___

19. a. Since Thanksgiving, have you had a sore throat? ÿ Yes ÿ No *(If no, skip to #20)*

b. When? _____ / _____ / _____

c. Was a throat swab for testing collected from you? ÿ Yes ÿ No d. If yes, specify month: _____

e. Was a rapid strep throat test done (you would have been given results immediately)?

f. If yes, specify month: _____ g. If yes, was the result positive? ÿ Yes ÿ No

h. Were you diagnosed with strep throat? ÿ Yes ÿ No i. If yes, specify month: _____

j. Did you miss work for this illness? ÿ Yes ÿ No k. How many days did you miss? _____

l. How many days were you ill? _____

m. Did you receive antibiotics for this condition? ÿ Yes ÿ No n. If yes, antibiotic name _____

20. a. Since Thanksgiving, did you have a rash, open wound, or skin infection? ÿ Yes ÿ No *(If no, skip to #21)*

b. When? _____ / _____ / _____ c. What was your diagnosis? _____

d. Did you miss work for this illness? ÿ Yes ÿ No How many days did you miss? _____

f. How many days were you ill? _____

g. Did you receive antibiotics for this condition? ÿ Yes ÿ No If yes, antibiotic name _____

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Appendix 1. Invasive GAS in Long Term Care Facility 2016
Employee Survey

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21. a. Since Thanksgiving, did you have fever, cough, and/or other respiratory infection? ÿ Yes ÿ No *(If no, skip to #22))*

b. When? _____ / _____ / _____

c. Did you miss work for this illness? ÿ Yes ÿ No How many days did you miss? _____

d. How many days were you ill? _____

e. Did you receive antibiotics for this condition? ÿ Yes ÿ No If yes, antibiotic name _____

f. What was your diagnosis? _____

22. If you're feeling sick before a work shift, how do you notify Warren Barr Gold Coast?

_____

23. a. How many people are in your household? _____ *(If none, END)*

b. How many children under 18 years of age are in your household? _____

c. Since Thanksgiving, did anyone in your household have a sore throat? ÿ Yes ÿ No

d. When? _____ / _____ / _____ e. Who (relationship)? _____

e. Was he/she diagnosed with strep throat? ÿ Yes ÿ No

g. Were they treated? ÿ Yes ÿ No If so, with what? _____

h. During the past 3 months, did anyone in your household have impetigo or cellulitis (skin infections)? ÿ Yes ÿ No

i. When? _____ / _____ / _____

END – *Thank you!*

Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016
Resident Record Abstraction Form

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

Person completing form _____ **Date Completed:** ____/____/____

Resident *(check one)***:** ÿ Case ÿ Control

If case, indicate disease classification: ☐invasive ☐noninvasive ☐colonized

If CONTROL, date of matched case's GAS culture: ____/____/____

Date 14 days prior to positive culture of case: ____/____/_____

Why was the culture obtained? ÿ Screening ÿ Illness

A. GAS TESTING RESULTS

1. Has the resident had any **cultures/tests** for GAS from July 17, 2015 to present?

   ÿ Yes ÿ No

#	Date obtained	Site cultured	Culture obtained for Screening	If nonsterile site, was culture associated with illness	Result
a.	____/_____/_____	ÿ Blood ÿ Skin/Wound: _____ ÿ Other _____ ÿ Throat ÿ Central line/TPN ÿ Catheter ÿ Diabetic ulcer ÿ Post-surgical wound ÿ G-tube	ÿ Yes ÿ No	ÿ Yes ÿ No	ÿ Positive ÿ Negative
b.	____/_____/_____	ÿ Blood ÿ Skin/Wound: _____ ÿ Other _____ ÿ Throat ÿ Central line/TPN ÿ Catheter ÿ Diabetic ulcer ÿ Post-surgical wound ÿ G-tube	ÿ Yes ÿ No	ÿ Yes ÿ No	ÿ Positive ÿ Negative

Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016
Resident Record Abstraction Form

c.	____/_____/_____	ÿ Blood ÿ Skin/Wound: _____ ÿ Other _____ ÿ Throat ÿ Central line/TPN ÿ Catheter ÿ Diabetic ulcer ÿ Post-surgical wound ÿ G-tube	ÿ Yes ÿ No	ÿ Yes ÿ No	ÿ Positive ÿ Negative
d.	____/_____/_____	ÿ Blood ÿ Skin/Wound: _____ ÿ Other _____ ÿ Throat ÿ Central line/TPN ÿ Catheter ÿ Diabetic ulcer ÿ Post-surgical wound ÿ G-tube	ÿ Yes ÿ No	ÿ Yes ÿ No	ÿ Positive ÿ Negative
e.	____/_____/_____	ÿ Blood ÿ Skin/Wound: _____ ÿ Other _____ ÿ Throat ÿ Central line/TPN ÿ Catheter ÿ Diabetic ulcer ÿ Post-surgical wound ÿ G-tube	ÿ Yes ÿ No	ÿ Yes ÿ No	ÿ Positive ÿ Negative
f.	____/_____/_____	ÿ Blood ÿ Skin/Wound: _____ ÿ Other _____ ÿ Throat ÿ Central line/TPN ÿ Catheter ÿ Diabetic ulcer ÿ Post-surgical wound ÿ G-tube	ÿ Yes ÿ No	ÿ Yes ÿ No	ÿ Positive ÿ Negative

B. RESIDENT BACKGROUND

2. Sex: ÿ Male ÿ Female 3. Age: _____ 4. Date of birth: ____/____/____

5a. Room history within 14 days prior to GAS culture:

Room # (floor/wing)	Dates in room	Roommate Yes/No	Roommate (dates)
	___/___/____ **to** ___/___/____	ÿ Yes ÿ No	___/___/____ **to** ___/___/____
	___/___/____ **to** ___/___/____	ÿ Yes ÿ No	___/___/____ **to** ___/___/____
	___/___/____ **to** ___/___/____	ÿ Yes ÿ No	___/___/____ **to** ___/___/____

Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016
Resident Record Abstraction Form

	___/___/____ **to** ___/___/____	ÿ Yes ÿ No	___/___/____ **to** ___/___/____
	___/___/____ **to** ___/___/____	ÿ Yes ÿ No	___/___/____ **to** ___/___/____
	___/___/____ **to** ___/___/____	ÿ Yes ÿ No	___/___/____ **to** ___/___/____

5b. Did the resident have a roommate with GAS infection or colonization within 30 days prior to GAS culture?

ÿ Yes ÿ No ÿ Unknown

If yes: initials of GAS+ roommate_____ Dates room shared:____/____/_____

5c. Number of visitors the resident had within 14 days prior to GAS culture? _____

6. Total length of stay at facility (most recent stay only) at time of GAS culture (*mark only one*):
_____ months and_____days

7a. Is the resident deceased? ÿ Yes ÿ No If yes, date of death: ____/____/____
b. If resident died, death was: ÿ Related to GAS infection ÿ Possibly related to GAS infection
ÿ Not related ÿ Not applicable

8. Resident's physicians within 14 days prior to GAS culture?

Physician's name	Specialty (e.g., wound care, etc.)

C. MEDICAL HISTORY

9. Which medical condition(s) does the resident have? (*mark ALL that apply)*:

ÿ Diabetes ÿ CHF/history of MI ÿ Peripheral vascular disease ÿ Stroke

ÿ Asthma/COPD ÿ Hypertension ÿ Chronic leg edema ÿ Recent herpes zoster

ÿ Dialysis ÿ Renal insufficiency ÿ Dementia □糧夕GC比糧出糧DC&出DC

ÿ Cancer, specify type: _____ ÿ Immunosuppressed/immunosuppression ÿ None

ÿ Cirrhosis ÿ Recent IV Drug Use ÿ Prosthetic ÿ Other: _____

□Malnutrition

Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016
Resident Record Abstraction Form

(**Note**: immunosuppression includes: HIV/AIDS, chemo, radiation, immunosuppressive meds, including tacrolimus [Prograf], sirolimus [Rapamune], mycophenolate mofetil [Cellcept], high-dose or chronic steroids [prednisone, methylprednisone, hydrocortisone, dexamethasone] methotrexate.)

10a. Weight: _____ lbs or kg *(circle unit of measure)* 10b. Height: _____

11. Did patient have any surgical wounds, pressure ulcers, or other wounds (defined as skin breakdown) at the time of admission to the facility?

ÿ Yes If yes, how many _____ ÿ No

If Yes, size of largest wound: _____ (e.g., largest width in inches or cm)

12. Did patient have any surgical wounds, pressure ulcers, or other wounds within 14 days prior to GAS culture?

ÿ Yes ÿ No

If yes, please specify site and number of wounds.

ÿ Right/Left upper extremity ____ ÿ Back____ ÿ Perineal___

ÿ Right/Left lower extremity ____ ÿ Abdomen____

ÿ Right/Left Hand ____ ÿ Sacrum____

ÿ Right/Left Foot ____ ÿ Chest____

□ Other _____

13. Did the patient receive Wound Care Team consultation services within 14 days prior to GAS culture?

ÿ Yes ÿ No

Dates	Initial(s) of doctors or nurses	Team

14. Did the patient receive wound care WITHOUT Wound Care Team consultation within 14 days prior to GAS culture?

ÿ Yes ÿ No ÿ Unkown

15. Products used for wound care (surgical and nonsurgical) within 14 days prior to GAS culture (*check all*):

ÿ Calcium Alginate ÿ Dakins ÿ Dry Gauze ÿ Foam: type_____ ÿ Hibicleanse ÿ Iodosorb

ÿ Medihoney ÿ Santyl ÿ Saf-gel ÿ Sterile Saline ÿ Antimicrobial cleanser/cream

ÿ Wound vac ÿ None ÿ Other: _____

Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016
Resident Record Abstraction Form

16a. Did resident have a wound vac at any time from July 17, 2015 – current? ÿ Yes ÿ No

b. Date applied? ___/___/_____ Date removed? ___/___/_____

ÿ Medela ÿ Pico ÿ Pressure: _____

c. Date applied? ___/___/_____ Date removed? ___/___/_____

ÿ Medela ÿ Pico ÿ Pressure: _____

d. Date applied? ___/___/_____ Date removed?

ÿ Medela ÿ Pico ÿ Pressure: _____

17. Has the patient had a surgical procedure within 14 days prior to GAS culture?

ÿ Yes ÿ No

Procedure	Date	Incision Site
	_____ / _____ / _____	
	_____ / _____ / _____	

18. Within 14 days of GAS culture, was the resident diagnosed with:

a.	Cellulitis	ÿ Yes	ÿ No	Date of onset ___/___/____
b.	Wound infection	ÿ Yes	ÿ No	Date of onset ___/___/____
c.	Pharyngitis	ÿ Yes	ÿ No	Date of onset ___/___/____
d.	Bacteremia	ÿ Yes	ÿ No	Date of onset ___/___/____
e.	Pneumonia	☐ Yes	☐No	Date of onset ___/___/____
f.	Joint Infection	☐ Yes	☐No	Date of onset ___/___/____
g.	Necrotizing fasciitis	☐ Yes	☐No	Date of onset ___/___/____
h.	Septic Shock	☐ Yes	☐No	Date of onset ___/___/____

19. Within 14 days of GAS culture, did the resident have any of the following signs or symptoms? (*mark ALL that apply)*

		Date of onset (dd/mm/yy)	
a.	ÿ Fever (≥100.5°F or 38°C)	_____ / _____ / _____	Max temp recorded:
b.	ÿ Sore throat	_____ / _____ / _____	
d.	ÿ Purulent discharge from wound	_____ / _____ / _____	Site:
e.	ÿ Wound – warm on touch	_____ / _____ / _____	Site:
f.	ÿ Wound – redness	_____ / _____ / _____	Site:

Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016
Resident Record Abstraction Form

g.	ÿ Edema at the site	_____ / _____ / _____	Site:
h.	ÿ Increased pain at the site	_____ / _____ / _____	Site:
i.	ÿ Joint – warm on touch	_____ / _____ / _____	Site:
j.	ÿ Joint – redness	_____ / _____ / _____	Site:

20. Was the resident hospitalized for GAS-related symptoms between July 17, 2015 to present?

ÿ Yes ÿ No ÿUnknown

a. Hospitalization date: ___/___/____

21. What medications was the resident taking within 14 days prior to GAS culture?

	Start Date	Finish Date	Indication
Antibiotics			
Chemotherapeutics			
Steroids			
Immunosuppressives			

C. RESIDENT BASELINE STATUS *(Can get further information from nursing)*

22. Which equipment does the resident use within 14 days prior to GAS culture (*mark ALL that apply)*:

ÿ Tracheostomy ÿ Nasal cannula ÿ Oxygen mask ÿ Chronic Foley
ÿ G or J tube ÿ Nasogastric tube ÿ Colostomy/ileostomy ÿ Temporary Foley
ÿ Dialysis catheter ÿ PICC line ÿ Other, specify: _____

23. Within 14 days prior to GAS culture was the resident ambulatory?

ÿ Yes ÿ No

Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016
Resident Record Abstraction Form

24. Within 14 days prior to GAS culture, was the resident incontinent of: (mark ALL that apply)

ÿ Not Incontinent ÿ Stool ÿ Urine ÿ Urinary catheter ÿ Colostomy/Ileostomy ÿ Unknown

25. Did the resident participate in the following within 14 days prior to GAS culture (mark ALL that apply):

a. ÿ PT/OT Times in 14 day period: _____
b. ÿ Speech pathology Times in 14 day period: _____
c. ÿ Podiatry Times in 14 day period: _____
d. ÿ Other: _____ Times in 14 day period: _____

Study ID #: _CHÿÿÿ

Appendix 3. Invasive GAS in Long Term Care Facility 2016
Wound Care Survey

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

A. Employee Background

1. Name: 2. Age:

3. Sex: ÿ Male ÿ Female 4. Employed at Facility since: _____/_____/_____

5. What is your level of professional training on the wound care team? ÿ RN ÿ MD ÿ LPN ÿ LVN ÿ Other_____

6. a. Have you received training in infection control practices? ÿ Yes ÿ No ÿ Unknown

b. If yes, when was your most recent training? ÿ ≤ 1month ÿ 2-6 months ÿ 6-12months ÿ >1year

B. Wound care

7. How many new wound consults do you see per day?
ÿ 0-4 ÿ 5-9 ÿ 10 or more

8. On average, how many patients with wounds do you see per day? ÿ 0-10 ÿ 10-20 ÿ 20-30 ÿ 30 or more

9. a. When evaluating a new consult or reassessing an old patient, do you perform a full skin examination? ÿ Yes ÿ No

b. If so, how do you report new wounds found on your exam?
ÿ Medical Chart ÿ Report to Nurse ÿ Report to Doctor ÿ Other

10. Is there a standardized risk assessment tool used to document skin breakdown/ pressure ulcer formation (e.g. Braden Scale) ÿ Yes ÿ No ÿ Unknown

11. How often do you reassess wounds and document wound healing?
ÿ Daily ÿ 3-7 days ÿ 8-14 days ÿ Monthly ÿ Quarterly ÿ Other: _____

12. What types of care do you perform on the wound care team?
ÿ Incision and Drainage ÿ Undressing/Redressing ÿ Cleaning wound ÿ Wound vac care ÿ Other:
_____

13. Have you ever discovered pieces of foam/cotton gauze present in the wound from previous dressing changes? ÿ Yes ÿ No ÿ Unknown

Study ID #: _CHÿÿÿ

Appendix 3. Invasive GAS in Long Term Care Facility 2016
Wound Care Survey

C. Negative-pressure wound therapy	14. Have you been specifically trained in the use of negative-pressure wound therapy? ÿ Yes ÿ No

15. If so, when was your most recent training? ÿ ≤ 1month ÿ 2-6 months ÿ 6-12months ÿ >1year

16. How many residents require negative-pressure wound therapy/wound vac? _____

17. What type of wound vac is used at your facility?_____

18. Who is responsible for the original placement and replacement of the wound vac?

ÿ Patient RN ÿ CNA ÿ MD ÿ Only wound care team ÿ Other

19. Who is allowed to change the wound vac cartridges and settings? (select more than 1 if applicable)?

ÿ Patient RN ÿ CNA ÿ MD ÿ Only wound care team ÿ Other

20. How often is a patient with a wound vac reassessed?

ÿ Daily ÿ 2-3xweek ÿ Weekly ÿ Monthly ÿ Other

21. Are their patients per week are found to have full drainage cartridges or fluid backing up into the drainage tubing?

22. If yes, how would this issue be reported?

ÿ Medical Chart ÿ Report to Nurse ÿ Report to Doctor ÿ Other

23. When replacing the wound vac on the same patient, are any of the following re-used?

(select more than 1 if applies)

ÿ foam/gauze ÿ adhesive dressing ÿ drainage tubing ÿ other

24. If worsening wound is observed, is the wound vac replaced before a physician consult?

ÿ Yes ÿ No ÿ Symptoms specific

25. If symptoms specific please specify what symptoms would prompt you to replace the wound vac *before* a physician consult?

26. What symptoms for a "worsening wound" prompts a physician consult?

ÿ change in character of drained fluid ÿ increase in fluid drainage ÿ increasing erythema ÿ pain ÿ increase in size

Parish_____ **Village** _____ **GPS Coordinates: Lat** _____**Long**_____ **Elevation (m)**_____ **DD** ____**/MM**____**/YY**_____

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No	**Animal Sample ID**	**Animal ID** (tagged) Or **Name/Color** (not tagged)	**Owner Sample ID** Or **Name**	**Age** I=Infant M=Middle Age A=adult	**Species** C=Cattle G=Goats S=Sheep	**Gender** M=Male F=Female C=Castrate	**Breed**	**Current Health:** (Vet) S=Sick H=Healthy A=aborted	**Past Year Health:** (Owner) S=Sick H=Healthy A=Aborted	**Comments:** · Symptoms · Abortion/stillbirth history · location of origin for slaughterhouse animals) *Common RVF symptoms: decreased appetite, decreased milk production, nose/eye discharge, diarrhea, jaundice, prostration, lymph node swelling
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Form Approved OMB
No. 0920-1011
Exp. Date 03/31/2017

Parish_____ **Village** _____ **GPS Coordinates: Lat** _____**Long**_____ **Elevation (m)**_____ **DD** ____**/MM**____**/YY**_____

No	**Animal Sample ID**	**Animal ID** (tagged) Or **Name/Color** (not tagged)	**Owner** **Sample ID** Or **Name**	**Age** I=Infant M=Middle Age A=adult	**Species** C=Cattle G=Goats S=Sheep	**Gender** M=Male F=Female C=Castrate	**Breed**	**Current Health Status:** (Vet) S=Sick H=Healthy A=aborted	**Past Year Health Status:** (Owner) S=Sick H=Healthy A=Aborted	**Comments:** · Symptoms · Abortion/stillbirth history · location of origin for slaughterhouse animals) *Common RVF symptoms: decreased appetite, decreased milk production, nose/eye discharge, diarrhea, jaundice, prostration, lymph node swelling

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Sample ID _____ **Date** ____/____/_____

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Human Questionnaire

Participant classification (A/B/C/D)_____ **Team (1/2)** _____ **Site (1/2/3/etc)** _____

Form Completed by

Name: _____ Position: _____District: _____

Phone Number/email: _____

Section 1. Assessment Participant Information

ID Number: _____ Family Name:_____ English Name _____Age: _____Gender: ☐ Male ☐ Female

Village/Town: _____ Parish: _____Sub-County: _____

District: _____Nationality: _____ Marital status: ☐ Married ☐ Single ☐ Widowed

GPS Coordinates: Lat_____Long _____ Elevation_____

Section 2. Epidemiological Risk Factors and Exposures

1. Education level: ☐None ☐Primary ☐Secondary ☐Post-Secondary ☐ Unkn ☐Other (specify)_____
2. Primary Occupation: ☐ Farmer ☐ Herdsman ☐ Housewife ☐ Student ☐ Child ☐ Animal Health worker ☐ Butcher ☐ Trader ☐Other (specify) _____
3. Do you own domestic animals ☐ Yes ☐ No **(If CATTLE/SHEEP/GOAT, COMPLETE LIVESTOCK FORM ON LAST PAGE)**
4. In the past year, have you had contact with domestic animals ☐ Yes ☐ No ☐ Unkn **(If NO/Unkn, skip to #7)**
5. If yes, which domestic animals have you had contact with *(tick all that apply)* ☐ Cattle ☐ Goat ☐ Sheep ☐ Pigs ☐ Poultry ☐ Dogs ☐others specify_____
6. If yes, which type of contact *(tick all that apply)* ☐ During milking ☐During grazing ☐Grooming ☐Caring for sick animals ☐Slaughtering/skinning/butchering ☐ Preparing or handling raw meat ☐Sleeping near animals ☐others specify_____
7. In the past one year, have you drunk raw milk ☐ Yes ☐ No ☐ Unkn
8. In the past one year, have you eaten raw/uncooked meat ☐ Yes ☐ No ☐ Unkn
9. In the past one year, have you been involved in handling or preparing meat ☐ Yes ☐ No ☐ Unkn
10. In the past one year, have you been involved in Fetus/*abortus* disposal ☐ Yes ☐ No ☐ Unkn
11. In the past one year, have you assisted livestock(cattle, sheep and goats) to give birth ☐ Yes ☐ No ☐ Unkn
12. In the past one year, have you been involved in butchering livestock ☐ Yes ☐ No ☐ Unkn
13. In the past one year, have you seen wild animals in this village ☐ Yes ☐ No ☐ Unkn **(If NO/Unkn, skip to #15)**
14. If yes, which ones: ☐ Monkeys ☐ Bats ☐ Antelopes ☐ Wild pigs ☐ Others (specify)_____
15. In past one year , have you any contact with wild animals ☐ Yes ☐ No ☐ Unkn **(If NO/Unkn, skip to #18)**
16. If yes, which wild animals do you usually get in contact with (tick all that apply) ☐Bats ☐Monkeys ☐Wild Pigs ☐Wild birds ☐Rodents ☐Antelopes ☐Others specify_____
17. If yes, which type of contact ☐During hunting ☐Accidental ☐Slaughtering ☐Other specify_____
18. In past one year , have you done hunting ☐Yes ☐No ☐Unkn, **(If NO/Unkn, skip to #21)**
19. If yes, how often do you do hunting_____
20. Which animals are usually hunted_____
21. In past one year, have you had contact with dead wild animals ☐ Yes ☐ No ☐ Unk
22. Do you use PPE when handling animals ☐ Yes ☐ No ☐ Unkn ☐ Not applicable **(If NO/Unkn/NA, skip to #24)**
23. If yes, which ones ☐Gloves ☐Gumboots ☐Mask ☐Eye protection ☐Aprons/ovals ☐Others (specify)_____
24. Have you eaten wild meat in the past one year ☐ Yes ☐ No ☐ Unk **(If NO/Unknown, skip to #26)**
25. If Yes, which species_____
26. Have you traveled outside your home or village/town in the past one year ☐ Yes ☐ No ☐ Unkn **(If NO/Unkn, skip to #28)**
27. If yes, specify location and date: _____
28. Did you ever suffer from undiagnosed fever or illness in the past one year ☐ Yes ☐ No ☐ Unkn **(If NO/Unkn, skip to #31)**
29. If Yes, when? Month _____ Year _____
30. If yes, did you seek medical attention: ☐ Yes ☐ No
31. Did someone you know in the last one year have unexplained fever or diagnosis? Yes ☐ No ☐ Unkn

32. Have you had *el nino* (have you had more rainfall than usual) rains in the last one year? ☐ Yes ☐ No ☐ Unkn
33. Have you had flooding in this sub-county in past one year? ☐ Yes ☐ No ☐ Unkn **(If NO/Unkn, skip to #35)**
34. If yes, which months do you get flooding_____
35. In the past year, have you seen more mosquitoes than usual in this village? ☐ Yes ☐ No ☐ Unkn
36. In the past year, have you been bitten by more mosquitoes than usual? ☐ Yes ☐ No ☐ Unkn
37. In the past year, have you been using a mosquito net? ☐ Yes ☐ No ☐ Unkn **(If NO/Unkn, skip to #39)**
38. If no, why_____
39. In past year, have you sprayed animals against external parasites? ☐ Yes ☐ No ☐ Unkn
40. Have you done indoor spraying against mosquitoes in the last one year? ☐ Yes ☐ No ☐ Unkn
41. Have you been the forest/bush in the past one year ☐ Yes ☐ No ☐ Unkn

Knowledge & Attitude Questions

42. Have you heard about Rift Valley Fever Disease? ☐Yes ☐No ☐Unkn **(If NO/Unkn, skip to #44)**
43. If yes, from whom: ☐Health worker ☐Radio ☐community leaders ☐others, specify_____
44. Do you know the signs and symptoms of RVF virus disease in humans? ☐Yes ☐No ☐ Unkn **(If NO/Unkn, skip to #46)**
45. If yes, what are some signs and symptoms? ☐bleeding ☐fever ☐vomiting ☐diarrhea ☐others specify_____
46. Do you know the signs and symptoms of RVF virus disease in animals? ☐Yes ☐No ☐Unkn **(If NO/Unkn, skip to #48)**
47. If yes, what are some signs and symptoms in animals? ☐bleeding ☐fever ☐nasal discharge ☐diarrhea ☐abortion ☐reduced milk production ☐prostration ☐loss of appetite ☐others, specify_____
48. Do you know who to contact in case you see a suspect case of RVF disease? ☐ Yes ☐ No ☐ Unkn
49. Do you believe RVF disease really exists? ☐ Yes ☐ No ☐ Unkn **(If YES, skip to #51)**
50. If no, why_____
51. Have you heard of any survivor of RVF disease? ☐ Yes ☐ No ☐ Unkn
52. Would you relate/interact with a survivor of RVF disease ☐ Yes ☐ No ☐ Unkn
53. Would you welcome someone back into their community/neighborhood after a neighbor has recovered from RVF? ☐Yes ☐No ☐Unkn **(If YES, skip to #55)**
54. If no, why? ☐fear of contracting disease ☐fear of stigma from community ☐others specify_____
55. Do you know how RVF disease is transmitted? ☐ Yes ☐ No ☐ Unkn **(If NO, skip to #58)**
56. If yes, how? ☐ body contact sick person ☐ through air ☐ through needle pricks ☐ contact with animals ☐contact with dead person ☐ contact with body fluids of sick person ☐biting mosquitoes(insects) ☐ others specify_____
57. If transmission through animals, which ones? ☐ goats ☐ Cattle ☐ Sheep ☐ Poultry ☐ Dogs ☐ monkeys ☐ bats ☐ antelopes ☐ wild pigs ☐ Others (specify)_____
58. How do you think you can protect yourself from acquiring RVF disease? ☐ vaccination ☐ avoiding contact with animals ☐ traditional medicine ☐ avoiding sick people ☐ sleeping in a mosquito net ☐ Unkn ☐ Others (specify)_____
59. How do you think RVF disease can best be healed or treated? ☐ Traditional medicine ☐ Spiritual healing ☐Modern medicine ☐Herbal medicine ☐ Unkn ☐ Others (specify)_____
60. Do you think you are at risk of contracting RVF virus disease? ☐ Yes ☐ No ☐ Unk
61. If yes/no, why_____

Thank you for your Time *End of Interview*

Section 3. Specimen Information

Specimen identification number:_____

Specimen collection date:___/___/_____ (DD/MM/YYYY)

Laboratory testing date:___/___/_____ (DD/MM/YYYY)

Results/Titer level: IgM _____ IgG _____

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Sample ID _____ **Date** ____/____/_____

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Exp. Date 03/31/2017

Livestock Assessment Form

Section 1. Herd Demographics

1) What is your relationship to the livestock? ☐ Owner ☐ Herdsman ☐ Other(specify)_____
2) Did your animals have blood samples collected today? ☐ Yes ☐ No ☐ Unkn ☐ Other (specify)_____
3) Herd location at time of survey? ☐Central collection area ☐ Grazing ground ☐Other, specify _____
4) Number of animals currently owned? **Cattle**_____ **Sheep**_____ **Goats**_____ **Pigs**_____
   Poultry _____ **Dogs** _____ **Cats** _____
5) What is the herd's typical grazing pattern? ☐Shared ☐Enclosed ☐Non-grazing ☐Other (specify)_____
6) In the past year, has the herd left the village? ☐Yes ☐No ☐Unknown
   If yes, why? ☐ Nomadic grazing ☐ Trade ☐ Gift/dowry ☐ Other (specify)_____
   If yes, to where? _____
   If yes, how many months ago? ☐ <1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months

Section 2. Herd Health Status

7) In the past year, has your **cattle** had unusual:
   - Abortions? ☐Yes ☐No If yes, how many? _____
   - Stillbirths? ☐Yes ☐No If yes, how many? _____
   - Deaths in adults? ☐Yes ☐No If yes, how many? _____
   - Deaths in young? ☐Yes ☐No If yes, how many? _____
   - Other health problems? ☐Yes ☐No If yes, what? _____

8) In the past year, has your **goats** had unusual:
   - Abortions? ☐Yes ☐No If yes, how many? _____
   - Stillbirths? ☐Yes ☐No If yes, how many? _____
   - Deaths in adults? ☐Yes ☐No If yes, how many? _____
   - Deaths in young? ☐Yes ☐No If yes, how many? _____
   - Other health problems? ☐Yes ☐No If yes, what? _____

9) In the past year, has your **sheep** had unusual:
   - Abortions? ☐Yes ☐No If yes, how many? _____
   - Stillbirths? ☐Yes ☐No If yes, how many? _____
   - Deaths in adults? ☐Yes ☐No If yes, how many? _____
   - Death in young? ☐Yes ☐No If yes, how many? _____
   - Other health problems? ☐Yes ☐No If yes, what? _____

*Common RVF symptoms: decreased appetite, decreased milk production, nose/eye discharge, diarrhea, jaundice, prostration, lymph node swelling

Section 3. Herd Treatment

10) Have your **cattle** received:
   - Vaccines? ☐Yes ☐No If yes, what vaccines? _____
   - Insecticide treatment? ☐Yes ☐No If yes, how often? _____
   - Other treatments? ☐Yes ☐No If yes, what treatment? _____

11) Have your **goats** received:
   - Vaccines? ☐Yes ☐No If yes, what vaccines? _____
   - Insecticide treatment? ☐Yes ☐No If yes, when? _____
   - Other treatments? ☐Yes ☐No If yes, what treatment? _____

12) Have your **sheep** received:
   - Vaccines? ☐Yes ☐No If yes, what vaccines? _____
   - Insecticide treatment? ☐Yes ☐No If yes, when? _____
   - Other treatments? ☐Yes ☐No If yes, what treatment? _____

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

Telephone Interview Form

SECTION A: General exposure and demographics. Circle response.

1. Did you (your child) visit the Oak Leaf Dairy farm?
   Yes No

(*If YES*) ► **PROCEED TO QUESTION 2**
(*If NO*) ►"Did anyone else in your household go to the farm? **IF yes,** may we speak to them? Go to question 2. **If No,** "Thank you for your time and participation, I have no further questions."

2. Since your visit to the farm have you been ill (defined as diarrhea (3 or more loose stools per day), vomiting, or abdominal cramps)?
   Yes No

(*If **NO***) ► **PROCEED TO QUESTION 3**
(*If YES*) ►"Are there other members of your household that went to the farm and have not been ill as defined above?"
If yes, "May we ask to interview and proceed to question 3.
If no, "Thank you for your time someone else from the health department may call you back to ask additional questions about your illness."

3. Are there others in your household who visited the farm and have also not been ill?
   Yes No
   If yes, How many family members visited the farm and are not ill? _____

4. What is your (your child's) birthdate? ____/____/_____ (mm/dd/yyyy)

5. What is your (your child's) gender?
   Male Female Prefer not to answer

6. What is your (your child's) town of residence? _____

SECTION B. Hand-to-mouth habits
"Let's talk about hand-to-mouth habits"

7. In general, do you (does your child) chew on or bite your (their) fingernails?
   Yes No Don't Know

8. In general, do you (does your child), suck your (their) thumb or fingers?
   Yes No Don't Know

SECTION C. Prior Animal exposure
"Let's talk about prior animal exposures"

9. Do you (does your child) live on a property where farm animals such as cattle, sheep, or goats are kept?
   Yes No Don't Know

IF NO, SKIP TO SECTION D

10. Which of these animals are kept on the property where you live (where your child lives)? Please answer yes or no.

Cattle	Yes	No
Sheep	Yes	No
Goats	Yes	No
Other	Yes	No

Specify other animals kept on property: _____

(If yes) How long have you owned: _____ (months)

SECTION D: Oak Leaf Dairy farm visit to tour.

"Let's talk about your / your child's visit to the Oak Leaf Dairy farm."

11. Did you (your child) visit the farm more than once? Yes No

12. On what date did you (your child) visit the farm? ____/____/____ (mm/dd/yyyy)

13. Approximately how much time did you (your child) spend at the farm?
    Less than 1 hour Between 1 and 2 hours Between 2 and 3 hours More than 3 hours

14. **(skip if only one visit)** On what date did you (your child) visit the farm? ____/____/____ (mm/dd/yyyy)

15. **(skip if only one visit)** Approximately how much time did you (your child) spend at the farm?
    Less than 1 hour Between 1 and 2 hours Between 2 and 3 hours More than 3 hours

16. **(skip if only one visit)** On what date did you (your child) visit the farm? ____/____/____ (mm/dd/yyyy)

17. **(skip if only one visit)** Approximately how much time did you (your child) spend at the farm?
    Less than 1 hour Between 1 and 2 hours Between 2 and 3 hours More than 3 hours

18. Did you (your child) attend the Goat Keeping 101 class before Open House on March 12th?
    Yes No Don't Know

"Now, let's talk about areas on the farm. In this first section we will discuss is the baby goat barn."

19. Did you (your child) enter the baby goat barn? Yes No Don't Know
IF NO SKIP TO QUESTION 34

20. Did you (your child) use hand sanitizer BEFORE visiting the baby goat barn?
Yes No Don't Know

21. Did you (your child) sit on the ground in the baby goat barn? Yes No Don't Know

22. Did you (your child) touch/pet the ***adult*** goats in the baby goat barn? Yes No Don't Know

23. Did you (your child) feed the ***adult*** goats in the baby goat barn? Yes No Don't Know

24. Did you (your child) enter a pen with the baby goats? Yes No Don't Know
(If yes) Did you (your child) sit on the ground in the pen? Yes No Don't Know
(If yes) Did you (your child) sit on a hay bale in the pen? Yes No Don't Know

25. Did you (your child) touch/pet the baby goats? Yes No Don't Know

26. Did you (your child) hold/snuggle the baby goats? Yes No Don't Know

27. Did you (your child) kiss the baby goats? Yes No Don't Know

28. Did the baby goats lick you (your child)? Yes No Don't Know

29. Did you (your child) feed the baby goats? Yes No Don't Know

30. Did you (your child) touch a railing while at the baby goat barn? Yes No Don't Know

31. Did you (your child) use your cell phone in the baby goat barn? Yes No N/A
If Yes:
Did you (your child) talk on your phone? Yes No Don't Know
Did you (your child) text on your phone? Yes No Don't Know
Did you (your child) take pictures with your phone? Yes No Don't Know
(If yes) Did you (your child) take pictures with goats? Yes No Don't Know
Did you (your child) place your phone down (on hay bales/on railings/on floor)?
Yes No Don't Know

32. Did you (your child) use hand sanitizer AFTER visiting the baby goat barn? Yes No Don't Know

33. Did you (your child) use baby wipes to clean your (their) hands AFTER visiting the baby goat barn? Yes No Don't Know

"Now, let's talk about the adult goat barn."

34. Did you (your child) visit the adult goat barn? Yes No Don't Know
IF NO, SKIP TO QUESTION 43
35. Did you (your child) use hand sanitizer BEFORE visiting the adult goat barn?
Yes No Don't Know
36. Did you (your child) touch/pet the adult goats at the adult goat barn? Yes No Don't Know
37. Did you (your child) feed the adult goats at the adult goat barn? Yes No Don't Know
38. Did you (your child) touch a railing while at the adult goat barn? Yes No Don't Know
39. Did you (your child) sit on a hay bale while at the adult goat barn? Yes No Don't Know
40. Did you (your child) use your cell phone while at the adult goat barn? Yes No N/A
If yes:
Did you (your child) talk on your phone? Yes No Don't Know
Did you (your child) text on your phone? Yes No Don't Know
Did you (your child) take pictures with your phone? Yes No Don't Know
If yes, Did you (your child) take pictures with goats?
Did you (your child) place your phone down (on hay bales/on railings/on floor)?
Yes No Don't Know
41. Did you (your child) use hand sanitizer AFTER visiting the adult goat barn?
Yes No Don't Know
42. Did you (your child) use baby wipes to clean your (their) hands AFTER visiting the adult goat barn? Yes No Don't Know

"Now, let's talk about other things you may have done at the farm."

43. Did your child have a pacifier at the farm?
Yes No N/A
If yes, did your child take it into the baby goat barn? Yes No Don't Know
If yes, did your child take it near the adult goat barn? Yes No Don't Know

44. Did your child have a sippy cup at the farm?
Yes No N/A
If yes, did your child take it into the baby goat barn? Yes No Don't Know
If yes, did your child take it near the adult goat barn? Yes No Don't Know

45. Did you (your child) chew gum while at the farm? Yes No Don't Know

46. Did you (your child) eat candy while at the farm? Yes No Don't Know

47. Did you bring a stroller on the farm? Yes No N/A
If yes, did you bring it in the baby goat barn? Yes No Don't Know
If yes, did you bring it near the adult goat barn? Yes No Don't Know

"Now, let's talk about other animal contact you may have had at the farm."

48. Did you (your child) use hand sanitizer BEFORE touching any animals besides goats?
    Yes No Don't Know

49. Did you (your child) touch/pet the rabbits? Yes No Don't Know

50. Did you (your child) touch/pet the dogs? Yes No Don't Know

51. Did you (your child) use hand sanitizer AFTER touching any animals besides goats?
    Yes No Don't Know

52. Did you (your child) use baby wipes to clean your (their) hands AFTER touching any animals besides goats? Yes No Don't Know

"Now I'm going to ask you some questions about eating and drinking at the farm."

53. Did you (your child) eat any food products you may have purchased while at the farm?
    Yes No Don't Know
    (IF NO SKIP TO QUESTION 58)
    If yes, did you (your child) use hand sanitizer BEFORE eating?
    Yes No Don't Know

54. Did you (your child) eat cheese bought from the farm while at the farm?
    Yes No Don't Know
    If yes, where did you (your child) eat the cheese bought from the farm **(circle all that apply)**?
    Farm store Picnic table Adult goat barn Baby goat barn
    Milking parlor Other Don't Know

55. Did you (your child) drink milk (pasteurized) bought from the farm while at the farm?
    Yes No Don't Know
    If yes, where did you (your child) drink milk (pasteurized) bought from the farm **(circle all that apply)**?
    Farm store Picnic table Adult goat barn Baby goat barn
    Milking parlor Other Don't Know

56. Did you (your child) drink raw milk (unpasteurized) bought from the farm while at the farm?
    Yes No Don't Know
    If yes, where did you (your child) drink raw milk (unpasteurized) bought from the farm **(circle all that apply)**?
    Farm store Picnic table Adult goat barn Baby goat barn
    Milking parlor Other Don't Know

57. Did you (your child) eat caramels bought from the farm while at the farm?

Yes No Don't Know

If yes, where did you (your child) eat caramels bought from the farm **(circle all that apply)**?

Farm store Picnic table Adult goat barn Baby goat barn
Milking parlor Other Don't Know

58. ►Did you (your child) taste any samples at farm? Yes No Don't Know

(IF NO SKIP TO QUESTION 63)

Did you (your child) use hand sanitizer BEFORE tasting the sample?

Yes No Don't Know

59. Did you (your child) taste cheese samples from the farm while at the farm?

Yes No Don't Know

If yes, where did you (your child) eat the cheese sample from the farm **(circle all that apply)**?

Farm store Picnic table Adult goat barn Baby goat barn
Milking parlor Other Don't Know

60. Did you (your child) drink milk (pasteurized) samples from the farm while at the farm?

Yes No Don't Know

If yes, where did you (your child) drink milk (pasteurized) sample from the farm **(circle all that apply)**?

Farm store Picnic table Adult goat barn Baby goat barn
Milking parlor Other Don't Know

61. Did you (your child) drink raw milk (unpasteurized) sample from the farm while at the farm?

Yes No Don't Know

If yes, where did you (your child) drink raw milk (unpasteurized) sample from the farm **(circle all that apply)**?

Farm store Picnic table Adult goat barn Baby goat barn
Milking parlor Other Don't Know

62. Did you (your child) eat caramels samples from the farm while at the farm?

Yes No Don't Know

If yes, where did you (your child) eat caramels samples from the farm **(circle all that apply)**?

Farm store Picnic table Adult goat barn Baby goat barn
Milking parlor Other Don't Know

63. ►Did you (your child) bring food to the farm and eat it on the farm (for example, to have a picnic)? Yes No Don't Know

(IF NO SKIP TO QUESTION 64)

Did you (your child) use hand sanitizer BEFORE eating? Yes No Don't Know

Where on the farm did you (your child) eat the food (circle all that apply)?

Farm store Picnic table Adult goat barn Baby goat barn
Milking parlor Other Don't Know

64. Did you (your child) drink any beverages that you brought with you at the farm?
Yes No Don't Know

(IF NO SKIP TO QUESTION 65)

Where on the farm did you (your child) drink it (circle all that apply)?
Farm store Picnic table Adult goat barn Baby goat barn
Milking parlor Other Don't Know

65. Did you (your child) drink any water from a faucet at the farm? Yes No Don't Know

"Now I'm going to ask you some questions about activities after leaving the farm."

66. After visiting the farm, did you (your child) stop to eat? Yes No Don't Know
If yes, did you (your child) wash your hands before eating? Yes No Don't Know
If yes, did you (your child) use hand sanitizer before eating? Yes No Don't Know

67. After visiting the farm, did you (your child) come home with any of the following?
Dirty or stained clothing? Yes No Don't Know
Dirty shoes? Yes No Don't Know

68. Did you (your child) remove shoes before walking in the home? Yes No Don't Know
69. Did you (your child) change your clothes immediately when you returned home?
Yes No Don't Know

SECTION E: General knowledge and awareness

"Now I would like to ask you some questions about general knowledge on interaction with animals."

70. In general, were you (was your child) aware that some diseases can be spread by having contact with farm animals? Yes No Don't Know

71. In general, were you (was your child) aware that some diseases can be spread by having contact with surfaces at a farm, such as the ground, railings?
Yes No Don't Know

SECTION H: Pre-existing medical conditions and medication use

"Now I would like to ask you a few questions about your (your child's) health in March, 2016. We would like to know about long-standing medical conditions or other specific medical conditions in the month of March. You do not need to answer the questions if you don't want to."

72. During the month of March did you (your child) have any of the following medical conditions?

PLEASE READ EACH CONDITION AND CHECK YES NO DK

	Yes	No	DK
Diabetes			
Kidney Disease			
If YES ► Are you/your child on dialysis?			
Organ or Bone Marrow Transplant			
Leukemia or Cancer			
If YES ► Treatment with radiation or chemotherapy in previous month?			

"I would now like to ask some questions about medications that you (your child) may have been taking in the month of March."

73. In the month of March, did you (your child) take any of the following types of medications?

PLEASE READ EACH MEDICATION AND CHECK YES NO DK	Yes	No	DK
Any antibiotics			
Any oral steroid, such as Prednisone?			
Any immune-suppressing medication, such as to treat juvenile arthritis?			

"Now, I would like to gather some additional information."

74. Did you hear or see in the media that the Department of Public Health was requesting ill and non-ill people that visited the farm to contact them? Yes No

75. What is your (your child's) race?
White
Black/African American
American Indian/Alaskan Native
Native Hawaiian or Pacific Islander
Asian
Other, specify: _____
Unknown
Prefer not to answer

74. Do you consider yourself (your child) to be of Hispanic ethnicity?
Yes No Prefer not to answer

75. If you (your child) visited the farm more than once, please describe any differences between your visits:

_____
_____
_____

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Exp. Date 03/31/2017

Undetermined agent, source, mode of transmission, and risk factors for Guillain-Barré Syndrome in the setting of Zika virus transmission— Colombia, 2016

Case Control Investigation Form

COL- ____ ____ - ____

Investigation ID Number COL- ____ ____ - ____ ☐ Case ☐ Control

The ID number begins with the 2 digit case number (for example COL01) followed by an "A" for the case patient, a "B" for the first control, a "C" for the second control, and a"D" for the third control. For example, the second control subject matched for case number 8 would be labeled "COL-08-C."

Interviewer: _____ Date of Interview: __ __ /__ __ /__ __
DD MM YYYY

Neuro Symptom Onset Date for Case __ __ /__ __ /__ __
DD MM YYYY

The following questions are to be asked of cases AND controls during the interview:

1. Current Address:
_____/_____/_____/_____
(Street) (Town) (Province) (District)

2. Onset Address:
_____/_____/_____/_____
(*for cases only if different from above; where cases spent most nights in the 2 months prior to neuro onset*)

3. GPS Coordinates (Onset for cases; current for controls): __ __. __ __ __ __ __ S, __ __ __. __ __ __ __ __ E

4. Sex: ☐ Male ☐ Female

5. Race: ☐ White ☐ Brown ☐ Indigenous ☐ Black/African decent ☐ Yellow ☐ Other:_____

6. Age when cases developed first neuro symptoms (or equivalent date for controls): _____ Years

7. What is your occupation? _____

8. What is the highest level of education you completed?

☐ Primary ☐ Secondary ☐ Technical ☐ University ☐ None

9. Did you travel anywhere two weeks prior to onset of symptoms?

☐ Yes ☐No ☐ Unknown

Where: _____

10. Have you ever been told by a clinician that you have any of the following medical conditions?

☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ High colesterol

☐ Stroke ☐ Kidney disease ☐ Liver disease ☐ Rheumatologic disease

☐ Asthma ☐ COPD ☐ Cancer ☐ Surgery (within 2 months of symptom onset)

☐ Other neurologic illness:_____

☐ Take any medication or have any condition that might impact your ability to fight infections (e.g. prednisone):

_____

11. a. In the 2 months prior to __ __ /__ __ /__ __ (neuro onset date for case), have YOU been sick at all?

☐ Yes ☐No ☐ Unknown

b. If so, when did you first feel sick? __ __ /__ __ /__ __

c. If so, what symptoms did you have (check all that apply)?

☐ Fevers ☐ Chills ☐ Nausea or Vomiting ☐ Diarrhea

☐ Muscle pains ☐ Joint pains ☐ Skin rash ☐ Abnormally red eyes

☐ Headache ☐ Pain behind eyes ☐ Stiff neck ☐ Confusion

☐ Abdominal pain ☐ Coughing ☐ Runny nose ☐ Sore throat ☐ Calf pain

☐ Pruritus

d. If so, did you see a doctor or go to the hospital for this illness?

☐ Yes ☐ No ☐ Unknown

Which doctor? _____ Which hospital? _____

e. If so, did they draw any blood for testing? ☐ Yes ☐ No ☐ Unknown

12. a. In the 2 months prior to __ __ /__ __ /__ __ (neuro onset date for case), has anyone in your HOUSEHOLD been sick at all?

☐ Yes ☐ No ☐ Unknown

b. If so, when did the first household member become sick? __ __ /__ __ /__ __

c. If so, what symptoms did any household members have (check all that apply)?

☐ Fevers ☐ Chills ☐ Nausea or Vomiting ☐ Diarrhea

☐ Muscle pains ☐ Joint pains ☐ Skin rash ☐ Abnormally red eyes

☐ Headache ☐ Pain behind eyes ☐ Stiff neck ☐ Confusion

☐ Abdominal pain ☐ Coughing ☐ Runny nose ☐ Sore throat ☐ Calf pain

☐ Pruritus

13. Which vaccinations have you received and when?

☐ Information verified on vaccine card ☐ Information provided verbally

Vaccine	DD MM YYYY	Additional doses
a. MMR	__ __ /__ __ /_____	_____
b. Polio	__ __ /__ __ /_____	_____
c. Yellow fever	__ __ /__ __ /_____	_____
d. BCG	__ __ /__ __ /_____	_____
e. DPT	__ __ /__ __ /_____	_____
f. HiB	__ __ /__ __ /_____	_____
g. Pneumococcal	__ __ /__ __ /_____	_____
h. Meningitis	__ __ /__ __ /_____	_____
i. Hepatitis B	__ __ /__ __ /_____	_____

j. Other vaccines (e.g. rabies, 23-pneumo, Japanese encephalitis, etc.):

_____ _____ __ __ /__ __ /__ __

_____ _____ __ __ /__ __ /__ __

_____ _____ __ __ /__ __ /__ __

COL- ____ ____ - ____

14. In the two months before onset of neurologic symptoms, what pets, farm, or other animals have lived in your house or on your property (check all that apply)?

☐ Dogs ☐ Cats ☐ Mice/rats ☐ Pet birds ☐ Pet lizards /turtles

☐ Goats ☐ Sheep ☐ Cows ☐ Chickens ☐ Pigs ☐ Other _____

15. In the two months before onset of neurologic symptoms, how often have you gotten your drinking water from the tap?

☐Almost always (>75%) ☐Often (25-75%) ☐Rarely (<25%) ☐Never (0%)

If ever, was the water boiled or treated? ☐Yes ☐No ☐Unknown

16. In the two months before onset of neurologic symptoms, how often have you gotten your drinking water from a well or river/stream/pond?

☐Almost always (>75%) ☐Often (25-75%) ☐Rarely (<25%) ☐Never (0%)

If ever, was the water boiled or treated? ☐Yes ☐No ☐Unknown

17. In the two months before onset of neurologic symptoms, how often do you walk around barefoot outside?

☐Almost always (>75%) ☐Often (25-75%) ☐Rarely (<25%) ☐Never (0%)

18. In the two months before onset of neurologic symptoms, have you swam or waded in a freshwater river, stream, or pond?

☐Daily ☐Weekly ☐Monthly ☐Rarely (<once per month) ☐Never

19. How much time do you spend outdoors each day?

☐<1 hour ☐1-4 hours ☐5-8 hours ☐>8 hours

20. How often do you wear long sleeves and pants?

☐Almost always (>75%) ☐Often (25-75%) ☐Rarely (<25%) ☐Never (0%)

22. Do you normally wear insect repellant?

☐Almost always (>75%) ☐Often (25-75%) ☐Rarely (<25%) ☐Never (0%)

23. Do you leave the windows open at your house?

☐Yes, during the day ☐Yes, at night ☐Yes, all times ☐Windows are not left open at this house

24. How many of your windows or doors have intact screens?

☐All of them ☐Some of them ☐None of them

25. Does your home use any of the following for air conditioning (check all that apply)?

☐Local air conditioning (at least 1 room) ☐Fans ☐None

26. How often do you have sources of standing water around the outside of your house (e.g. buckets, water storage/cistern, septic tank, pond)?

☐Daily ☐2-3 times/week ☐Once/week ☐Every other week ☐Never

27. Are these containers covered?

☐ Yes ☐ No ☐ Unknown

28. In the two months before onset of neurologic symptoms, have you handled any dead animals?

☐Yes ☐No ☐Unknown
Which? _____

29. In 2016, have you eaten or drunk any of the following foods at least once per week (check all that apply)?

☐ Beef ☐ Lamb ☐ Chicken ☐ Fish ☐ Shellfish

☐ Milk ☐ Cheese ☐ Yogurt ☐ Fresh salad / uncooked greens

30. Hughes Disability Score: (Date recorded __ __ /__ __ /__ __)

Hughes Disability Score (0 to 6): _____ ☐ Unknown

[0 = Complete recovery; no sequelae, 1 = Minor symptoms and capable of running, 2 = Able to walk 10 metres or more without assistance but unable to run, 3 = Able to walk 10 metres with help, 4 = Bedridden or chairbound (unable to walk 10 meters with help), 5 = Requiring assisted ventilation for at least part of the day, 6 = Dead]

Formulario Aprobado
OMB No. 0920-1011
Fecha de vencimiento: 03/31/2017

Cuestionario de Caracterización
Síndrome de Guillain-Barré – Colombia, 2016

INSTITUTO NACIONAL DE SALUD

COL- ____ ____ ____ - ____

Número de Identificación COL- ____ ____ ____ - ____ ☐ Caso ☐ Control

El número de identificación comienza con los 3 dígitos del número de caso (por ejemplo COL001) seguido por una "A" para el paciente que sea un caso, una "B" para el primer control, una "C" para el segundo control.. Por ejemplo, el segundo individuo control emparejado con el caso número 8 sería marcado como "COL-008-C".

Entrevistador: _____ Fecha de Entrevista: __ __ /__ __ /_____
DD MM AAAA

Fecha de Inicio de Síntomas Neurológicos: __ __ /__ __ /_____
DD MM AAAA

Las siguientes preguntas son para ser realizadas durante la entrevista:

1. Dirección actual:
_____/_____/_____
Dirección Ciudad o Municipio Distrito o Departamento

2. Dirección donde se presentaron los síntomas:
_____/_____/_____/_____
(solamente si es diferente de la dirección actual; donde los casos pasaron el mayor número de noches en los dos meses previos al inicio del cuadro neurológico)

3. Coordenadas GPS (Inicio de síntomas): __ __. __ __ __ __ __ N, __ __. __ __ __ __ __ O

4. Sexo: ☐ Masculino ☐ Femenino

5. Pertenencia étinica: ☐ Indígena ☐ ROM/Gitano ☐ Raizal ☐ Palenquero
☐ Negro/mulato/Afrocolombiano ☐ Otro

6. Edad cuando presentó los primeros síntomas neurológicos: _____ años

7. ¿Cuál es su ocupación? _____

8. Cuál es su nivel educativo (marque si fue cursado completo): □ Primaria □ Secundaria
□ Técnica □ Universitaria □ Ninguno

9. Dos semanas antes del inicio de los síntomas neurológicos viajó a otro lugar?
☐ Sí ☐No ☐ No sabe
A dónde: _____

10. ¿Ha sido informado por algún médico que usted padece alguna de las siguientes condiciones médicas?
☐ Diabetes ☐ Presión Arterial Alta ☐ Enfermedad del Corazón ☐ Colesterol Elevado
☐ Accidente Cerebrovascular (Derrame cerebral) ☐ Enfermedad Renal ☐ Enfermedad Hepática
☐ Enfermedad Reumatológica
☐ Asma ☐ Enfermedad Obstructiva Pulmonar Crónica ☐ Cáncer
☐ Cirugía (dentro de los meses de inicio de síntomas)
☐ Otra enfermedad neurológica: _____

INSTITUTO NACIONAL DE SALUD

COL- ____ ____ ____ - ____

☐ Toma algún medicamento o ha tenido alguna condición que pueda afectar su capacidad para defenserse las infecciones (por ejemplo: prednisona) _____

11. a. ¿En los dos meses anteriores a __ __ /__ __ /____(fecha de inicio de cuadro neurológico), estuvo enfermo (a)? DD MM AAAA

☐ Sí ☐No ☐ No sabe

b. Si estuvo enfermo (a), ¿cuándo se sintió enfermo(a) por primera vez? __ __ /__ __ /_____
DD MM AAAA

c. Si estuvo enfermo (a) ¿Qué síntomas tuvo? (Marque todos los que aplican)

☐ Fiebre ☐ Escalofrío ☐ Nausea o Vómito ☐ Diarrea

☐ Dolor muscular ☐ Dolor articular ☐ Rash cutáneo ☐ Ojos anormalmente rojos

☐ Dolor de cabeza ☐ Dolor retro ocular ☐ Rigidez nucal ☐ Confusión

☐ Dolor abdominal ☐ Tos ☐ Secreción nasal ☐ Odinofagia ☐ Dolor de pantorrillas

d. Si estuvo enfermo (a), ¿vió a algún médico o fue al hospital por esta enfermedad?

☐ Sí ☐ No ☐ No sabe

¿Cuál médico? _____ ¿Qué hospital? _____

e. Si estuvo enfermo (a), ¿le tomaron muestra de sangre? ☐ Sí ☐ No ☐ No sabe

12. a. En los dos meses anteriores a __ __ /__ __ /_____ (fecha de inicio de síntomas neurológicos), ¿hubo
DD MM AAAA
alguien en su hogar que haya estado enfermo (a)?

☐ Sí ☐ No ☐ No sabe

b. Si la respuesta es afirmativa, ¿en qué fecha se enfermó la primera persona de su hogar?

__ __ /__ __ /_____
DD MM AAAA

c. Si alguien en su hogar estuvo enfermo (a) ¿Qué síntomas tuvo? (Marque todos los que aplican)

☐ Fiebre ☐ Escalofrío ☐ Nausea o Vómito ☐ Diarrea

☐ Dolor muscular ☐ Dolor articular ☐ Rash cutáneo ☐ Ojos anormalmente rojos

☐ Dolor de cabeza ☐ Dolor retro ocular ☐ Rigidez nucal ☐ Confusión

☐ Dolor abdominal ☐ Tos ☐ Secreción nasal ☐ Odinofagia ☐ Dolor de pantorrillas

13. ¿Qué vacunas ha recibido y cuándo?

☐ Información verificada en el carné de vacunas ☐ Información proveída verbalmente

	DD MM AAAA	
a. Triple viral (SRP o MMR)	__ __/__ __/_____	Dosis adicionales: _____
b. Polio	__ __/__ __/_____	_____
c. Fiebre Amarilla	__ __/__ __/_____	_____

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COL- ____ ____ ____ - ____

d. BCG __ __/__ __/_____ _____
e. DPT __ __/__ __/_____ _____
f. Haemophilus Influenza B __ __/__ __/_____ _____
g. Neumococo __ __/__ __/_____ _____
h. Meningitis __ __/__ __/_____ _____
i. Hepatitis B __ __/__ __/_____ _____
j. Otras vacunas (ejemplo: rabia, encefalitis Japonesa, etc.):
¿Cuál? _____ __ __/__ __/_____

14. En los dos meses antes del inicio de los síntomas neurológicos, ¿qué mascotas, animales de granja u otros animales vivieron en su casa o su propiedad? (Marque todos los que apliquen)

☐ Perros ☐ Gatos ☐ Ratones/ratas ☐ Pájaros domésticos

☐ Lagartijas /tortugas ☐ Cabras ☐ Ovejas ☐ Vacas ☐ Gallinas

☐ Cerdos ☐ Otros _____

15. En los dos meses antes del inicio de los síntomas neurológicos, ¿qué tan frecuentemente tomó agua que no estaba hervida o tratada?

☐Casi siempre (>75%) ☐A veces (25-75%) ☐Rara vez (<25%) ☐Nunca (0%)

16. En los dos meses antes del inicio de los síntomas neurológicos, ¿qué tan a menudo tomó agua de un pozo, rio, quebrada o lago?

☐Casi siempre (>75%) ☐A veces (25-75%) ☐Rara vez (<25%) ☐Nunca (0%)

Si tomó alguna vez, ¿hirvieron o trataron el agua? ☐Sí ☐No ☐No sabe

17. En los dos meses antes del inicio de los síntomas neurológicos, ¿qué tan a menudo salió de su casa a caminar descalzo(a)?

☐Casi siempre (>75%) ☐A veces (25-75%) ☐Rara vez (<25%) ☐Nunca (0%)

18. En los dos meses antes del inicio de los síntomas neurológicos, ¿nadó o cruzó por sus propios medios un rio, arroyo, o lago?

☐Diariamente ☐Semanalmente ☐Mensualmente ☐Rara vez (menos de una vez al mes)

☐Nunca

19. ¿Cuántas horas al día está al aire libre?

☐Menos de 1 hora ☐1-4 hora ☐5-8 horas ☐>8 horas

20. Qué tan frecuente es el uso de ropa con mangas y pantalón largos?

☐Casi siempre (>75%) ☐A menudo (25-75%) ☐Rara vez (<25%) ☐Nunca (0%)

21. ¿Usa repelente de insectos?

☐Casi siempre (>75%) ☐A menudo (25-75%) ☐Rara vez (<25%) ☐Nunca (0%)

22. ¿Fumiga dentro su vivienda?

☐Casi siempre (>75%) ☐A menudo (25-75%) ☐Rara vez (<25%) ☐Nunca (0%)

COL- ____ ____ ____ - ____

23. ¿Deja las ventanas de su casa abiertas?

☐Sí, durante el día ☐Sí, en la noche ☐Sí, todo el tiempo ☐Las ventanas no se dejan abiertas en esta casa

24. ¿Cuántas de sus ventanas o puertas tienen angeos intactos?

☐Todas ☐Algunas de ellas ☐Ninguna

25. ¿Tienen en su casa alguno de los siguientes tipos de aire acondicionado?

☐Aire acondicionado central ☐Aire acondicionado por habitación ☐Ninguno

26. ¿Qué tan a menudo tiene recipientes alrededor de su casa donde puede haber agua estancada? (por ejemplo: baldes, cisternas, tanques, inservibles)

☐Diariamente ☐2-3 veces/semana ☐Una vez a la semana ☐Semana de por medio ☐Nunca

27. Estos recipientes se encuentran tapados

☐Sí ☐No ☐No sabe

28. En los dos meses antes del inicio de los síntomas neurológicos, ¿ha manipulado algún animal muerto? ☐Sí ☐No ☐No sabe

¿Cuál? _____

29. En el año 2016, ¿ha consumido alguno de los siguientes alimentos o bebidas por lo menos una vez a la semana? (Marque todos los que apliquen)

a. ☐ Carne ☐ Cordero ☐ Pollo ☐ Pescado ☐ Mariscos

b. ☐ Leche ☐ Queso ☐ Yogurt ☐ Ensalada / verduras crudas

30. Puntaje de Discapacidad de Hughes: (Fecha de registro: __ __ /__ __ /_____)

Puntaje de Discapacidad de Hughes (0 a 6): _____ ☐ Desconocido

[0= Recuperación completa; sin secuelas, 1= Síntomas menores y capaz de correr, 2= Puede caminar 10 metros o más sin asistencia pero no puede correr, 3=Puede caminar 10 metros con ayuda, 4= Postrado en cama o en silla de ruedas (no puede caminar 10 metros con ayuda), 5= Requiere ventilación asistida por lo menos una parte del día, 6=Muerto]

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

Undetermined agent, source, mode of transmission, and risk factors for Guillain-Barré Syndrome in the setting of Zika virus transmission— Colombia, 2016

Chart Abstraction Form

Study ID Number COL-____ ____ Encounter level (Brighton 1-5) or not neuro (6): ____

The ID number begins with the 2 digit case number (for example COL-01). Information as documented by attending physician.

The following pages are to be abstracted from the medical records / exam:

Chart Abstractor: _____ Abstraction Date: __ __ /__ __ /_____
MRN: _____ MM DD YYYY

1. First name: _____ Middle name: _____
2. Paternal name: _____ Maternal name: _____
3. Age (years): _____ Date of birth: __ __ /__ __ /_____
MM DD YYYY

4. Sex: ☐ Male ☐Female

5. Patient address: _____

6. Patient phone number: _____

7. Date of neuro symptom onset: __ __ /__ __ /_____ Date first sought care: __ __ /__ __ /_____
MM DD YYYY MM DD YYYY

Date of admission: __ __ /__ __ /_____ Date of discharge/death: __ __ /__ __ /_____
MM DD YYYY MM DD YYYY

8. Discharged to:

☐ Home ☐ Rehab/skilled nursing facility ☐ Transferred ☐ Died ☐ Other (specify) _____

CURRENT ILLNESS

9. How long from onset until hospital admission? _____minutes/hours/days/weeks

10. What were the initial neurologic symptoms (i.e. within the three days of illness onset)? (check all that apply, signs from PE, symptoms from HPI)

☐ Leg weakness ☐ Arm weakness ☐ Diplopia/Ophthalmoplegia
☐ Leg numbness/paresthesias ☐ Arm numbness/paresthesias ☐ Face numbness/paresthesias
☐ SOB / respiratory distress ☐ Gait imbalance (not weakness)/ataxia ☐ Hand clumsiness/ataxia
☐ Hyporeflexia/areflexia ☐ Face weakness ☐ Dysarthria ☐ Dysphagia ☐ Dysautonomia

11. What neurologic symptoms occurred AT ANY TIME during the neuro illness? (check all that apply, signs from PE, symptoms from HPI)

☐ Leg weakness ☐ Arm weakness ☐ Diplopia/Ophthalmoplegia
☐ Leg numbness/paresthesias ☐ Arm numbness/paresthesias ☐ Face numbness/paresthesias

☐ SOB / respiratory distress ☐ Gait imbalance (not weakness)/ataxia ☐ Hand clumsiness/ataxia

☐ Hyporeflexia/areflexia ☐ Face weakness ☐ Dysarthria ☐ Dysphagia ☐ Dysautonomia

12. How long from onset until maximum/worst neuro symptoms? _____ minutes/hours/days/weeks

13. At the worst point during this neuro illness, check all that apply for the patient:

☐ Unable to walk without assistance (e.g. cane, walker) ☐ Unable to walk at all

☐ Admitted to the hospital ☐ Admitted to the ICU/CCU ☐ Intubated

14. If any blood was taken for this neurologic illness, please fill out the following for the INITIAL blood draw:

Date __ __ /__ __ /_____ WBC ____ HgB____ Plts _____ Na ____ K____
MM DD YYYY

BUN ____ Cr _____ Glucose____ TBili____ AST ____ ALT____ AlkPhos ___

15. Was there documented hyporeflexia/areflexia? ☐ Yes ☐ No ☐ Unknown

16. a. Was there documentation of upper motor neuron signs?

☐ Yes ☐ No ☐ Unknown

b. If yes, which:

☐ Hyperreflexia ☐ Increased tone/spasticity ☐ Babinski/Hoffman ☐ Sustained clonus

17. Was there any sensory level documented? ☐ Yes ☐ No ☐ Unknown

LABORATORY, IMAGING, AND ELECTROPHYSIOLOGIC STUDIES

18. Was a lumbar puncture (LP) done? ☐ Yes ☐ No ☐ Unknown

LP date ___/____/____ RBCS _____ WBCS _____ Protein (mg/dL)_____ Glucose (mg/dL) _____
MM DD YYYY

Differential_____IgG index_____ Oligoclonal bands_____ IgG synthesis_____

LP date ___/____/____ RBCS _____ WBCS _____ Protein (mg/dL)_____ Glucose (mg/dL) _____
MM DD YYYY

Differential_____IgG index_____ Oligoclonal bands_____ IgG synthesis_____

19. Did they receive any targeted treatment (IVIG/steroids/plasma exchange) for this neuro illness?

IVIG ☐ Yes ☐ No ☐ Unknown Start date __ __ /__ __ /_____
MM DD YYYY

Plasma exchange ☐ Yes ☐ No ☐ Unknown Start date __ __ /__ __ /_____
MM DD YYYY

Steroids ☐ Yes ☐ No ☐ Unknown Start date __ __ /__ __ /_____
MM DD YYYY

Mechanical ventilation ☐ Yes ☐ No ☐ Unknown Start date __ __ /__ __ /_____
MM DD YYYY

Other ☐ Yes ☐ No ☐ Unknown Start date __ __ /__ __ /_____
MM DD YYYY

20. Did the patient receive blood transfusion/blood products? (other than IVIG)

☐ Yes ☐ No ☐ Unknown which one_____ Start date __ __ /__ __ /_____
MM DD YYYY

21. Were any of the following diseases tested for? If so, what was the result? (including specimen and type of test)

a. *Campylobacter jejuni* ☐ Yes ☐ No Result:_____

b. *Mycoplasma pneumoniae* ☐ Yes ☐ No Result:_____

c. *Haemophilus influenzae* ☐ Yes ☐ No Result:_____

d. *Salmonella spp.* ☐ Yes ☐ No Result:_____

e. Cytomegalovirus (CMV) ☐ Yes ☐ No Result:_____

f. Epstein-Barr virus (EBV) ☐ Yes ☐ No Result:_____

g. Varicella-zoster virus (VZV) ☐ Yes ☐ No Result:_____

h. Human immunodeficiency virus (HIV) ☐ Yes ☐ No Result:_____

i. Enterovirus / Rhinovirus ☐ Yes ☐ No Result:_____

j. Arboviruses ☐ Yes ☐ No Result:_____

k. Other ☐ Yes ☐ No Result:_____

22. Was neuro imaging done? If so, what was the result? (Transcribe the impression)

☐ Yes ☐ No Result:_____
_____ Date __ __ /__ __ /_____
MM DD YYYY

23. Were electro-diagnostics done (e.g. EMG)? If so, what were the results? (Transcribe the impression)

☐ Yes ☐ No Result:_____
_____ Date __ __ /__ __ /_____
MM DD YYYY

24. What was the GBS Brighton level? 1 2 3 4 5

Levels of Diagnostic Certainty

Level 1	***Level 2***	***Level 3***	***Level 4****	***Level 5***
Absence of an alternative diagnosis for weakness				NOT a case
Acute onset of bilateral and relatively symmetric flaccid weakness of the limbs			* Lacking documentation to	
Decreased or absent deep tendon reflexes in affected limbs				

Monophasic illness pattern with weakness nadir between 12 hours and 28 days, followed by clinical plateau			fulfill minimal case criteria	
Albuminocytologic dissociation (elevation of CSF protein level above laboratory normal value and CSF total white cell count < 50 cells/mm^3)	CSF with a total white cell count < 50 cells/mm^3 (with or without CSF protein elevation above laboratory normal value) or if CSF not collected or results not available, and electrodiagnostic studies consistent with GBS			
Electrophysiologic findings consistent with GBS				

ANTECEDENT ILLNESS

25. a.) In the 2 months prior to neuro onset date, did the individual experience an acute illness? (other than their neuro illness)? ☐ Yes ☐No ☐ Unknown

b.) How long from prior acute illness onset until admission for neuro illness? _____ minutes/hours/days/weeks

26. a.) What symptoms did they report having or what signs were noticed? (check all that apply)

☐ Fevers ☐ Chills ☐ Nausea or Vomiting ☐ Diarrhea

☐ Muscle pains ☐ Joint pains ☐ Skin rash ☐ Conjunctivitis

☐ Headache ☐ Pain behind eyes ☐ Stiff neck ☐ Confusion

☐ Back pain ☐ Abdominal pain ☐ Coughing ☐ Runny nose

☐ Sore throat ☐ Calf pain ☐ Pruritis

b.) If any blood was taken for this acute illness, please fill out the following for the INITIAL blood draw:

Date __ __ /__ __ /_____ WBC ____ HgB____ Plts _____ Na ____ K____
DD MM YYYY

BUN ____ Cr _____ Glucose____ TBili____ AST ____ ALT____ AlkPhos ___

c.) Were they hospitalized for this acute illness? ☐ Yes ☐ No ☐ Unknown

d.) Did they receive any blood products / IVIG for this illness? ☐ Yes ☐ No ☐ Unknown

What product? _____ Date? __ __ /__ __ /_____
MM DD YYYY

e.) Did they receive plasmapheresis / plasma exchange for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, date? __ __ /__ __ /_____
MM DD YYYY

27. Is there a test result available for dengue from this medical visit? ☐ Yes ☐ No ☐ Unknown

If yes, please specify:_____

28. Is there a test result available for chikungunya from this medical visit? ☐ Yes ☐ No ☐ Unknown

If yes, please specify:_____

29. Is there a test result available for Zika from this medical visit? ☐ Yes ☐ No ☐ Unknown

If yes, please specify:_____

PAST MEDICAL, SOCIAL AND FAMILY HISTORY

30. What medical conditions are listed in the admission history and physical (H&P)?

☐ Hypertension ☐ Diabetes ☐ HIV ☐ Autoimmune disorder_____

☐ Prior GBS ☐ Hemoglobinopathy ☐ B12 deficiency ☐ Cancer _____

31. What social conditions are listed in admission H&P?

☐ Alcohol use ☐ Drug use ☐ Tobacco ☐ Other _____

32. What conditions are listed in family history of H&P?

☐ Autoimmune disorder (specify)_____ ☐ Cancer (specify) _____

☐ Hemoglobinopathy (specify) _____ ☐ Neuro (specify) _____

Instituto Nacional de Salud

Formulario Aprobado
OMB No. 0920-1011
Fecha de vencimiento: 03/31/2017

Instrumento para la recolección de datos de historias clínicas. Caracterización de casos con Síndrome de Guillain-Barré – Colombia, 2016

Número de Identificación COL-____ ____ ____ Nivel (Brighton 1-5) o no neurológico (6): ____

El número de identificación comienza con los 3 dígitos del número de caso (por ejemplo COL-001). Información según lo documentado por el médico tratante

Las siguientes páginas son para ser tomadas a partir de las historias clínicas/exámenes:

Revisor de Historia Clínica: _____ Fecha de revisión: __ __ /__ __ /_____
Número de Historia Clínica: _____ MM DD YYYY

1. Primer Nombre: _____ Segundo Nombre: _____
2. Primer Apellido: _____ Segundo Apellido: _____
3. Edad (años): _____ Fecha de Nacimiento: __ __ /__ __ /_____
MM DD YYYY

4. Sexo: ☐ Masculino ☐ Femenino

5. Dirección de residencia del paciente (Incluir dirección completa, ciudad o municipio y departamento):
_____

6. Número de teléfono del paciente: _____

7. **a.)** Fecha de ingreso hospitalario: __ __ /__ __ /_____
MM DD YYYY
b.) Fecha en la que buscó atención por primera vez: __ __ /__ __ /_____
MM DD YYYY
c.) Fecha de egreso hospitalario/muerte: __ __ /__ __ /_____
MM DD YYYY

8. Egresó hacia:

☐ Hogar ☐ Centro de Rehabilitación ☐ Remitido a otra institución hospitalaria

☐ Muerte ☐ Otro (Especifique) _____

ENFERMEDAD ACTUAL

9. ¿Cuánto tiempo transcurrió desde el inicio de los síntomas hasta el ingreso al hospital?___minutos/horas/días/semanas

10. ¿Cuáles fueron los síntomas neurológicos iniciales dentro de los tres días previos al inicio de la enfermedad? (Marque todas las opciones que apliquen, signos del examen físico y síntomas de historia de enfermedad actual)

☐ Debilidad en extremidades inferiores ☐ Debilidad en extremidades superiores ☐ Diplopia/Oftalmoplejía

☐ Adormecimiento de extremidades inferiores/parestesias

☐ Adormecimiento de extremidades superiores/parestesias

☐ Adormecimiento de la cara/parestesias

☐ Dificultad para respirar/distress respiratorio ☐ Trastornos de la marcha (sin debilidad)/ataxia

☐ Trastornos de la motricidad manual/ataxia

☐ Hiporeflexia/areflexia ☐ Debilidad en la cara ☐ Disartria ☐ Disfagia ☐ Disautonomía

11. ¿Qué síntomas neurológicos ocurrieron en CUALQUIER MOMENTO durante la enfermedad neurológica? (Marque todas las opciones que apliquen, signos del examen físico y síntomas de historia de enfermedad actual)

☐ Debilidad en extremidades inferiores ☐ Debilidad en extremidades superiores ☐ Diplopia/Oftalmoplejía

☐ Adormecimiento de extremidades inferiores /parestesias

☐ Adormecimiento de extremidades superiores /parestesias

☐ Adormecimiento de la cara /parestesias

☐ Dificultad para respirar / distress respiratorio ☐ Trastornos de la marcha (sin debilidad)/ataxia

☐ Trastornos de la motricidad manual/ataxia

☐ Hiporeflexia/areflexia ☐ Debilidad en la cara ☐ Disartria ☐ Disfagia ☐ Disautonomía

12. ¿Cuánto tiempo transcurrió desde el inicio hasta la presentación de los síntomas neurológicos más severos?
____ minutos/horas/días/semanas

13. Marque todas las opciones que apliquen al paciente que se presentaron al momento de mayor severidad del cuadro neurológico:

☐ Incapacidad para caminar sin asistencia (por ejemplo: bastón, caminador) ☐ Incapacidad total para caminar

☐ Ingreso al hospital ☐ Ingreso a Unidad de Cuidado Intensivo (UCI) ☐ Intubación

14. Si se extrajo muestra de sangre como parte de los análisis de laboratorio para el cuadro neurológico, por favor complete las siguiente información de la muestra de sangre obtenida INICIALMENTE:

Fecha __ __ /__ __ /_____ Recuento de blancos _____ Hemoglobina _____ Plaquetas _____
MM DD YYYY

Sodio _____ Potasio_____ BUN _____ Creatinina _____ Glucosa _____ Bilirrubina Total_____

AST _____ ALT_____ Fosfatasa Alcalina _____

15. ¿Se documentó hiporeflexia/areflexia? ☐ Sí ☐ No ☐ Desconocido

16. a.) ¿Hubo evidencia de signos de motoneurona superior?

☐ Sí ☐ No ☐ Desconocido

b.) En caso afirmativo, ¿Se documentó algunos de los siguientes hallazgos?

☐ Hiperreflexia ☐ Aumento en el tono/espasticidad ☐ Babinski/Hoffman ☐ Clonus sostenido

Número de Identificación COL-____ ____ ____ Nivel (Brighton 1-5) o no neurológico (6): ____

17. ¿Se documentó algún nivel sensitivo? ☐ Sí ☐ No ☐ Desconocido

☐ Guante y Bota ☐ Cervical ☐ Dorsal ☐ Lumbar

LABORATORIO, IMÁGENES DIAGNOSTICAS Y ESTUDIOS ELECTROFISIOLÓGICOS

18. ¿Se llevó a cabo una punción lumbar? ☐ Sí ☐ No ☐ Desconocido

Fecha punción lumbar ___/____/_____ Recuento de eritrocitos _____ Recuento de leucocitos _____
MM DD YYYY

Proteínas (mg/dL) _____ Glucosa (mg/dL) _____ Diferencial_____

Gram_____

Fecha punción lumbar ___/____/_____ Recuento de eritrocitos _____ Recuento de leucocitos _____
MM DD YYYY

Proteínas (mg/dL) _____ Glucosa (mg/dL) _____

Diferencial_____ Gram_____

19. ¿Recibieron algún tratamiento específico para manejar esta enfermedad neurológica (Inmunoglobulina intravenosa/esteroides/recambio plasmático)?

a. Inmunoglobulina intravenosa ☐ Sí ☐ No ☐ Desconocido Fecha de inicio __ __ /__ __ /_____
MM DD YYYY

b. Recambio plasmático ☐ Sí ☐ No ☐ Desconocido Fecha de inicio __ __ /__ __ /_____
MM DD YYYY

c. Esteroides ☐ Sí ☐ No ☐ Desconocido Fecha de inicio __ __ /__ __ /_____
MM DD YYYY

d. Ventilación mecánica ☐ Sí ☐ No ☐ Desconocido Fecha de inicio __ __ /__ __ /_____
MM DD YYYY

e. Otro ☐ Sí ☐ No ☐ Desconocido Fecha de inicio __ __ /__ __ /_____
MM DD YYYY

20. ¿Recibió el paciente transfusión de sangre o algún otro hemoproducto? (otros diferentes a Inmunoglobulina intravenosa)

☐ Sí ☐ No ☐ Desconocido ¿Cuál? _____ Fecha de inicio __ __ /__ __ /_____
MM DD YYYY

21. ¿Fueron algunos de los siguientes patógenos estudiados? En caso afirmativo, ¿cuál fue el resultado? (incluyendo el espécimen y el tipo de prueba)

a. *Campylobacter jejuni* ☐ Sí ☐ No Resultado: _____

b. *Mycoplasma pneumoniae* ☐ Sí ☐ No Resultado: _____

c. *Haemophilus influenzae* ☐ Sí ☐ No Resultado: _____

d. *Salmonella spp.* ☐ Sí ☐ No Resultado: _____

e. Citomegalovirus (CMV) ☐ Sí ☐ No Resultado: _____

f. Virus Epstein-Barr (EBV) ☐ Sí ☐ No Resultado: _____

g. Virus Varicella-zoster (VZV) ☐ Sí ☐ No Resultado: _____

h. Virus de Inmunodeficiencia Humana (VIH) ☐ Sí ☐ No Resultado: _____

i. Enterovirus / Rhinovirus ☐ Sí ☐ No Resultado: _____

j. Arbovirus ☐ Sí ☐ No Resultado: _____

k. Otro. ¿Cuál?_____ ☐ Sí ☐ No Resultado: _____

22. ¿Se llevaron a cabo neuroimágenes diagnósticas?. En caso afirmativo, ¿cuál fue el resultado? (Transcriba el resultado reportado)

☐ Sí ☐ No

Resultado_____

_____

_____

Fecha __ __ /__ __ /_____

MM DD YYYY

23. ¿Se llevaron a cabo pruebas electrodiagnósticas? (por ejemplo: electromiografías). En caso afirmativo, ¿cuál fue el resultado? (Transcriba el resultado reportado)

☐ Sí ☐ No

Resultado_____

_____

_____

Fecha __ __ /__ __ /_____

MM DD YYYY

24. ¿Cuál fue el nivel de SGB en la escala de Brighton? **1 2 3 4 5**

Niveles de Certeza Diagnóstica

Nivel 1	***Nivel 2***	***Nivel 3***	***Nivel 4****	***Level 5***
Ausencia de un diagnóstico alternativo para debilidad				NO es un caso
Inicio agudo de debilidad flácida bilitaral y relativamente simétrica de las extremidades			* Al carecer de documentación para cumplir con	
Reflejos tendinosos profundos disminuidos o ausentes en las extremidades afectadas				
Patrón de enfermedad monofásica con nadir de debilidad entre 12 horas y 28 días, seguido de meseta clínica				

Disociación albuminocitológica (elevación del nivel de proteínas en el LCR por encima del valor normal de laboratorio y recuento total de glóbulos blancos en LCR <50 células / mm3)	LCR con un total de recuento de glóbulos blancos<50 células / mm3 (con o sin elevación de proteínas en LCR sobre el valor normal de laboratorio) o si el LCR no fue recolectado o los resultados no están disponibles y los estudios de electrodiagnóstico son consistentes con SGB		los criterios mínimos de caso	
Hallazgos electrofisiológicos consistentes con SGB				

ANTECEDENTES DE LA ENFERMEDAD

25. a.) ¿En los dos meses anteriores a la fecha de inicio de síntomas neurológicos, tuvo el paciente una enfermedad aguda? (diferente a su enfermedad neurológica)

<u>Si la respuesta es No o Desconocido, vaya a pregunta 30, sección Antecedentes Clínicos, Sociales y Familiares</u>

☐ Sí ☐ No ☐ Desconocido

b.) ¿Cuánto tiempo se presentó desde el inicio de la enfermedad aguda hasta el ingreso hospitalario por la condición neurológica? _____ minutos/horas/días/semanas

26. a.) ¿Qué síntomas reportaron haber tenido o qué signos fueron evidenciados? (Marque todas las opciones que apliquen)

☐ Fiebre ☐ Escalofrío ☐ Nausea o Vómito ☐ Diarrea

☐ Dolor muscular ☐ Dolor articular ☐ Rash cutáneo ☐ Conjuntivitis

☐ Cefalea ☐ Dolor retro ocular ☐ Rigidez nucal ☐ Confusión

☐ Dolor de espalda ☐ Dolor abdominal ☐ Tos ☐ Secreción nasal

☐ Odinofagia ☐ Dolor de pantorrilla

b.) Si se extrajo muestra de sangre como parte de los análisis de la enfermedad aguda, por favor complete la siguiente información para la muestra de sangre obtenida INICIALMENTE:

Fecha __ __ /__ __ /_____ Recuento de blancos _____ Hemoglobina_____ Plaquetas _____
MM DD YYYY

Sodio ____ Potasio____ BUN ____ Creatinina _____ Glucosa_____ Bilirrubina Total_____

AST ____ ALT____ Fosfatasa Alcalina _____

c.) ¿Hubo hospitalización por esta enfermedad aguda? ☐ Sí ☐ No ☐ Desconocido

d.) ¿Recibió alguna transfusión de cualquier hemoproducto/administración de Inmunoglobulina intravenosa para esta enfermedad aguda? ☐ Sí ☐ No ☐ Desconocido

Número de Identificación COL-____ ____ ____ Nivel (Brighton 1-5) o no neurológico (6): ____

En caso afirmativo, ¿Qué producto?_____ Fecha: __ __ /__ __ /_____
MM DD YYYY

e.) ¿Recibió plasmaféresis / recambio plasmático para esta enfermedad aguda? ☐ Sí ☐ No ☐ Desconocido

En caso afirmativo, ¿qué fecha? __ __ /__ __ /_____
MM DD YYYY

27. ¿Hay algún resultado de laboratorio para dengue en esta visita médica? ☐ Sí ☐ No ☐ Desconocido

Resultado ☐ Positivo ☐ Negativo ☐ Desconocido

28. ¿Hay algún resultado de laboratorio para chikungunya en esta visita médica? ☐ Sí ☐ No ☐ Desconocido

Resultado ☐ Positivo ☐ Negativo ☐ Desconocido

29. ¿Hay algún resultado de laboratorio para zika en esta visita médica? ☐ Sí ☐ No ☐ Desconocido

Resultado ☐ Positivo ☐ Negativo ☐ Desconocido

ANTECEDENTES CLINICOS, SOCIALES Y FAMILIARES

30. ¿Qué antecedentes clínicos están registrados en la historia clínica de ingreso?

☐ Hipertensión ☐ Diabetes ☐ VIH

☐ Trastorno autoimmune. En caso afirmativo, ¿cuál? _____

☐ SGB previo ☐ Hemoglobinopatía ☐ Deficiencia de Vitamina B12

☐ Cancer. En caso afirmativo, ¿cuál? _____

31. ¿Qué antecedentes sociales están registrados en la historia clínica de ingreso?

☐ Uso de alcohol ☐ Uso de drogas ☐ Tabaquismo

☐ Otros. En caso afirmativo, ¿cuáles? _____

32. ¿Qué antecedentes familiares están registrados en la historia clínica de ingreso?

☐ Trastornos autoinmunes (Especifique) _____

☐ Cáncer (Especifique) _____

☐ Hemoglobinopatías (Especifique) _____

☐ Neurológicos (Especifique) _____

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

Case Abstraction Form

Demographics

Question	Code	Variable
RVCT number		RVCT
Last Name		Lname
First Name		Fname
Alternate Names/Nicknames/Aliases:		Alias
Date of Birth (MM/DD/YY)		DOB
Age (years)		Age
Gender (1=Male, 2=Female, 3=Other, 99=missing)		Sex
Race/Ethnicity (1=Black, 2=White, 3=Hispanic/Latino, 4= American Indian/Alaskan Native, 5=Native Hawaiian/Pacific Islander, 6=Asian, 7=Other, 99=Missing) [Mark all that apply]		Race
Tribe If American Indian, then specify tribe:		Tribe
Tribe A residence If lives on Tribe A reservation, specify which area: 1=northwest of Yuma, 2=southwest of Yuma, 3=south of Yuma		Residence
If lives elsewhere, specify		Other
Locating Information, if available: Addresses: Phones: How long at this address? Be sure to list any other known addresses during last 3 years.		
Country of Birth (1=United States, 2=Other [foreign-born], 99=missing) If foreign-born, then specify country:		Birth Country
Date of arrival (MM/DD/YY) For patients born outside the		Arrival

United States, enter the date of arrival in the United States.		

TB Risk Factors

Question	Code	Variable
HIV infection (0=No, 1=Yes, 99=Unknown)		HIV
Diabetes (0=No, 1=Yes, 99=Unknown)		DM
If diabetic, most recent HbA1C		A1C
Chronic Renal Failure (0=No, 1=Yes, 99=Unknown)		ESRD
Immunosuppression other than HIV (e.g. organ transplant, chemotherapy, medications such as steroids, TNF blockers. 0=No, 1=Yes, 99=Unknown)		Immune
Mental illness (0=No, 1=Yes, 99=Unknown) (Axis I diagnosis not related to substance abuse, e.g. mood disorders, schizophrenia, anxiety disorders)		Mental
Injection drug use-recent (Within 1 year of TB diagnosis. 0=No, 1=Yes, 99=Unknown)		IDU_rvct
Injection drug use-ever (Prior to 1 year of TB diagnosis. 0=No, 1=Yes, 99=Unknown)		IDU_ever
Injection drug names (open ended) list all drugs injected ever		IDU_list
Non-injection drug use-recent (Within 1 year of TB diagnosis. 0=No, 1=Yes, 99=Unknown)		NIDU_rvct
Non-injection drug use-ever (Prior to 1 year of TB diagnosis. 0=No, 1=Yes, 99=Unknown)		NIDU_ever
Non-Injection drug names (open ended) list all non-injection drugs used ever		NIDU_list
Excess alcohol use-recent (Within 1 year of TB diagnosis. 0=No, 1=Yes, 99=Unknown)		EtOH_rvct
Excess alcohol use-ever (Prior to 1 year of TB diagnosis. 0=No, 1=Yes, 99=Unknown)		EtOH_ever
Smoking commercial tobacco regularly (i.e., most days) for at least 1 year at time of diagnosis (0=No, 1=Yes, 99=Unknown)		Tobacco
Homeless/unstable housing within 1 year of diagnosis? (0=No, 1=Yes 99=Unknown)		Home1
Homeless/unstable housing >1 year before diagnosis? (0=No, 1=Yes 99=Unknown)		Home2
Use of homeless shelter within 1 year of diagnosis? 0=No, 1=Yes 99=Unknown		Shelter1
Use of homeless shelter >1 year before diagnosis? 0=No, 1=Yes 99=Unknown		Shelter2
Shelter names (open ended) list all homeless shelters used		Shelter_list
At least 1 night in correctional/detention facility within 1		Incarc1

year of diagnosis**? (**0=No, 1=Yes 99=Unknown**)**		
At least 1 night in correctional/detention facility >1 year before diagnosis? (0=No, 1=Yes 99=Unknown)		Incarc2
Incarceration facility names (open ended) list all correctional/detention facilities where stayed at least 1 night		Incarc_list
Residence in long term care facility within 1 year of diagnosis? **(**0=No, 1=Yes 99=Unknown)		LTCF1
Residence in long term care facility>1 year before diagnosis? **(**0=No, 1=Yes 99=Unknown)		LTCF2
If known exposure to TB case, exposure type: **(**1=own household, 2=homeless shelter, 3=jail, 4=other household, 5=bar, 6= hotel, 7=Other: _____**)** List name of site if known:_____		TBexp ExpOth ExpSite

TB Case Characteristics

Question	Code	Variable
How was case recognized or detected? (1=symptoms, 2=contact investigation, 3=routine TB screening by healthcare provider, 4=incidental finding by healthcare provider, 5=other, 99=unknown)		Caserec
Cough (0=not present 1= present, 99=unknown)		Cough
Fever (0=not present 1= present, 99=unknown)		Fever
Night Sweats (0=not present 1= present, 99=unknown)		Sweats
Weight Loss (0=not present 1= present, 99=unknown)		Weight
Other TB Symptoms (list)		OthSx
Date of first symptom onset (Enter the first date the patient began experiencing symptoms in the format MM/DD/YY)		DateSx
Site of disease (1=pulmonary, 2=extrapulmonary, 3=both pulmonary and extrapulmonary)		TBSite
Diagnostic CXR result (1=Negative, 2=Abnormal, possibly TB, 3=Abnormal, not consistent with TB, 4=Unknown [not completed or not available])		CXRrslt
Diagnostic chest radiograph (CXR) result date (Enter the date of the patient's most recent CXR completed as part of current diagnostic workup leading to patient's current diagnosis of TB. MM/DD/YY)		CXRdate
Cavitary disease on CXR? (0=No, 1=Yes, 99=Unknown)		CavCXR
Cavitary disease on CT? (0=No, 1=Yes, 99=Unknown)		CavCT

Sputum AFB smear positive disease? (0=No, 1=Yes, 2=Sputum never submitted)		Sputum
Sputum smear converted to negative (0=No, 1=Yes ≤2 months of treatment, 2=Yes >2 months of treatment, 3=Unknown/NA)		Smearconv
Other site AFB smear positive? (0=No, 1=Yes, 99=Unknown) Specify Site:_____		OthSmear OthSite
Culture-confirmed disease? (0=No, 1=sputum only, 2=non-sputum specimen, 3=both sputum and non-sputum specimens, 4=specimens never submitted, 99=Unknown)		Culture
If culture confirmed, list GENType		GENType
Culture converted to negative (0=No, 1=Yes ≤2 months of treatment, 2=Yes >2 months of treatment, 3=Unknown/NA)		Cxconv
Diagnosis date (MM/DD/YY) (the earliest date of the following: positive smear, positive culture, positive PCR test, or abnormal chest x-ray/CT scan)		Dxdate
Drug susceptibility based on molecular testing (1=Pan-susceptible, 2=INH resistance, 3=rifampin resistance, 4=multiple resistance, including MDR TB, 88=pending, 99=unknown)		Suscept_Mol
Drug susceptibility based on culture (1=Pan-susceptible, 2=INH resistance, 3=rifampin resistance, 4=multiple resistance, including MDR TB, 88=pending, 99=unknown)		Suscept_DST
INH resistance level (highest concentration at which isolate is resistant)		INHR
RIF resistance level (highest concentration at which isolate is resistant)		RIFR
Specify any other detected resistance		Oth_R
Diagnostic TST result (Enter the patient's TST result, if completed as part of the diagnostic workup leading to the patient's current diagnosis of TB. 1=negative, 2=positive, 3=positive with conversion [≥10mm increase in last 2 years], 4=not done due to prior positive TST, 5=not done for other reason, 99=result unknown)		TST
Diagnostic TST reading (mm reading)		TSTmm
Diagnostic TST date (MM/DD/YY)		TSTdate
Diagnostic QFT result (Enter the patient's qualitative QFT result, if completed as part of the diagnostic workup leading to the patient's current diagnosis of TB. 1=negative, 2=positive, 3=indeterminate, 4=not done, 99=unknown)		QFT
Diagnostic QFT value (result-nil). (Enter the quantitative		QFTvalue

result of the patient's current QFT result, 99=Unknown. Leave blank if not performed.)		
Diagnostic QFT date (MM/DD/YY)		QFTdate
Diagnostic T.Spot result (Enter the patient's qualitative result, if completed as part of the diagnostic workup leading to the patient's current diagnosis of TB. 1=negative, 2=positive, 3=indeterminate, 4=borderline, 5=not done, 99=unknown)		TSpot
Diagnostic T.Spot value (Enter the quantitative result of the patient's current result, 99=Unknown. Leave blank if not performed.)		TSpotvalue
Diagnostic T.Spot date (MM/DD/YY)		TSpotdate
Treatment (1=On treatment, 2=Completed full treatment, 3=Completed partial treatment, 4=Died during treatment, 5= Died before treatment, 6=died after treatment, 7=awaiting treatment initiation, 8=refused treatment, 99=Unknown)		TBrx
Start date of initial TB treatment (Enter the date of antituberculosis medication in the format MM/DD/YY.)		TBRxdate
If applicable, date of change to MDR TB regimen (Enter the date of antituberculosis medication in the format MM/DD/YY.)		MDRRxdate
List MDR TB regimen		MDRregimen
Date of treatment completion if done (Enter the date of antituberculosis medication in the format MM/DD/YY.)		Rxcomp
History of loss to follow-up or non-compliance during this TB treatment course (0= No, 1= Yes, 99=Unknown)		TBfu
If died, then enter date of death (MM/DD/YY)		Deathdate
If died, then enter cause of death		Deathcause

Previous TB episodes and LTBI history

Question	**Code**	**Variable**
Prior TB disease? (0=No, 1=Yes, 99=Unknown)		PrevTB
Year of previous diagnosis (YYYY)		Prevyr
If prior TB, exposure type (1=own household, 2=homeless shelter, 3=jail, 4=other household, 5=bar, 6= hotel, 7=Other: _____**)**		PrevTBexp PrevTBexp oth
If prior TB, drug susceptibility (1=Pan-susceptible, 2=INH resistance, 3=rifampin resistance, 4=multiple resistance, incl. MDR TB, 88=pending, 99=unknown)		Prevresist
If prior TB, Genotype (GENType)		PrevGENty

		pe
TB treatment completed (0= No, 1= Yes, 2=In progress, 99=Unknown)		PrevTBRx
History of loss to follow-up or non-compliance during TB treatment (0= No, 1= Yes, 99=Unknown)		PrevTBfu
Previous positive test for LTBI 0= No, 1= Pos TST, 2=Pos IGRA, 99=Unknown)		HxLTBI
Previous TST result date (Enter the date of the patient's most recent TST *before* any test conducted as part of current diagnostic workup leading to patient's current diagnosis of TB. MM/DD/YY)		PrevTSTdate
Previous TST result (MM) (Enter the mm reading of the patient's previous TST result. 99=Unknown)		PrevTSTmm
Previous TST interpretation (1=Negative, 2=Positive, 3=Unknown)		PrevTSTrslt
Previous QFT result date (Enter the date of the patient's most recent QFT *before* any a test conducted as part of current diagnostic workup leading to patient's current diagnosis of TB. MM/DD/YY)		PrevQFTdate
Previous QFT result (Enter value [result-nil]. 99= unknown)		PrevQFTnum
Previous QFT interpretation (1=Negative, 2=Convertor, 3=Unknown)		PrevQFTrslt
Diagnostic T.Spot result (Enter the patient's qualitative result, if completed as part of the diagnostic workup leading to the patient's current diagnosis of TB. 1=negative, 2=positive, 3=indeterminate, 4=not done, 99=unknown)		PrevTSpot
Diagnostic T.Spot value (Enter the quantitative result of the patient's current result, 99=Unknown. Leave blank if not performed.)		PrevTSpotvalue
Diagnostic T.Spot date (MM/DD/YY)		PrevTSpotdate
Previous chest radiograph (CXR) result date (Enter the date of the patient's most recent CXR *before* any CXR conducted as part of current diagnostic workup leading to patient's current diagnosis of TB. MM/DD/YY)		DateprevCXR
Previous CXR result (1=Negative, 2=Abnormal, possibly TB, 3=Abnormal, not consistent with TB, 99=Unknown [not completed or not available])		PrevCXRrslt
Initiated treatment for LTBI? 0=offered but refused, 1=never offered by provider, 2=yes, initiated, 99=unknown		LTBIRxStart
Prior LTBI treatment completed 0= No, 1= Yes, 99=Unknown		HxLTBIRx

Infectious Period Determination

Question	**Code**	**Variable**

Date of infectious period beginning (format MM/DD/YY) -For symptomatic patients, start the infectious period 3 months before “Date of symptom onset” recorded on page 2. -For asymptomatic patients who have sputum smear-positive or cavitary disease, start the infectious period 3 months before the “Diagnosis date” recorded on page 2. -For asymptomatic patients without sputum smear-positive or cavitary disease, start the infectious period 1 month before the “Diagnosis date” recorded on page 2		IPopen
Date of infectious period end (format MM/DD/YY) For patients who are not isolated, the infectious period can be closed when the following three conditions are met: 1) Treatment with an adequate regimen (based on drug susceptibility results) for ≥2 weeks, AND 2) The patient shows clinical improvement, AND 3) Three consecutive sputum smears are negative (which have been obtained at least 8 hours apart) For patients who are isolated (e.g. in a hospital) until these three conditions are met, then use date of isolation as the end of the infectious period.		IPend

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Case Interview Form

Participant Information

Question	Response	Variable Name
Case Last Name		Lname
Case First Name		Fname
Alternate Names/Nicknames/Aliases:		Alias
Age		Age
Date of Birth		DOB
If proxy interviewed, name and relationship to case patient:		

Check the database for the patient's estimated infectious period.

Start of infectious period: _____

End of infectious period: _____

Explain to the patient that you have been asked by the health department to help determine why there have been more cases of tuberculosis, or TB. Explain that you will be asking a series of questions to try to identify where the health department might be able to find other people who have TB, as well as to figure out where the patient might have gotten sick. Acknowledge that the patient has already participated in many interviews with health care providers. Reassure the patient that all answers will be kept confidential, and that the purpose of the interview is to learn information that can help stop the spread of TB and prevent other people from getting sick (emphasize protection of families). Thank the patient for his or her time and for speaking with us.

Note that throughout the interview, the period of interest is
2 years before the start of the infectious period to the end of the infectious period.

Ask patient whether they are from the Tribe A Reservation.
If not, ask where patient came from and when he/she came to the area.

Discuss symptom onset date. *Confirm based on chart data.*

"We are interested in learning where you could have been exposed to TB in the 2 years before you got sick with TB. People sick with TB often have a bad cough, or might lose a lot of weight. TB is spread through the air when a person who is sick coughs or speaks and does anything that brings up air from the lungs. How do you think that you got TB?" *Mention household exposure (i.e. people you visited or people who visited you). Attempt to elicit names of sick contacts who might have been source patients. Note when and where the exposure occurred. Emphasize that these people are not in trouble, and we are not trying to blame anyone. We are trying to make sure we can find all sick people and treat them.*

"TB is commonly spread among people staying in the same household. We're worried about people who may have been staying with you or people you may have stayed with when you were coughing a lot or started feeling sick. I know it might be hard to remember, but please try your best. During [infectious period**], where did you live, and who was staying with you?"** *Emphasize protecting family.*

Time period(s)	**Last time visited**	**Location**	**People in household**

“TB can also be spread to people you spend a lot of time around, even if you don’t stay in the same household. During [infectious period**], could you tell us where you worked, where you hung out, and who else was usually there?”** *Emphasize protecting friends and family. Mention work sites, bars, friends’ homes.*

Location	**Dates of first attendance**	**Dates of most recent attendance**	**Frequency of attendance**	**Contacts present**

Ask patient how else he/she passes time. *As examples, you could mention cards, bingo, video lottery. Record locations and contacts present.*

Activity	**Location**	**Dates of first attendance**	**Dates of most recent attendance**	**Contacts present**

Ask the patient whether he/she visits friends or family or attends social events ON any of the reservations in the area, or whether friends/family from on a reservation visited the patient. *Ask for location and dates of visit. Record exposed contacts.*

Ask the patient whether he/she visits friends or family or attends social events OFF the reservations in the area, or whether friends/family from off the reservations visited the patient. *Ask for location and dates of visit. Record exposed contacts.*

Explain to patient that certain activities make the body less able to fight off a TB infection, and make a person more likely to become sick.
Ask about the following TB risk factors. *Circle response.*

Smoking commercial tobacco during the year before diagnosis?
0=None
1=Less than Daily
2=Daily
3=Does not recall or refuses

Smoking traditional tobacco during the year before diagnosis?
0=None
1=Less than Daily
2=Daily
3=Does not recall or refuses

If so:

What substance:_____

Participates in "sweats" (traditional sweat lodge purification ceremony): Y N

Location: _____

Alcohol use ("drinking") within 1 year before diagnosis?
0=Never
1=Rarely (1-2 times ever)
2=Occasionally (more than 1 or 2 times, but less than most days or nights)
3=Frequently (most days or nights of the week)
4=Does not recall or refuses

Note the locations where patient drank alcohol? Smoked?

With whom would the patient usually drink? Smoke?

Among the group that the patient drank with/smoked with, did anyone possibly have TB?

Non-injection drug ("taking anything for recreation, e.g. marijuana") use within 1 year before diagnosis
0=Never
1=Rarely (1-2 times ever)
2=Occasionally (more than 1 or 2 times, but less than most days or nights)
3=Frequently (most days or nights of the week)
4=Does not recall or refuses

What kinds of drugs were used before diagnosis? *Circle all that apply.*

Marijuana Crack or cocaine Methamphetamine Heroin Prescription drugs

Other drugs: _____

Note the locations where non-injection drugs were used:

Drug use with anyone with possible TB?

Injection drug use ("shooting up") within 1 year before diagnosis

0=Never
1=Rarely (1-2 times ever)
2=Occasionally (more than 1 or 2 times, but less than most days or nights)
3=Frequently (most days or nights of the week)
4=Does not recall or refuses

What kinds of drugs were used before diagnosis? _____

Note the locations where injection drugs were used or obtained:

Drug use with anyone with possible TB?

ANY drug use prior to the year before diagnosis

What kinds of drugs were used? _____

Note the locations where drugs were used or obtained:

Drug use with anyone with possible TB?

Does the patient have any other ideas about places where TB might have spread (i.e., where people were coughing a lot) or people we should contact?

Any other contacts not yet discussed:

Name of Contact (and contact info if available)	**Where and when had contact**	**How often had contact?** (1=daily, 2=few times/week, 3=weekly or less, 99=unk)	**Activities Together**	**Smoked together?** (0=no, 1=yes, 99=unk)	**Drank together?** (0=no, 1=yes, 99=unk)	**Drugs together?** (0=no, 1=yes, 99=unk)	**Comments**

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Tuberculosis Contact Screening Form

Contact Name:	q Male q Female	DOB: _____/_____/_____	Age:
Current Location:			

Contact Exposure History (During the Infectious Period)	
Contact's Relationship to Index:	**Date of Last Exposure:** _____/_____/_____
Location of Exposure:	
1. How much time did you spend **in the same room or house** as the index while he/she was contagious (during the infectious period)?	Number of days per week: Number of hours per day:
2. How much time did you spend **in a bar or drug-using location** as the index while he/she was contagious (during the infectious period)?	Number of days per week: Number of hours per day:
3. How much time did you spend in the same room **in the hospital** while he/she was contagious (during the infectious period)?	Number of days per week: Number of hours per day:
4. **If you are a healthcare worker**, did you perform any procedures on the index patient that may have caused them to cough (such as suctioning, collecting sputum, performing CPR, using a bag mask, or intubation)	q Yes (If Yes, person is automatically a close contact) q No
IF YES, specify type of procedure(s) and date(s)	
5. Specify **other contact** setting and any related details	
Ø **Based upon the answers above, is this a "close" contact?** A "close" contact is a person who spent ≥4 hours multiple times *or* spent ≥8 hours at least one time inside the same room as the index patient (during the infectious period)?	q **Yes** q **No**

TB Symptom Screening (Current Symptoms)		**Start Date and Duration**
Instructions: Screen to see if the contact *currently* has TB symptoms. Consider the contact "symptomatic for TB" if they have: (1) A cough for ≥2 weeks duration *OR* (2) Two "yes" responses to symptoms #2-8 that cannot be explained by another medical condition		
1. Have you been coughing for ≥2 weeks?	q Yes q No	
2. Have you been coughing up blood?	q Yes q No	

3. Have you had difficulty breathing?	q Yes q No	
4. Have you had fevers or chills?	q Yes q No	
5. Have you had night sweats? (completely soaking your clothes at night)	q Yes q No	
6. Have you been tired or feeling weak lately?	q Yes q No	
7. Have you lost your appetite?	q Yes q No	
8. Have you had unplanned weight loss?	q Yes q No q Unknown	If yes, how much?
Ø **Is this contact symptomatic for TB?**	q **Yes** q **No** **If yes, specify symptom start date: ____/____/_____**	

TB Risk Factor Screening		**Notes**
Instructions: Screen to see if the contact has risk factors that could increase their risk for progression to active TB disease.		
1. Is this contact >50 years old?	q Yes q No	
2. Was this contact <5 years old during the exposure period?	q Yes q No	
3. Do you have diabetes?	q Yes q No or Unknown	
4. Do you have HIV?	q Yes q No or Unknown	
5. Do you have cancer?	q Yes q No or Unknown	
6. Do you take prednisone every day?	q Yes q No	
7. Do you smoke tobacco?	q Yes q No	
8. Do you drink alcohol?	q Yes q No	If yes, specify amount/frequency
9. Do you use any other substances?	q Yes q No	If yes, include types/routes, frequency, and locations where substances acquired and used
Ø **Does this contact have a high-risk condition?** If the contact answers "yes" to **questions 1-6** above, then the contact has a high-risk condition.		q **Yes** q **No**

Additional Questions
1. Have you ever been diagnosed with active TB disease? If so, please provide details including treatment if any.
2. Have you ever been diagnosed with latent TB infection? If so, please provide details including treatment if any.
3. **Have you ever known anybody with TB?** If yes, what was/is the nature of your relationship and contact? What did/does this person do during the day? How did/does he/she spend his/her time? Who spent/spends a lot of time with that person?

4. **Do you know anybody now who might have TB symptoms?**
(e.g., cough ≥2 weeks, fevers, chills, unintended weight loss)

END QUESTIONS

Test Results		Date TST Placed	Date TST Read	MM	Chest X-Ray
	TST 1:				CXR Date: _____/_____/_____
	TST 2:				CXR Result: q Not Suggestive of TB q Suggestive of TB
	TST Interpretation: q Negative q Positive If pos, Conversion? q				

Test Results		Date of IGRA	IGRA Result	Chest X-Ray
	IGRA 1:			CXR Date: _____/_____/_____
	IGRA 2:			CXR Result: q Not Suggestive of TB q Suggestive of TB
	IGRA Interpretation: q Negative q Positive If pos, Conversion? q			

Treatment	Treatment Outcome
Rx Start Date: _____/_____/_____ Rx End Date: _____/_____/_____ Rx Regimen:	q Completed LTBI treatment q Adverse effects of medicine q Lost to follow-up q Refused treatment q Provider decision to stop q Moved q Died q Other (specify): _____

TB Status			
q LTBI	q TB Disease	q Not infected (test negative 8 weeks after last exposure)	q Lost to follow-up

Interviewer Name: _____ **Date:** _____/_____/_____