

# Tularemia

Agency: \_\_\_\_\_

Investigator: \_\_\_\_\_

Phone number: \_\_\_\_\_

### FOR STATE USE ONLY

Status:  Confirmed  Probable  
 Suspect  Not a case

Reviewer initials: \_\_\_\_\_

Referred to another state: \_\_\_\_\_

## CASE

Last name: \_\_\_\_\_  
First and middle name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated?  Age: \_\_\_\_\_

Maiden name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Gender:  Female  Male  Other \_\_\_\_\_

Pregnant:  Yes  No  Unk Est. delivery date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address line: \_\_\_\_\_

Marital status:  Single  Married  Separated  
 Divorced  Parent with partner  Widowed

Zip: \_\_\_\_\_ City: \_\_\_\_\_

Race:  American Indian or Alaskan Native  Unknown  
 Black or African American  White  
 Hawaiian or Pacific Islander  Asian

State: \_\_\_\_\_ County: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Facility phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

Long-term care resident:  Yes  No  Unknown

Parent/Guardian phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Facility name: \_\_\_\_\_

## EVENT

Tularemia type:  Glandular  Oropharyngeal  Typhoidal  
 Intestinal  Pneumonic  Ulceroglandular  
 Oculoglandular

Diagnosis date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Last name: \_\_\_\_\_

Event outcome:  Survived this illness  Died from this illness  
 Died unrelated to this illness  Unknown

First name: \_\_\_\_\_

Date of death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Event exception:  Case could not be found  
 Case could not be interviewed  
 Case refused interview  
 Other – see notes

Provider title:  ARNP  MD  
 DO  NP  PA

Outbreak related:  Yes  No  Unknown

Outbreak name: \_\_\_\_\_

Facility name: \_\_\_\_\_

Exposure setting: \_\_\_\_\_

Address line 1: \_\_\_\_\_

Epi-linked:  Yes  No  Unknown

Address line 2: \_\_\_\_\_

Location acquired:  In USA, in reporting state  
 In USA, outside reporting state  
 Outside USA  
 Unknown

Zip code: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Healthcare provider information

## LABORATORY FINDINGS

Laboratory: \_\_\_\_\_ Accession #: \_\_\_\_\_ Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Specimen source: \_\_\_\_\_ Test type: \_\_\_\_\_

Result type:  Preliminary  Final Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result:  Positive  Negative

Organism: **Francisella** Type (e.g. serotype): \_\_\_\_\_

Laboratory: \_\_\_\_\_ Accession #: \_\_\_\_\_ Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Specimen source: \_\_\_\_\_ Test type: \_\_\_\_\_

Result type:  Preliminary  Final Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result:  Positive  Negative

Organism: **Francisella** Type (e.g. serotype): \_\_\_\_\_

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: <b>Francisella</b>	Type (e.g. serotype): _____	

**OCCUPATIONS**

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____)____-____-____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____)____-____-____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**HOSPITALIZATIONS**

Was the case hospitalized?  Yes  No  Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

**CLINICAL INFO & DIAGNOSIS**

- Symptoms:**
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Headache              | <input type="checkbox"/> Sore throat         |
| <input type="checkbox"/> Chills         | <input type="checkbox"/> Malaise               | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Fever          | <input type="checkbox"/> Red eyes w/ discharge |  |

Lesion location: \_\_\_\_\_

**OTHER LAB FINDINGS**

Biopsy performed:  Yes  No  Unk Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Site: \_\_\_\_\_ Result: \_\_\_\_\_

**TREATMENT**

Antibiotics prescribed?  Yes  No  Unknown

Antibiotic: \_\_\_\_\_ Antibiotic: \_\_\_\_\_ Antibiotic: \_\_\_\_\_

