

If plague is suspected, please contact CDPHE at 303-692-2700 before completing this form!

Plague Case Investigation Report – Clinical

Date of Report: ____/____/____ *(Shaded areas to be filled in but not to be placed in the database)*
 Person making call: _____ Person taking call: _____
 Agency: _____ Agency: _____
 Contact Information: _____ Contact Information: _____

Patient ID

Patient Name:
 Last _____ First _____ Middle _____
 Address: _____

 Telephone: (____) _____ Other contact information: _____

Patient Demographics

ID: CDC _____ State _____
 City: _____ State: _____ County: _____
 DOB: _____ Age: _____ Gender: Male Female
 Race/Ethnicity: White (non Hispanic) White (Hispanic) Black Asian
 Pacific Islander American Indian/Alaskan native Unknown
 Other: _____
 Occupation location: Inside only Outside only Inside and Outside Unknown
 Occupation: _____ Unknown
 Exposure Address (if different from above): _____
 Exposure City: _____ Exposure State: _____ Exposure County: _____

Medical History

Any underlying medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<u>Medical conditions:</u>	Yes	No	Unknown
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunocompromised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal disease (Renal failure, dialysis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (Coronary Artery Disease, Heart attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease (asthma, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (specify type below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify _____			
Medications prior to becoming ill: (check all that apply and specify)			
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Systemic Steroids	<input type="checkbox"/> Antibiotics	
<input type="checkbox"/> Antivirals	<input type="checkbox"/> Antifungals	<input type="checkbox"/> Antidiabetics agents	
<input type="checkbox"/> Cardiovascular agents	<input type="checkbox"/> Psychotherapeutic agents	<input type="checkbox"/> Respiratory agents	
<input type="checkbox"/> Hormones/Contraceptives	Other/Specify: _____		
For females, pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

Disease Onset

Date of onset of initial symptoms: ____/____/____ unknown

Date first seen by medical person: ____/____/____ unknown

Where? Office Clinic Emergency department Urgent care center
 Hospital Unknown Other _____

Symptoms at presentation No symptoms recorded

	Yes	No	Unk		Yes	No	Unk
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Joint Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats/Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness/Lethargy/Malaise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion/Delirium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insect Bite/Wound infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shock or Cardiac Arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen tender glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff neck/Photophobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	which? <input type="checkbox"/> Axillary; <input type="checkbox"/> Cervical; <input type="checkbox"/> Inguinal; <input type="checkbox"/> Other			
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other symptoms _____			

Vital Signs (at initial presentation)

Temperature: _____ °F or °C (circle) Heart Rate: _____

Respiratory Rate: _____ Blood pressure _____/_____

Date antibiotic treatment first started: ____/____/____ (record specific antibiotics below)

Date hospitalized: ____/____/____ Not hospitalized Unknown

Hospitalized where? _____

Laboratory Findings

CXR done? Yes No Unknown, if yes, date: ____/____/____ Unknown

Results: Clear/Normal; Unilateral infiltrate; Bilateral infiltrate; Pleural effusion;
 Hilar adenopathy; Pulmonary abscess; Pulmonary nodules; Interstitial changes

Initial blood counts Results (*circle one*): Known/Unknown

If results known, record below:

WBC (x10³) _____ Differential (indicate %) Seg _____ Bands _____ Lymphs _____
 Monos _____ Baso _____ Eos _____ Atyp Lymphs _____ Other _____

Platelet count (x 10³) _____ BUN (U/dL) _____
 Hemoglobin (mg/dL) _____ OR Hct _____ Creatinine (mg/dL) _____

Diagnosis of Plague determined **first** by: (*circle one*) Date: ____/____/____
 Staining Serology Culture – blood/Sputum/Bubo PCR
 If staining, what type? DFA Gram Wayson Wrights Giemsa

Bacteria seen on blood smear: Yes No Unknown Date: ____/____/____
 What? _____

Blood cultures taken: Yes No Unknown

Date: ____/____/____ Results _____
 Date: ____/____/____ Results _____
 Date: ____/____/____ Results _____
 Date: ____/____/____ Results _____
 Date: ____/____/____ Results _____

Bubo aspirate obtained: Yes No Unknown Date: ____/____/____
 Where? (circle) Axilla/Inguinal/Cervical/Other Results: POS NEG

Sputum sample obtained: Yes No Unknown Date: ____/____/____
 Results: POS NEG if positive, organism _____

CSF sample obtained: Yes No Unknown Date: ____/____/____
 Results: WBC _____ diff: seg _____ lymps _____ Monos _____ other _____
 RBC _____ Protein _____ Glucose _____
 Culture: POS NEG if positive, organism _____

Serologies (circle one)
 Date drawn: ____/____/____ Acute/Convalescent/Unknown Results _____
 Date drawn: ____/____/____ Acute/Convalescent/Unknown Results _____
 Date drawn: ____/____/____ Acute/Convalescent/Unknown Results _____

Clinical Course/Treatment

Antibiotic Therapy
 Did they get treated with antibiotics? Yes No Unknown

<i>Antibiotic</i>	<i>Yes</i>	<i>No</i>	<i>Unk</i>	<i>Date started</i>	<i>Date stopped</i>
Chloramphenicol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Ciprofloxacin (Cipro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Co-trimoxazole (Septra, Septrin, Bactrim, TMP-SMX)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Doxycycline (Vibramycin, Monodox)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Gentamicin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Other Antibiotic 1: _____				____/____/____	____/____/____
Other Antibiotic 2: _____				____/____/____	____/____/____
Other Antibiotic 3: _____				____/____/____	____/____/____
Other Antibiotic 4: _____				____/____/____	____/____/____
Other Antibiotic 5: _____				____/____/____	____/____/____

If side effect noted, which antibiotic and what was the reaction: _____

Maximum temperature noted within first 72 hours of hospitalization _____ °F or °C (circle)
 Date when improvement noted (i.e., afebrile for 24 hours): ____/____/____,
 OR Number of days into illness _____ unknown

Was the patient in isolation? Yes No Unknown
 Date isolated: ____/____/____
 Type: Respiratory Contact Other _____

Date of hospital discharge: ____/____/____ Never hospitalized unknown

<u>Complications during hospitalization:</u> (<input type="checkbox"/> unknown)	Yes	No	Unknown
Bacterial Sepsis (positive blood culture)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/DIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limb ischemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amputation If yes, what? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shock (SBP <90)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal Failure (Creatinine >2.0mg/dL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complications during hospitalization (<i>Cont.</i>)	Yes	No	Unknown
Multisystem organ failure (two or more organs involved, i.e., elevated liver enzymes, kidney failure, intubated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intubated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date intubated ____/____/____		Date extubated ____/____/____	
Other (specify) _____			
Initial diagnosis given: _____			<input type="checkbox"/> unknown
Date when plague diagnosis first given: ____/____/____			<input type="checkbox"/> unknown
PRIMARY Form of plague as diagnosed (check one only):			
Bubonic Plague <input type="checkbox"/>	Pneumonic Plague <input type="checkbox"/>	Septicemic Plague <input type="checkbox"/>	
Pharyngeal Plague <input type="checkbox"/>	Meningitic Plague <input type="checkbox"/>	Ocular Plague <input type="checkbox"/>	
Gastrointestinal <input type="checkbox"/>	Unknown <input type="checkbox"/>		
Secondary form of plague (check as many as that apply):			
Bubonic Plague <input type="checkbox"/>	Pneumonic Plague <input type="checkbox"/>	Septicemic Plague <input type="checkbox"/>	None <input type="checkbox"/>
Pharyngeal Plague <input type="checkbox"/>	Meningitic Plague <input type="checkbox"/>	Ocular Plague <input type="checkbox"/>	
Gastrointestinal <input type="checkbox"/>	Unknown <input type="checkbox"/>		
Outcome:			
<input type="checkbox"/> Unknown		<input type="checkbox"/> Recovered, complications unknown	
<input type="checkbox"/> Recovered, no complications		<input type="checkbox"/> Recovered, with complications,	
Please specify _____			
<input type="checkbox"/> Died; Date ____/____/____		Autopsy performed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Cause of death _____			

Contact During Illness

Indicate Name, type of exposure and date of exposure if known
Family and Household: _____
Work or school: _____
Friend/Acquaintances: _____
Hospital: _____

Environmental Investigation

Source and type of infection: <input type="checkbox"/> Unknown
<input type="checkbox"/> Contact with known plague patient, Indicate ID case number if known _____
<input type="checkbox"/> Contact with someone ill in last week <input type="checkbox"/> Ingestion <input type="checkbox"/> Hunting <input type="checkbox"/> Flea bite
<input type="checkbox"/> direct animal handling, what animal? _____
was the animal? <input type="checkbox"/> healthy, <input type="checkbox"/> dead, <input type="checkbox"/> sick, or <input type="checkbox"/> unknown
<input type="checkbox"/> Other activity _____
Where is the most likely source of exposure?
<input type="checkbox"/> In or around home <input type="checkbox"/> Away from home, indicate where below
List places traveled to in last 10 days: _____
Presence of pets in the home:
<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other _____
<input type="checkbox"/> Indoor only <input type="checkbox"/> Outdoor only <input type="checkbox"/> Indoor/Outdoor
Principal habitat classification: _____
Other pertinent information: _____