

<b>P A T I E N T</b>	Last Name _____ First Name _____ MI _____ Patient's Phone Number _____			
	Street Address _____		City _____	County _____ Zip _____
	Age: _____	Date of Birth: _____	Sex: M F	
	Race: White Black Asian Native American Other _____		Hispanic: Yes No Unknown	
<b>C O U R S E</b>	Date of onset: _____ Was patient hospitalized? YES NO If YES, which hospital: _____			
	Date of admission: _____ Date of discharge: _____		Discharge diagnosis: _____	
	Recovered? YES NO Died? YES NO Date of death: _____ Sequelae? YES NO If Yes, explain in comment section			
	Attending Physician: _____ (Name)		( ) _____ (Phone 1)	( ) _____ (Phone 2)
	Address: _____ City _____ State _____ Zip _____ Document additional hospitalizations and physician data in Comment Section.			
<b>C L I N I C A L</b>	<b>Circle Response (Yes, No, Unknown):</b>			
	Fever Y N U Max temp: _____ ° F Pulse at time of max temp: _____	Anorexia Y N U	Cough Y N U	
	Chills Y N U	Severe malaise Y N U	If Yes, was Cough (Circle)	
	Headache Y N U	Weight Loss Y N U	Productive Bloody Purulent	
	Skin Lesion: Y N U <b>NOTE: Attach photo of lesion to report.</b>	Nausea/vomiting Y N U	Shortness of breath Y N U	
	If Y, Location(s): _____	Diarrhea Y N U	Pneumonia Y N U	
	Circle all that apply to Skin Lesions	Abdominal pain Y N U	Chest Pain Y N U	
	Itchy Swollen Tender Oozing	Conjunctivitis Y N U	Meningitis Y N U	
Satellite Blisters Eschar Surrounding edema	Sepsis Y N U	Other:		
	Lymphadenopathy Y N U			
<b>O T H E R  E P I D E M I O L O G Y</b>	Occupation: _____ (Give exact job, type of business or industry, location)			
	Recent military service: YES NO If YES, date of discharge: _____			
	Does the patient have a history of travel outside of home county within 15 days of onset? YES NO If yes, document travel history.			
	Does the patient work outdoors or around wildlife, exotic pets or livestock? Y N U (If Yes, document in Comments Section on reverse)			
	In the 3 weeks prior to illness, did the patient have any contact with wildlife (hunting, camping, etc)? Y N U (If Yes, document in Comments Section)			
	Has the patient been bitten by ticks or deer flies in the three weeks prior to illness? Y N U (If Yes, document in Comments Section)			
Are there exotic rodents or other pets in the patient's household? Y N U If Yes, have any of these pets been ill recently? Y N U (If Yes, document in Comments Section)				
Have any household members experienced similar symptoms recently? Y N U (If Yes, provide details)				

Patient's Name: \_\_\_\_\_

<b>S E R O L O G I C</b>	<b>Tests for</b>	<b>Date of specimen ==&gt;</b>			<b>Laboratory Name</b>	
		<b>Type of test</b>	<b>Results</b>	<b>Results</b>		
<b>C U L T U R E</b>	<b>Specimen date</b>	<b>Specimen type</b>	<b>Results</b>		<b>Laboratory Name</b>	
<b>O T H E R  L A B</b>	<b>Test</b>	<b>Specimen date</b>	<b>Results</b>	<b>Specimen Date</b>	<b>Results</b>	
	WBC					
	Diff					
	Platelets					
	SGOT					
	SGPT					
	Other (Specify)					
<b>X R A Y</b>	<b>Type</b>	<b>Date</b>	<b>Results</b>			
<b>O T H E R  C O M M E N T S</b>						

Investigated by: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

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

PHEP Surveillance Control Measure Tracking Form - **Tularemia**

NBS Patient ID: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Case Status: \_\_\_\_\_

Onset Date: \_\_\_/\_\_\_/\_\_\_

Date Reported: \_\_\_/\_\_\_/\_\_\_

Date Reported to Central Office: \_\_\_/\_\_\_/\_\_\_

Action	Public Health Control Measure Initiated	Date Initiated	Within 2 days of Report?
1. Contact medical provider. Obtain clinical data, lab reports, verify diagnosis, and provide recommendations.	<input type="checkbox"/> Provide medical provider with disinfection precautions for suspected cases.	1. ___/___/___	1. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason:
2. Alert laboratory personnel when tularemia is suspected so procedures can be conducted in recommended biosafety level conditions.	<input type="checkbox"/> Alert laboratory personnel when tularemia is suspected so procedures can be conducted in recommended biosafety level conditions.	2. ___/___/___	2. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason:
3. Consult with laboratory regarding select agent requirements for <i>Francisella tularensis</i> isolates.	<input type="checkbox"/> Educate laboratory personnel regarding select agent requirements for <i>Francisella tularensis</i> isolates including (1) Unless directed otherwise by the HHS Secretary or Administrator, within seven calendar days after identification, transfer the isolate in accordance with § 73.16 or 9 CFR part 121.16 or destroy it on-site by a recognized sterilization or inactivation process, (2) Secure the isolate against theft, loss, or release during the period between identification and transfer or destruction and report any theft, loss, or release of the isolate, and (3) Report the identification of <i>Francisella tularensis</i> to DSHS and to CDC or APHIS immediately by telephone. This report must be followed by submission of APHIS/CDC form 4 within seven calendar days after identification.	3. ___/___/___	3. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason:
4. Interview case patient. Complete patient history and identify potential source of exposure.	<input type="checkbox"/> Educate case patient on measures to avoid disease transmission. <input type="checkbox"/> Identify potential source of infection. (Describe)	4. ___/___/___	4. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason:
<b>Outbreaks</b>			
5. Initiate alerts to public health preparedness staff locally and at central office and law enforcement if there is an unusual presentation such as a cluster of cases or pneumonic illness.	<input type="checkbox"/> Report suspected outbreaks or intentional exposures. <input type="checkbox"/> Initiate bio-terrorism response procedures as needed.	5. ___/___/___	5. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason:
6. Look for additional cases and interview them to determine scope and source of outbreak.	<input type="checkbox"/> Initiate active case finding <input type="checkbox"/> Alert the medical community to enhance case recognition, reporting, and prompt treatment	6. ___/___/___	6. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason:
7. Search for sources of infection related to arthropods, animal hosts, water, and environments soiled by small mammals including hay.	<input type="checkbox"/> Conduct field studies. <input type="checkbox"/> Compare exposure histories.	7. ___/___/___	7. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason: