

Q Fever

PATIENT DEMOGRAPHICS

Name (last, first): _____		Birth date: ___/___/___	Age: _____
Address (mailing): _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk	
Address (physical): _____		Ethnicity: <input type="checkbox"/> Not Hispanic or Latino	
City/State/Zip: _____		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk	
Phone (home): _____	Phone (work/cell): _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer.	
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other		(Mark all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native	
Name: _____ Phone: _____		<input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk	

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigation Start Date: ___/___/___	Case Classification:
Earliest date reported to LHD: ___/___/___	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect
Earliest date reported to DIDE: ___/___/___	<input type="checkbox"/> Not a case <input type="checkbox"/> Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: <input type="checkbox"/> Laboratory <input type="checkbox"/> Hospital <input type="checkbox"/> HCP <input type="checkbox"/> Public Health Agency <input type="checkbox"/> Other	
Reporter Name: _____	Reporter Phone: _____
Primary HCP Name: _____	Primary HCP Phone: _____

CLINICAL

Onset date: ___/___/___	Diagnosis date: ___/___/___	Recovery date: ___/___/___
Clinical Findings Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever (Highest measured temperature: _____ °F) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rigors <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Retrobulbar pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Acute hepatitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pneumonia (CXR confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Culture-negative endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Suspected infection of a vascular aneurysm <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Suspected infection of a vascular prosthesis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic hepatitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic osteomyelitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic osteoarthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic pneumonitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Absence of other known etiology <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diagnosed as Q fever (specify: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic)		Clinical Findings (continued) Y N U Y N U Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Malaise <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rash <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Myalgia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Splenomegaly <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatomegaly Clinical Risk Factors Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Immunocompromised <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Valvular heart disease or vascular graft Hospitalization Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient hospitalized for this illness If yes, hospital name: _____ Admit date: ___/___/___ Discharge date: ___/___/___ Death Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient died due to this illness If yes, date of death: ___/___/___

VACCINATION HISTORY

Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Previously received Q fever vaccine If yes, date: ___/___/___
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TREATMENT

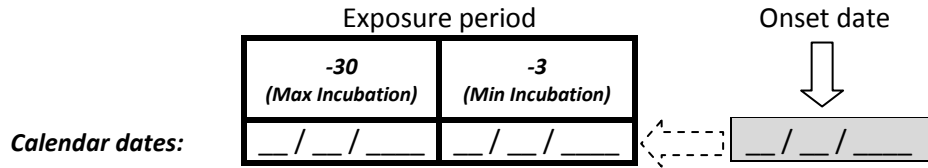
Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient received antibiotic therapy for this infection If yes, type: _____ Duration: _____

LABORATORY (Please submit copies of all labs, including metabolic panels associated with this illness to DIDE)

Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elevated liver enzymes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fourfold change in IgG-specific antibody titer to <i>C. burnetii</i> phase II antigen by IFA between paired serum specimens <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Detection of <i>C. burnetii</i> DNA in a clinical specimen via amplification of a specific target by PCR assay <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Demonstration of <i>C. burnetii</i> antigen in a clinical specimen by immunohistochemical (IHC) methods <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Isolation of <i>C. burnetii</i> from a clinical specimen by culture <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Single IFA IgG titer of $\geq 1:128$ to phase II antigen <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Serologic evidence of elevated IgG or IgM antibody reactive with <i>C. burnetii</i> antigen by ELISA, dot-ELISA, or latex agglutination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Serological evidence of IgG antibody to <i>C. burnetii</i> phase I antigen $\geq 1:800$ by IFA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <i>C. burnetii</i> phase I titer $>$ <i>C. burnetii</i> phase II titer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Antibody titer to <i>C. burnetii</i> phase I IgG antigen $\geq 1:128$ and $< 1:800$ by IFA

INFECTION TIMELINE

Instructions: Enter onset date in grey box. Count backward to determine probable exposure period



EPIDEMIOLOGIC EXPOSURES (based on the above exposure period, unless otherwise noted)

Y N U

History of travel during exposure period up to **one year** (if yes, complete travel history below):

Destination (City, County, State and Country)	Arrival Date	Departure Date	Reason for Travel

Possible occupational exposure (indicate occupation at date of illness onset below):

- | | | | | |
|--|---|--|---|---------------------------------------|
| <input type="checkbox"/> Wool or felt plant | <input type="checkbox"/> Tannery or rendering plant | <input type="checkbox"/> Dairy | <input type="checkbox"/> Animal research | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Laboratory worker | <input type="checkbox"/> Slaughterhouse worker | <input type="checkbox"/> Rancher | <input type="checkbox"/> Medical research | |
| <input type="checkbox"/> Lives with a person who works in any of the specified occupations | | <input type="checkbox"/> Other occupation: _____ | | |

Contact with animals in **2 months** prior to illness onset

If yes, specify: Cattle Sheep Goats Pigeons Cats Rabbits Other: _____

Contact with birthing animals

If yes, specify: Animal: _____ Date: __/__/__ Location: _____

Consumption of unpasteurized milk

If yes, specify: Animal: _____ Date: __/__/__ Location: _____

Family members ill with similar illness in past **year**

Organ or tissue transplant recipient

If yes, date: __/__/__

Blood transfusion or blood products recipient

If yes, date: __/__/__

Where did exposure most likely occur? County: _____ State: _____ Country: _____

PUBLIC HEALTH ISSUES

Y N U

- Case donated blood products, organs or tissue in the 30 days prior to symptom onset
Date: __/__/__
Agency/location: _____
Type of donation: _____
- Case is pregnant (Due date: __/__/__)
- Case knows someone who had shared exposure and is currently having similar symptoms
- Epi link to another confirmed case of same condition
- Case is part of an outbreak
- Other:

PUBLIC HEALTH ACTIONS

Y N U

- Notify blood or tissue bank or other facility where organs donated
- Notify patient obstetrician
- Disease education and prevention information provided to patient and/or family/guardian
- Outreach provided to employer to reduce employee risk
- Facilitate laboratory testing of other symptomatic persons who have a shared exposure
- Patient is lost to follow-up
- Other:

WVEDSS

Y N U

Entered into WVEDSS (Entry date: __/__/__) Case Status: Confirmed Probable Suspect Not a case Unknown

NOTES

