

Case ID PID-3 _____

First Name: _____

Last Name: _____

PSITTACOSIS HUMAN CASE SURVEILLANCE REPORTGENERIC MMGPsittacosis RIBD_V1.0_MMG_F_20191003

Investigation Information				
Report Date 77995-9 ____/____/_____ MM/DD/YYYY	Patient Status <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Deceased	Diagnosis Date 77975-1 ____/____/_____ MM/DD/YYYY	Onset Date 11368-8 ____/____/_____ MM/DD/YYYY	
Patient Information				
Patient ID (State or Local HD) 77993-4	Last Name	First Name	Middle Name	
Street Address				
City PID-11.3	County PID-11.9	State PID-11.4	Zip PID-11.5	
Home Phone (Ext.) ###-###-####	Current Occupation 85658-3	Other Phone <input type="checkbox"/> Work <input type="checkbox"/> Business <input type="checkbox"/> Cell ###-###-####	Ext.	
If Patient <18 yrs:				
Parent/Guardian Last Name		First Name	Middle Name	
Demographics				
Sex PID-8 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth PID-7 ____/____/_____ MM/DD/YYYY	Age 77998-3 _____ <input type="checkbox"/> Years <input type="checkbox"/> Months	OBX-6 for 77998-3	
Race PID-10 <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) 32624-9 _____				
Ethnicity PID-22 <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown			If female, pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No 77996-7	
Report Information				
Person Providing Report				
First 74549-7	Last 74549-7	Phone 74548-9 ###-###-####	Ext.	Email 74547-1
City	County 77967-8	State 77969-4	Zip 52831-5	City
Primary Physician				
First	Last	Phone ###-###-####	Ext.	Email
Street Address				
City	County	State	Zip	

Clinical Information			
Brief clinical description (Symptoms and signs 56831-1, note maximum temperature, etc.) <input type="checkbox"/> Fever; Maximum temperature: 81265-1 _____ <input type="checkbox"/> F <input type="checkbox"/> C OBX-6 for 81265-1 <input type="checkbox"/> Cough INV919 <input type="checkbox"/> Pneumonia (<input type="checkbox"/> CXR confirmed or <input type="checkbox"/> clinical diagnosis) <input type="checkbox"/> Myalgia <input type="checkbox"/> Rash <input type="checkbox"/> Chills <input type="checkbox"/> Photophobia <input type="checkbox"/> Headache <input type="checkbox"/> Other (describe/details): _____			
Specific Therapy: (Specify products, dosage, and dates 86948-7 of treatment)			
Outcome: <input type="checkbox"/> Hospitalized 77974-4 <input type="checkbox"/> Required ICU care 309904001 <input type="checkbox"/> Recovered <input type="checkbox"/> Unknown Date of discharge ____/____/____ 8649-6 <div style="text-align: center; font-size: small;">MM/DD/YYYY</div>		If patient died, date of death: PID-29 ____/____/____ <div style="text-align: center; font-size: small;">MM/DD/YYYY</div>	
Laboratory Information			
Test Name/Test Method INV290	Date Specimen Collected MM/DD/YYYY 68963-8	Test Result INV291	Name of Laboratory 68994-3
<i>C. psittaci</i> PCR (preferred) LAB696 <input type="checkbox"/> blood <input type="checkbox"/> sputum <input type="checkbox"/> other (specify): _____	____/____/____		
Respiratory secretions <i>C. psittaci</i> culture (preferred) LAB695 <input type="checkbox"/> sputum <input type="checkbox"/> BAL <input type="checkbox"/> other (specify): _____	____/____/____		
<i>C. psittaci</i> Fourfold increase in antibody titer Acute-phase serum LAB698 <input type="checkbox"/> CF <input type="checkbox"/> MIF LAB654 <input type="checkbox"/> Other (specify) _____ Convalescent-phase serum LAB698 <input type="checkbox"/> CF <input type="checkbox"/> MIF LAB654 <input type="checkbox"/> Other (specify) _____	____/____/____	IgM: _____ IgG: _____	
<i>C. pneumoniae</i> PCR LAB696 <input type="checkbox"/> blood <input type="checkbox"/> sputum <input type="checkbox"/> other (specify): _____	____/____/____		
<i>C. pneumoniae</i> Fourfold increase in antibody titer Acute-phase serum LAB698 <input type="checkbox"/> CF <input type="checkbox"/> MIF LAB654 <input type="checkbox"/> Other (specify) _____ Convalescent-phase serum LAB698 <input type="checkbox"/> CF <input type="checkbox"/> MIF LAB654 <input type="checkbox"/> Other (specify) _____	____/____/____	IgM: _____ IgG: _____	

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<i>Chlamydia trachomatis</i> [any test(s)]	___/___/___		
Autopsy <input type="checkbox"/> lung <input type="text" value="127458004"/> <input type="checkbox"/> other: <input type="text" value="OTH"/> _____	<input type="text" value="75711-2"/> ___/___/___	<input type="text" value="85691-4"/>	<input type="text" value="LAB656"/>
Chest X-ray done: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, date: <input type="text" value="INV1096"/> ___/___/___ MM/DD/YYYY	If yes, results: <input type="text" value="INV923"/>	

Epidemiologic Information (cont'd. on the next page)

Occupation at date of onset: <input type="text" value="INV1099"/>	Specific duties: <input type="text" value="INV1098"/>
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At the time of exposure which of the following personal protective equipment was the patient using?

Respiratory Protective Equipment: Surgical mask Filtering piece/N95

Elastomeric – half face or full face (with cartridges) – specify types of cartridges if known

N or P 95

N or P 99 or 100

Other: _____

▪ Does the patient get annual respirator fit testing and training ___ Yes ___ No

Gloves (if known, specify the material by circling the appropriate from the list below)

- Plastic (latex or nitrile)
- Cloth
- Leather
- Double gloves, i.e., nitrile underneath, leather over (describe) _____

Goggles

Face shield

Rubber boots/disposable overshoes

Disposable surgical cap

Overalls

No personal protective equipment was being used

Other (describe details): _____

Indicate which of the following contacts the patients had during the 5 weeks prior to onset:

(Check all that apply)

Birds Human case of psittacosis (specify) _____

Other (specify) _____ No known exposure

If exposure to birds, complete the following table:

Type of Bird <input type="text" value="INV1051"/>	Species <input type="text" value="INV1052"/>	Approximate Number <input type="text" value="INV1053"/>	Were birds healthy? <input type="text" value="INV1054"/> (Y=Yes N=No UNK=Unknown)
Psittacines* <input type="text" value="107100000"/>			
Pigeons <input type="text" value="422719004"/>			
Domestic fowl <input type="text" value="359839008"/>			
Other birds <input type="text" value="OTH"/>			

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If birds were not healthy, please elaborate: INV1055

*Psittacine Birds include: Cockatoos, Cockatiels, Macaws, Parakeets, Conures, Parrots

Indicate where the exposure may have occurred. If the patient had multiple contacts, specify to what they were exposed at each place of exposure.

Type of Establishment INV1102	Owner of Establishment	Address of Establishment INV1057	Exposure To (Species) INV1052	Exposure Setting 81267-7	Date of Exposure INV1058
1=Private home 2=Private aviary 3=Commercial aviary 4=Pet shop 5=Pigeon loft 6=Poultry establishment (specify processor or farm) 7=Bird fair show 8=Backyard poultry 9=Healthcare 10=Long term Nursing Home 11=Swap meet 12=Other 13=Unknown				I = Indoors O = Outdoors	

If other, specify:

If pet birds, domestic pigeons, or fowl are implicated as the source of the human psittacosis, or if any such bird is shown by laboratory methods to be infected, it is important to learn where these birds originated and where they were subsequently purchased or obtained by the present owner. These birds may have acquired a latent form of the infection at any place where they have been detained since hatching.

List the address of every known place where the birds were harbored, including approximate dates.

Additional Relevant Information

Submitted By:	Date: 77970-2 ____/____/_____ MM/DD/YYYY	Health Dept. 48766-0
Phone Number: ###-###-####	Ext.	