MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SUSPECT TULAREMIA CASE INVESTIGATION FORM

Today's date: ____/____/_____ **ID :**

Patient name **First** _____ **Last** _____

Sex: ☐ **Male** ☐ **Female**	**Date of birth:**___/___/____	**Age:** _____
Home address:	**Zip:**	**Phone 1:**
City/Borough:	**County::**	**Phone 2:**
Employer:	**Occupation:**	**Work location:**
Work address:	**Zip:**	**Phone:**
City/Borough	**County:**	

Any recent travel outside of MO? **Y** **N** **Unknown** **If yes, where and when:**

MEDICAL HISTORY: **Dr.'s name and contact info:**

Has patient experienced any of the following symptoms for the first time since _____**?**
(Circle one answer for each symptom)

New onset skin lesions (i.e., rash, papule, ucler, vesicle, pustule, purpuric lesions)?

Y **N** **Unknown** **Onset date:** _____/_____/_____

Location of lesion(s):		**Initial description:**	**Progression:**
		Date **Notes**	**Date** **Notes**
Itchy	**Y N Unk**		
Swollen	**Y N Unk**		
Tender	**Y N Unk**		
Oozing	**Y N Unk**		
Satellite blisters	**Y N Unk**		
Eschar	**Y N Unk**		
Surrounding Edema	**Y N Unk**		

Fever	**Y**	**N**	**Unknown**	**If yes, max temp:** _____ **F**	**Onset date:** _____/_____/_____
Chills	**Y**	**N**	**Unknown**		**Onset date:** _____/_____/_____
Malaise	**Y**	**N**	**Unknown**		**Onset date:** _____/_____/_____
Muscle aches	**Y**	**N**	**Unknown**		**Onset date:** _____/_____/_____
Headache	**Y**	**N**	**Unknown**		**Onset date:** _____/_____/_____
Pharyngitis/Tonsillitis	**Y**	**N**	**Unknown**		**Onset date:** _____/_____/_____
Diaphoresis	**Y**	**N**	**Unknown**		**Onset date:** _____/_____/_____
Weight loss	**Y**	**N**	**Unknown**		**Onset date:** _____/_____/_____

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Pulse-temperature dissociation	**Y N Unknown**	**Onset date: _____/_____/_____**
Cough	**Y N Unknown** ☐ **Productive** ☐ **Bloody** ☐ **Purulent**	**Onset date: _____/_____/_____**
Chest pain/discomfort	**Y N Unknown**	**Onset date: _____/_____/_____**
Shortness of breath	**Y N Unknown**	**Onset date: _____/_____/_____**
Pneumonia	**Y N Unknown**	**Onset date: _____/_____/_____**
Respiratory distress	**Y N Unknown**	**Onset date: _____/_____/_____**
Abdominal pain	**Y N Unknown**	**Onset date: _____/_____/_____**
Nausea/vomiting	**Y N Unknown**	**Onset date: _____/_____/_____**
Diarrhea	**Y N Unknown** ☐ **Bloody**	**Onset date: _____/_____/_____**
Lymphadenopathy	**Y N Unknown If yes, where? _____** ☐ **Painful**	**Onset date: _____/_____/_____**
Conjunctivitis	**Y N Unknown If yes, where? _____**	**Onset date: _____/_____/_____**
Sepsis	**Y N Unknown**	**Onset date: _____/_____/_____**
Meningitis ☐ **Hemorrhagic**	**Y N Unknown**	**Onset date: _____/_____/_____**
Other signs/symptoms:		

Care:	**Name and Location**	**Date of visit/consult:**	**Comments**
☐ **Admitted to hospital:**	_____		
☐ **Seen by PMD:**	_____		
☐ **Seen by ID:**	_____		
☐ **Other** _____			

Antibiotics given? **Y N Unknown**

If yes, give name:_____

_____

Dose: _____

Start date: _____ **Stop date:**_____

Other Treatment given? **Y N Unknown**

If yes, describe:

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Current clinical status	☐ **Improved**	☐ **No change**	☐ **Worsened**	☐ **Back to baseline**
Describe progression:				
Disposition	☐ **Discharged**	☐ **Admitted to ward**	☐ **Admitted to ICU**	☐ **Outpatient** ☐ **Died**
			If died, date of death	_____/ _____/ _____
Current diagnosis	☐ **Tularemia**			
	☐ **Pneumonic**	☐ **Typhoidal**	☐ **Ulceroglandular**	
	☐ **Glandular**	☐ **Oculoglandular**	☐ **Oropharyngeal**	
	☐ **Non-Specific Febrile Illness**			
	☐ **Pneumonia of Unknown Etiology**			
	☐ **Other (specify)** _____			
	_____			

LABORATORY SPECIMENS OBTAINED:				
Blood/serum	**Y**	**N**	**Unknown**	**Status:** ☐ **at hospital** ☐ **sent to SPHL** ☐ **sent to CDC**
Tracheal/lung aspirate	**Y**	**N**	**Unknown**	**Status:** ☐ **at hospital** ☐ **sent to SPHL** ☐ **sent to CDC**
Sputum	**Y**	**N**	**Unknown**	**Status:** ☐ **at hospital** ☐ **sent to SPHL** ☐ **sent to CDC**
Skin biopsy or skin lesion material	**Y**	**N**	**Unknown**	**Status:** ☐ **at hospital** ☐ **sent to SPHL** ☐ **sent to CDC**
Conjunctival exudate	**Y**	**N**	**Unknown**	**Status:** ☐ **at hospital** ☐ **sent to SPHL** ☐ **sent to CDC**
Pharyngeal exudate	**Y**	**N**	**Unknown**	**Status:** ☐ **at hospital** ☐ **sent to SPHL** ☐ **sent to CDC**
CSF	**Y**	**N**	**Unknown**	**Status:** ☐ **at hospital** ☐ **sent to SPHL** ☐ **sent to CDC**
Other	**Describe:**			

Specimens available now?	**Y N Unknown**
	If yes, what is available and where?

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LAB RESULTS:					
Specimen	**Date Obtained**	**Test Ordered**	**Laboratory**	**Result**	**Current Location of Specimen**
Blood/serum					
Tracheal/lung aspirate					
Sputum					
Skin biopsy or skin lesion material					
Conjunctival exudate					
Pharyngeal exudate					
CSF					
Other, specify					
Other, specify					
Other, specify					

OTHER DIAGNOSTIC TESTS:	
Chest x-ray	**Y N Unknown** **If yes, describe findings:**
Other	**Describe:**

ENVIRONMENTAL SAMPLING/TESTING			
Location of Specimen	☐ **Residence**	☐ **Work Place**	☐ **Other, specify** _____
Type of Specimen(s)			
Where was specimen(s) collected			
Date(s) collected			
Type of test(s) performed			
Result(s) of test(s)			
Date(s) of test result(s)			
Name of laboratory performing test(s)			
Address of Laboratory performing test(s)			
Telephone number of laboratory performing test(s)			

ACTIVITIES DURING THE THREE WEEKS PRIOR TO ONSET OF SIGNS/SYMPTOMS

This section of the questionnaire should be completed for activities that took place at a second residence, at work, during recent travel outside home town or city, at sporting events, at religious meetings, at recreational events, at volunteer activities, at other meetings/events, at other outdoor activities and while doing hobby activities.

Month																						
Date for past three weeks ®																						
Day of the week* ®																						
Residence 2 (e.g., vacation home) Location (address):																						
Work 1: Location: Shift: % time outdoors:																						
Work 2: Location: Shift: % time outdoors:																						
Recent travel 1 outside home town or city describe:	Location:																					
Recent travel 2 outside home town or city describe:	Location:																					
Sporting Event 1 describe:	Location:																					
Sporting Event 2, describe:	Location:																					
Religious Meeting 1, describe:	Location:																					

*Use following acronyms: S=Sunday, M=Monday, T=Tuesday, W=Wednesday, Th=Thursday, F=Friday and Sa=Saturday.

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Date for past three weeks ®																						
Day of the week* ®																						
Religious Meeting 2, describe:	Location:																					
Recreational Event 1, describe:	Location:																					
Recreational Event 2, describe:	Location:																					
Volunteer Activity 1, describe:	Location:																					
Volunteer Activity 2, describe:	Location:																					
Other Meetings/Events 1, describe:	Location:																					
Other Meetings/Events 2, describe:	Location:																					
Other Outdoor Activity 1, describe:	Location:																					
Other Outdoor Activity 2, describe:	Location:																					
Hobby Activity 1, describe:	Location:																					
Hobby Activity 2, describe:	Location:																					

*Use following acronyms: S=Sunday, M=Monday, T=Tuesday, W=Wednesday, Th=Thursday, F=Friday and Sa=Saturday.

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POTENTIAL RISK EXPOSURES

YES	NO	UNK	
☐	☐	☐	**Contact With Animals** **If yes, describe** _____
☐	☐	☐	**Occupational Associated With Animals** **If yes, describe** _____
☐	☐	☐	**Own Pets** **If yes, describe** _____
☐	☐	☐	**Contact With Rats, Mice, Ground Squirrels, Rabbits, Prairie Dogs, Chipmunks or Other Small Mammals** **If yes, describe** _____
☐	☐	☐	**Presence of Rats, Mice, or Other Small Mammals in Home or Place of Work** **If yes, describe** _____
☐	☐	☐	**Hobbies** **If yes, describe** _____

OTHER POTENTIAL RISK EXPOSURES IN THE 3 WEEKS PRIOR TO ONSET OF SIGNS/SYMPTOMS

YES	NO	UNK	
☐	☐	☐	**Presence of Rats. Mice, or Other Small Mammals in Any Locations Visited in the 3 Weeks Prior to Onset of Signs/Symptoms** **If yes, describe** _____
☐	☐	☐	**Contact With Ticks, Mosquitoes, or Biting Flies** **If yes, describe** _____
☐	☐	☐	**Hunting Trips** **If yes, describe** _____
☐	☐	☐	**Trap Animals** **If yes, describe** _____
☐	☐	☐	**Butcher Animals** **If yes, describe** _____
☐	☐	☐	**Hiking Trips** **If yes, describe** _____
☐	☐	☐	**Camping Trips** **If yes, describe** _____
☐	☐	☐	**Contact With Hay or Straw** **If yes, describe** _____
☐	☐	☐	**Contact With Unusual Powders, Dusts, or Aerosols** **If yes, describe** _____
☐	☐	☐	**Any Unusual Occurrences** **If yes, describe** _____

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ASSOCIATED CASES

YES	NO	UNK	
☐	☐	☐	**Contact (within 3 weeks of onset of illness) With Persons With a Febrile, Flu-Like, and/or Respiratory Illness, or an Ulcerated Skin Lesion** **Name(s)**_____ **Address(es) or Other Locating Information**_____ **Description of Illness(es)**_____ **Date(s) of Onset (if known)**_____
☐	☐	☐	**Patient/Family Aware of Other Persons With a Febrile, Flu-Like, and/or Respiratory Illness or an Ulcerated Skin Lesion** **Name(s)**_____ **Address(es) or Other Locating Information**_____ **Description of Illness(es)**_____ **Date(s) of Onset (if known)**_____
☐	☐	☐	**Other Associated Cases** **Number**_____ **Describe Association With Patient**_____

Name of person completing form:	**Phone:**

1. **Phone and Fax numbers at Missouri Department of Health and Senior Services (MDHSS)** Emergency Response Center**: Ph: 1-800-392-0272, FAX: 573-526-8389.**
2. **If further information becomes available on this patient, ask them to call the Division of Environmental Health and Communicable Disease Prevention (573-751-6113) during business hours, or after hours, call Department Emergency Response Management Center (1-800-392-0272) and ask for the on call officer.**
3. **If there are any questions by the provider re: prophylaxis or specimen preparation, refer them to or fax them the appropriate MDHSS Alert** or CDC web site or information.