

PLAGUE CASE INVESTIGATION REPORT

Date of Report

| | | |
|-----|-----|------|
| Mo. | Day | Year |
| | | |

PATIENT IDENTIFICATION

| | | | | | | | | | |
|---|-----|---|---|---|--|-----|--|--|--|
| Name (last, first, M.I.) _____ | | Telephone No. _____ | | | | | | | |
| | | (Area Code) _____ | | | | | | | |
| Address _____ | | City _____ | State _____ | | | | | | |
| | | County _____ | | | | | | | |
| AGE <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> | | | SEX 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female | RACE 1 <input type="checkbox"/> White (not Hispanic) 2 <input type="checkbox"/> Black (not Hispanic) 3 <input type="checkbox"/> Hispanic 4 <input type="checkbox"/> Asian or Pacific Islander | 5 <input type="checkbox"/> Amer. Indian or Alaskan 6 <input type="checkbox"/> Unspecified | | | | |
| | | | | | | | | | |
| Date Hospitalized | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; text-align: center;">Mo.</td> <td style="width: 20px; text-align: center;">Day</td> <td style="width: 20px; text-align: center;">Yr.</td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> | | Mo. | Day | Yr. | | | |
| Mo. | Day | Yr. | | | | | | | |
| | | | | | | | | | |
| Person making call _____ | | Person taking call _____ | | | | | | | |
| Agency _____ | | Agency _____ | | | | | | | |
| Telephone (Area Code) _____ | | Telephone (Area Code) _____ | | | | | | | |

Has local health department been notified? Yes No If Yes, give name and address of person contacted.

Physician(s) _____ Telephone(s) (Area Code) _____

City _____ Hospital _____ Telephone (Area Code) _____

ILLNESS

Date of Onset of Illness

| | | |
|-----|-----|-----|
| Mo. | Day | Yr. |
| | | |

 Symptoms: _____

Signs

Temperature _____ R _____ BP _____ P _____ Date

| | | |
|-----|-----|-----|
| Mo. | Day | Yr. |
| | | |

Bubo Inguinal Femoral Other Size (cm) Describe _____
 Cervical Axillary --R --L Tender Yes No Erythema Yes No

Skin Ulcer Yes No Location _____ Insect Bite(s) Yes No Location _____

Cough? Yes No Date of Onset of Cough

| | | |
|-----|-----|-----|
| Mo. | Day | Yr. |
| | | |

 Cough productive? Yes No

Current condition and prognosis: _____

Outcome: Survived Discharge date

| | | |
|-----|-----|-----|
| Mo. | Day | Yr. |
| | | |

 Died Autopsy: Yes No (If yes, please attach autopsy report.)

PRIVACY ACT STATEMENT

The Centers for Disease Control, an Agency of the Department of Health and Human Services, is authorized to solicit this information under provisions of the Public Health Service Act, Section 301, (42 U.S.C. 241). Response in this case is voluntary, and there is no penalty for non response. The information requested is considered relevant and necessary to the investigation of health problems associated with plague. The individually-identified data requested may be shared with health departments and other public health or cooperating medical authorities. An accounting of such disclosures will be made available to the subject individual upon request.

LABORATORY

Chest X-ray Yes No Unknown Pneumonia Yes No Unknown Date Mo. Day Yr.

WBC Count _____ Left Shift --- Yes -- No Bands _____ Polys _____ Lymph _____

Mono _____ Eos _____ Bas _____

Bacteria on blood smear? Yes No Don't know _____

Blood cultures taken? Yes No How many? _____ Results? _____

| | | | | | | | |
|---|--|--------------------------|--------------------------|--|--|--------------------------|--------------------------|
| Bubo Aspirate: <input type="checkbox"/> Yes <input type="checkbox"/> No | | POS. | NEG. | Sputum: <input type="checkbox"/> Yes <input type="checkbox"/> No | | POS. | NEG. |
| Date | <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Yr. | <input type="checkbox"/> | <input type="checkbox"/> | Date | <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Yr. | <input type="checkbox"/> | <input type="checkbox"/> |
| | Gram Stain | <input type="checkbox"/> | <input type="checkbox"/> | | Gram Stain | <input type="checkbox"/> | <input type="checkbox"/> |
| | Wayson Stain (or Wright's, Giemsa) | <input type="checkbox"/> | <input type="checkbox"/> | | Wayson Stain (or Wright's, Giemsa) | <input type="checkbox"/> | <input type="checkbox"/> |
| | FA (Plague) | <input type="checkbox"/> | <input type="checkbox"/> | | FA (Plague) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Culture | <input type="checkbox"/> | <input type="checkbox"/> | | Culture | <input type="checkbox"/> | <input type="checkbox"/> |

Serologies:

S₁ result _____ Date(s) Serum Drawn Mo. Day Yr.

S₂ result _____ Mo. Day Yr.

ANTIBIOTICS

| Treatment | Date Started Mo. Day | Date Stopped Mo. Day | Dosage & Schedule |
|-----------|---|---|-------------------|
| 1 _____ | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 1. _____ |
| 2 _____ | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 2. _____ |
| 3 _____ | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 3. _____ |

Isolation: Respiratory Wound precautions only None

EPIDEMIOLOGY

Whereabouts during 10 days before onset on (dates) (Include all outdoor activities):

Other persons ill after same exposure? Names and whereabouts:

Did patient handle sick or dead rodents, rabbits, or other animals? Yes No If so, where? _____

Patient recall flea or other insect bites? Yes No Contact with human plague patient? Yes No

Wild animal contact, including hunting? Yes No Contacts or relatives who died in past week? Yes No

Pets (kind and number) _____

Illness in pets? Yes No Describe: _____

Pets free roaming? Yes No Don't know

EPIDEMIOLOGY (Cont'd.)

| Community Contacts During Illness: Name* | Location and Time (Setting and Circumstances) | Date |
|---|--|------|
| a) Family and household: | | |
| b) Work or school: | | |
| c) Friends/acquaintances: | | |
| d) Hospital: | | |

*When a group too large to list is involved, the location, setting, time and date will allow relevant persons to be traced (e.g., church, school, social activities, etc.)

To carry out field investigation in the home or work area, it would be helpful to get permission to enter and work on private property.

Who should be contacted for such permission? Name: _____ Telephone No.: _____
(Area Code)