Tularemia Case Investigation Form

Local record ID: _____

State of patient residence: _____

County of patient residence: _____

Case classification:

Current case definition can be found at https://ndc.services.cdc.gov/case-definitions/tularemia/

◯ Confirmed ◯ Probable ◯ Suspect ◯ Not a case

Sex:

◯ Female ◯ Male ◯ Unknown

Birth date: _____

Age: *(specify units if not years)* _____

Ethnic group:

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Other ◯ Unknown

Current occupation:

_____

Race: *(select all that apply)*

◯ White ◯ Black or African American
◯ Asian ◯ American Indian or Alaska Native
◯ Native Hawaiian or Other Pacific Islander ◯ Unknown
◯ Other, specify: _____

Onset and Hospitalization Information

Date of illness onset: _____

Date first seen by a medical professional: _____

Date reported: _____

Patient pregnant?

◯ Yes ◯ No ◯ Unknown

Patient hospitalized?

◯ Yes ◯ No ◯ Unknown

Admission date: _____

Discharge date: _____

Patient died?

◯ Yes ◯ No ◯ Unknown

Deceased date: _____

Underlying Health Conditions

Condition	Yes/No/Unknown	Additional Comments
Cancer	◯ Yes ◯ No ◯ Unknown	
Chronic kidney disease	◯ Yes ◯ No ◯ Unknown	
Chronic liver disease	◯ Yes ◯ No ◯ Unknown	
Diabetes	◯ Yes ◯ No ◯ Unknown	
History of transplant	◯ Yes ◯ No ◯ Unknown	
Immunosuppression	◯ Yes ◯ No ◯ Unknown	
Other, specify: _____	◯ Yes ◯ No ◯ Unknown	

Clinical Findings

Primary clinical form:

◯ Glandular ◯ Oculoglandular ◯ Oropharyngeal ◯ Pneumonic ◯ Typhoidal ◯ Ulceroglandular ◯ Unknown

◯ Other, specify: _____

Signs and Symptoms	Yes/No/Unknown	Additional Comments
Abdominal pain	◯ Yes ◯ No ◯ Unknown	
Altered mental status	◯ Yes ◯ No ◯ Unknown	
Chest pain	◯ Yes ◯ No ◯ Unknown	
Conjunctivitis	◯ Yes ◯ No ◯ Unknown	
Cough	◯ Yes ◯ No ◯ Unknown	
Diarrhea	◯ Yes ◯ No ◯ Unknown	
Fever	◯ Yes ◯ No ◯ Unknown	
Lesion or wound	◯ Yes ◯ No ◯ Unknown	
Lymphadenopathy	◯ Yes ◯ No ◯ Unknown	

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Signs and Symptoms	Yes/No/Unknown	Additional Comments
Pharyngitis	◯ Yes ◯ No ◯ Unknown	
Shortness of breath	◯ Yes ◯ No ◯ Unknown	
Vomiting	◯ Yes ◯ No ◯ Unknown	
Other, specify: _____	◯ Yes ◯ No ◯ Unknown	

Relevant Antimicrobial Treatment

Medications	Yes/No/Unknown	Date Started	Additional Comments
Amikacin	◯ Yes ◯ No ◯ Unknown		
Azithromycin	◯ Yes ◯ No ◯ Unknown		
Ciprofloxacin	◯ Yes ◯ No ◯ Unknown		
Doxycycline	◯ Yes ◯ No ◯ Unknown		
Gentamicin	◯ Yes ◯ No ◯ Unknown		
Levofloxacin	◯ Yes ◯ No ◯ Unknown		
Minocycline	◯ Yes ◯ No ◯ Unknown		
Moxifloxacin	◯ Yes ◯ No ◯ Unknown		
Ofloxacin	◯ Yes ◯ No ◯ Unknown		
Plazomicin	◯ Yes ◯ No ◯ Unknown		
Tetracycline	◯ Yes ◯ No ◯ Unknown		
Tobramycin	◯ Yes ◯ No ◯ Unknown		
Other, specify: _____	◯ Yes ◯ No ◯ Unknown		

Exposures

Exposure state: _____

Exposure county: _____

Exposure associated with occupation?

◯ Yes ◯ No ◯ Unknown

Arthropod bite?

◯ Yes ◯ Suspected ◯ No ◯ Unknown

Type of arthropod: *(select all that apply)*

☐ Deerfly ☐ Tick ☐ Unknown

Outdoor work/activities?

◯ Yes ◯ Suspected ◯ No ◯ Unknown

Type of outdoor work/activity: *(select all that apply)*

☐ Gardening ☐ Aerosol-generating activity *(mowing, pressure washing, etc.)*

☐ Unknown ☐ Other, specify: _____

Direct animal contact? ◯ Yes ◯ Suspected ◯ No ◯ Unknown

Type of animal: *(select from dropdown)*	**Type of contact:** *(select from dropdown)*

Consumption of wild game meat?

◯ Yes ◯ Suspected ◯ No ◯ Unknown

Ingestion of or exposure to potentially contaminated water?

◯ Yes ◯ Suspected ◯ No ◯ Unknown

Transplant recipient?

◯ Yes ◯ Suspected ◯ No ◯ Unknown

Other?

◯ Yes ◯ Suspected ◯ No ◯ Unknown

Specify: _____

Any other details associated with exposure:

Imaging and Laboratory Testing

Imaging conducted? ◯ Yes ◯ No ◯ Unknown **Imaging date:** _____

Imaging result: *(select all that apply)*

☐ Normal ☐ Abnormal; not otherwise specified ☐ Hilar adenopathy ☐ Lobar consolidation ☐ Pleural effusion ☐ Pulmonary infiltrates/bilateral
☐ Pulmonary infiltrates/unilateral ☐ Pulmonary nodules ☐ Unknown ☐ Other, specify: _____

Laboratory Test 1

Test type: *(select only one)*

◯ Culture ◯ IHC ◯ PCR ◯ Sequencing ◯ Serology
◯ Other, specify: _____

Date of specimen collection: _____

Specimen type: *(select only one)*

◯ Blood ◯ CSF ◯ Serum ◯ Tissue ◯ Ulcer/Skin Wound
◯ Other, specify: _____

Test result: ◯ Positive ◯ Negative ◯ Unknown

Test result comments:

Laboratory Test 2

Test type: *(select only one)*

◯ Culture ◯ IHC ◯ PCR ◯ Sequencing ◯ Serology
◯ Other, specify: _____

Date of specimen collection: _____

Specimen type: *(select only one)*

◯ Blood ◯ CSF ◯ Serum ◯ Tissue ◯ Ulcer/Skin Wound
◯ Other, specify: _____

Test result: ◯ Positive ◯ Negative ◯ Unknown

Test result comments:

Laboratory Test 3

Test type: *(select only one)*

◯ Culture ◯ IHC ◯ PCR ◯ Sequencing ◯ Serology
◯ Other, specify: _____

Date of specimen collection: _____

Specimen type: *(select only one)*

◯ Blood ◯ CSF ◯ Serum ◯ Tissue ◯ Ulcer/Skin Wound
◯ Other, specify: _____

Test result: ◯ Positive ◯ Negative ◯ Unknown

Test result comments:

Laboratory Test 4

Test type: *(select only one)*

◯ Culture ◯ IHC ◯ PCR ◯ Sequencing ◯ Serology
◯ Other, specify: _____

Date of specimen collection: _____

Specimen type: *(select only one)*

◯ Blood ◯ CSF ◯ Serum ◯ Tissue ◯ Ulcer/Skin Wound
◯ Other, specify: _____

Test result: ◯ Positive ◯ Negative ◯ Unknown

Test result comments:

Comments

Use this field, if needed, to communicate anything unusual about this case which is not already covered in other sections. Do not include any personally identifiable information (PII).

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