Plague

Agency:

Investigator:

Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom:
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: *Yersinia pestis* Antigen:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Negative ☐ Positive
Organism: *Yersinia pestis* Antigen:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Negative ☐ Positive
Organism: *Yersinia pestis* Antigen:

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type:
Handle food: ☐ Yes ☐ No ☐ Unknown Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown Direct patient care duties in
Attend school: ☐ Yes ☐ No ☐ Unknown lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown Health care worker type:

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type:
Handle food: ☐ Yes ☐ No ☐ Unknown Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown Direct patient care duties in
Attend school: ☐ Yes ☐ No ☐ Unknown lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____
Admission date: / / Discharge date: / / Days hospitalized: _____
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Type: Bubonic ☐ Yes ☐ No ☐ Unk Pneumonic ☐ Yes ☐ No ☐ Unk[CA1]
Pharyngeal ☐ Yes ☐ No ☐ Unk Septicemic ☐ Yes ☐ No ☐ Unk

Fever: ☐ Yes ☐ No ☐ Unk Onset date: / / Highest known fever: ____ ☐ Celsius ☐ Fahrenheit

Cough: ☐ Yes ☐ No ☐ Unk Onset date: / / **Productive cough:** ☐ Yes ☐ No ☐ Unk Onset date: / /

Bubo: ☐ Yes ☐ No ☐ Unk Bubo: Cervical ☐ Left ☐ Right Femoral ☐ Left ☐ Right
Auxiliary ☐ Left ☐ Right Inguinal ☐ Left ☐ Right

Bubo size: ____ ☐ inches ☐ cent Tender: ☐ Yes ☐ No ☐ Unk

Chest x-ray: ☐ Yes ☐ No ☐ Unk Date: / / Result: _____

TREATMENT

Antibiotics prescribed: ☐ Yes ☐ No ☐ Unknown

Antibiotic: _____ Antibiotic: _____ Antibiotic: _____
Date started: / / Date started: / / Date started: / /
Dose: _____ Dose: _____ Dose: _____
Unit: ☐ mg ☐ ml ☐ IU # of days: _____ Unit: ☐ mg ☐ ml ☐ IU # of days: _____ Unit: ☐ mg ☐ ml ☐ IU # of days: _____

# of times a day: ____	Route: ____	# of times a day: ____	Route: ____	# of times a day: ____	Route: ____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.

EXPOSURE PERIOD — Onset — COMMUNICABLE PERIOD

The incubation period for **Plague** is 1-7 days.

Plague is typically spread by infected fleas. Plague may be spread person to person if there is contact with pus from suppurating buboes.

RISK FACTORS/TRAVEL

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk City in Iowa: ____________ Departure date: ___/___/___ Return date: ___/___/___

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: ______ City: ____________ Departure date: ___/___/___ Return date: ___/___/___

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk Country: ____________ Departure date: ___/___/___ Return date: ___/___/___

Worked with a Case: ☐ Yes ☐ No ☐ Unk From date: ___/___/___ To date: ___/___/___

Lived with another Case: ☐ Yes ☐ No ☐ Unk From date: ___/___/___ To date: ___/___/___

CONTACTS

Number of people living in case's household: _____

Others in contact or with the same exposures

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

NOTES: