Psittacosis

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 ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ 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 ☐ Unknown
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: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Chlamydia psittaci***

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

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

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
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care 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
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care 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

Symptoms

Symptom				Symptom			
Chest Pain	☐ Yes	☐ No	☐ Unk	Muscle pain	☐ Yes	☐ No	☐ Unk
Chills	☐ Yes	☐ No	☐ Unk	Myocarditis	☐ Yes	☐ No	☐ Unk
Cough	☐ Yes	☐ No	☐ Unk	Rash	☐ Yes	☐ No	☐ Unk
Encephalitis	☐ Yes	☐ No	☐ Unk	Thrombophlebitis	☐ Yes	☐ No	☐ Unk
Headache	☐ Yes	☐ No	☐ Unk	Fever	☐ Yes	☐ No	☐ Unk

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

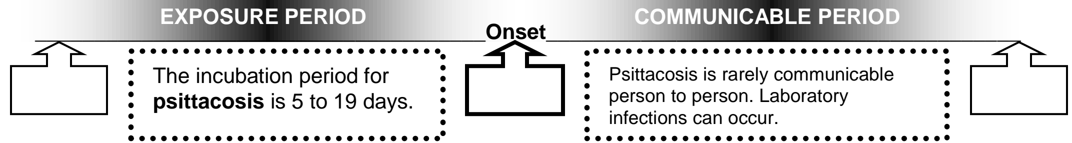
Antibiotic: ______________
Date started: ___/___/___
Dose: ______________
Unit: ☐ mg ☐ ml ☐ IU # of days: ______
Number of times a day: ______________
Route: ______________

Antibiotic: ______________
Date started: ___/___/___
Dose: ______________
Unit: ☐ mg ☐ ml ☐ IU # of days: ______
Number of times a day: ______________
Route: ______________

Antibiotic: ______________
Date started: ___/___/___
Dose: ______________
Unit: ☐ mg ☐ ml ☐ IU # of days: ______
Number 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.



RISK FACTORS/TRAVEL

In the 4 weeks prior to the onset of symptoms, did the case:

Have contact with birds or contaminated environments:

Bird				Bird				Bird			
Duck	☐ Yes	☐ No	☐ Unk	Parakeet	☐ Yes	☐ No	☐ Unk	Turkey	☐ Yes	☐ No	☐ Unk
Goose	☐ Yes	☐ No	☐ Unk	Parrot	☐ Yes	☐ No	☐ Unk				
Love bird	☐ Yes	☐ No	☐ Unk	Pigeon	☐ Yes	☐ No	☐ Unk	Other bird: ______			

Which bird: ______	**Which bird:** ______	**Which bird:** ______
Contact date: __/__/__	**Contact date:** __/__/__	**Contact date:** __/__/__
Location name: ______	Location name: ______	Location name: ______
Address: ______	Address: ______	Address: ______
City: ______	City: ______	City: ______
State/Zip: ______	State/Zip: ______	State/Zip: ______
Phone: ( )- -	Phone: ( )- -	Phone: ( )- -

CONTACTS

Contacts with the same exposures? ☐ Yes ☐ No ☐ Unknown

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: