Q Fever

Agency: ____

Investigator: ____ Phone number: ____

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ NR ☐ 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 ☐ Parent with partner ☐ Separated ☐ 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: ***Coxiella burnetii*** Type (e.g. antigen):

Laboratory: ____ Accession #: ____ Collection date: / /
Date received: / / Specimen source: ____ Test type: ____
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Coxiella burnetii*** Type (e.g. antigen):

Laboratory: ____ Accession #: ____ Collection date: / /
Date received: / / Specimen source: ____ Test type: ____
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Coxiella burnetii*** Type (e.g. 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
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:

Chills	☐ Yes ☐No ☐ Unk	Headache	☐ Yes ☐No ☐ Unk	Muscle Pain	☐ Yes ☐No ☐ Unk
Cough	☐ Yes ☐No ☐ Unk	Hepatitis	☐ Yes ☐No ☐ Unk	Pneumonia	☐ Yes ☐No ☐ Unk
Endocarditis	☐ Yes ☐No ☐ Unk	Hepatomegaly	☐ Yes ☐No ☐ Unk	Retrobulbar pain	☐ Yes ☐No ☐ Unk
Fever(>100.5)	☐ Yes ☐No ☐ Unk	Malaise	☐ Yes ☐No ☐ Unk	Splenomegaly	☐ Yes ☐No ☐ Unk

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

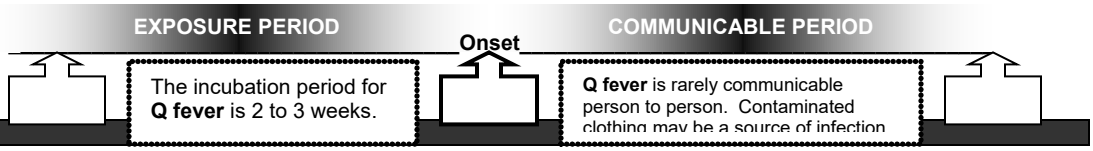
Antibiotic: _____ Date started: / / Dose: _____ Unit: ☐ mg ☐ ml ☐ IU # of days: _____ # of times a day: _____ Route: _____

Antibiotic: _____ Date started: / / Dose: _____ Unit: ☐ mg ☐ ml ☐ IU # of days: _____ # of times a day: _____ Route: _____

Antibiotic: _____ Date started: / / Dose: _____ Unit: ☐ mg ☐ ml ☐ IU # of days: _____ # 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 Information – *In the 4 weeks prior to onset of symptoms did the case:*

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: __/__/__

Unpasteurized milk: ☐ Yes ☐ No ☐ Unk From dates consumed: __/__/__ To dates consumed: __/__/__

List all source/types: ______ List all brand names: ______

Other unpasteurized products: ☐ Yes ☐ No ☐ Unk From dates consumed: __/__/__ To dates consumed: __/__/__

List all source/types: ______ List all brand names: ______

Animal contact:

Bison	☐ Yes	☐ No	☐ Unk	Goats	☐ Yes	☐ No	☐ Unk
Caribou	☐ Yes	☐ No	☐ Unk	Horses	☐ Yes	☐ No	☐ Unk
Cats	☐ Yes	☐ No	☐ Unk	Mice	☐ Yes	☐ No	☐ Unk
Cattle	☐ Yes	☐ No	☐ Unk	Pigs	☐ Yes	☐ No	☐ Unk
Deer	☐ Yes	☐ No	☐ Unk	Rats	☐ Yes	☐ No	☐ Unk
Dogs	☐ Yes	☐ No	☐ Unk	Sheep	☐ Yes	☐ No	☐ Unk

Animal birthing: ☐ Yes ☐ No ☐ Unk

CONTACTS

Are there contacts of the case with 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: