HANSEN DISEASE (LEPROSY) INVESTIGATION FORM

Comments:_____
_____
_____

Basic Demographic Data

Last Name: _____ First Name:_____
Middle Name:_____ Suffix: _____
DOB: __ __ / __ __ /__ __ __ __ Current Sex*:* ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Deceased Date: __ __ / __ __ /__ __ __ __
Marital Status: (Circle) S / M / D / W/ Annulled/ Cohabitating/ Legally Separated/ Polygamous/Unknown

SSN: __ __ __ / __ __ /__ __ __ __
Identification Information: Type:_____ Assigning Authority_____ ID Value_____
Street Address 1: _____
Street Address 2: _____
City: _____ State:_____
Zip Code*:* __ __ __ __ __- __ __ __ __ County:_____ Country:_____

Home Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Work Phone: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race : ☐Unknown ☐ American Indian or Alaska Native ☐Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Reporting Source

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____
Earliest Date Reported to: County : __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __
Reporter's Name:_____

Clinical

Physician's Name: _____
Physician's Phone Number: (__ __ __) -- __ __ __ - __ __ __ __ Ext. __ __ __ __
Physician's Address: _____
City:_____ State:_____
Zip Code: __ __ __ __ __- __ __ __ __ County:_____ Country

Hospital

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes
If yes: Hospital Name: _____
Admission Date__ __ / __ __ /__ __ __ __ Discharge Date __ __ / __ __ /__ __ __ __
Total Duration of stay within hospital _____days

Condition

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __
Illness End Date: __ __ / __ __ /__ __ __ __
Illness Duration: _____ Circle: days/hrs./minutes/months/unknown/weeks/years
Age at Onset: _____ Circle: days/hrs./minutes/months/unknown/weeks/years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes

Epidemiologic

Is this patient associated with a day care facility?	☐No ☐Unknown ☐Yes	Is this patient a food handler?	☐No ☐Unknown ☐Yes
Is this case part of an outbreak?	☐No ☐Unknown ☐Yes	If yes, outbreak name:	

Where was the disease acquired?

☐ Indigenous within jurisdiction	☐ Out of Country	☐ Out of jurisdiction, from another jurisdiction
☐ Out of state	☐Unknown	

If the answer is out of Country, Jurisdiction, or State	
Imported Country:	Imported State:
Imported City:	Imported County:

Transmission Mode

☐ Airborne	☐ Bloodborne	☐ Dermal	☐ Foodborne	☐ Indeterminate	☐ Mechanical
☐ Nosocomial	☐ Sexually Transmitted	☐ Vectorborne	☐ Waterborne	☐ Zoonotic	☐ Other

Detection Method

☐ Patient Self-referral	☐ Prenatal Testing	☐ Prison Entry Screening	☐ Provider Reported	☐ Routine Physical	☐ Other

Confimation Method

☐ Active Surveillance	☐ Case Outbreak Investigation	☐ Clinical Diagnosis	☐ Epidemiologically Linked
☐ Laboratory Confirmed	☐ Laboratory Report	☐ Local/State Specified	☐ Medical Record Review
☐ No information given	☐ Occupational Disease Surveillance	☐ Provider Certified	☐ Other

Confirmation Date: : __ __ / __ __ /__ __ __ __

CASE STATUS: (Required for Notification) ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown

MMWR Week _____ MMWR Year _____

Custom Fields

Date Due __ __ / __ __ /__ __ __ __

Investigation Ready for Supervisor Review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete) ☐ Reviewed (Not a case) ☐ Yes

Date Investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Condition Specific Custom Fields	
Has Patient Ever Touched Armadillos:	☐ No ☐ Unknown ☐ Yes
Date Entered U.S.:	__ __ / __ __ /__ __ __ __
Leprosy Type: ☐ Dimorphous/Borderline ☐ Indeterminate ☐ Lepromatous ☐ Tuberculoid	
Diagnosis of Disease	
Was Biopsy Performed:	☐ No ☐ Unknown ☐ Yes
If yes, Date Performed:	_ _ / _ _ / _ _ _ _
Acid Fast Stain of smear or Section:	☐ No ☐ Unknown ☐ Yes
Regarding Household Contacts of Patient	
Have any been examined:	☐ No ☐ Unknown ☐ Yes
Were additional cases found:	☐ No ☐ Unknown ☐ Yes
Have Household members been started on Prophylaxis:	☐ No ☐ Unknown ☐ Yes
Clinical criteria for case classification	
A. Tuberculoid: One or few well-demarcated, hypopigmented and anesthetic skin lesions, frequently with active spreading edges and a clearing center, peripheral nerve swelling or thickening may occur :	☐ No ☐ Unknown ☐ Yes
B.Lepromatous: a number of erythematous papules and nodules or an inflitration of the face, hands, and feet with lesions in a bilateral and symmetrical distribution that progress to thickening of the skin :	☐ No ☐ Unknown ☐ Yes
C. Borderline (dimorphous): skin lesions characteristic of both the tuberculoid and the lepromatous forms :	☐ No ☐ Unknown ☐ Yes
D. Indeterminate: early lesions, usually hypopigmented macules, without developed tuberculoid or lepromatous features :	☐ No ☐ Unknown ☐ Yes
Laboratory criteria for case classification	
Demonstration of acid-fast bacilli in skin or dermal nerve, obtained from the full-thickness skin biopsy of a lepromatous lesion :	☐ No ☐ Not tested ☐ Unknown ☐ Yes