

PSITTACOSIS (ORINITHOSIS) 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/ Cohabiting/ 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

Investigation Summary

Investigation Start Date: ___/___/____ Investigation Status: Open Closed
Investigator: _____ Date assigned: ___/___/____

Reporting Source

Date of Report: ___/___/____ Reporting Source: _____
Earliest Date Reported to: County: ___/___/____ State: ___/___/____
Reporter: _____

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?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes	Is this patient a food handler?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
Is this case part of an outbreak?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes	If yes, outbreak name: _____	

Where was the disease acquired?

<input type="checkbox"/> Indigenous within jurisdiction	<input type="checkbox"/> Out of Country	<input type="checkbox"/> Out of jurisdiction, from another jurisdiction
<input type="checkbox"/> Out of state	<input type="checkbox"/> Unknown	

If the answer is out of Country, Jurisdiction, or State

Imported Country:	Imported State:
Imported City:	Imported County:

Transmission Mode

<input type="checkbox"/> Airborne	<input type="checkbox"/> Bloodborne	<input type="checkbox"/> Dermal	<input type="checkbox"/> Foodborne	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Mechanical
<input type="checkbox"/> Nosocomial	<input type="checkbox"/> Sexually Transmitted	<input type="checkbox"/> Vectorborne	<input type="checkbox"/> Waterborne	<input type="checkbox"/> Zoonotic	<input type="checkbox"/> Other

Detection Method

<input type="checkbox"/> Patient Self-referral	<input type="checkbox"/> Prenatal Testing	<input type="checkbox"/> Prison Entry Screening	<input type="checkbox"/> Provider Reported	<input type="checkbox"/> Routine Physical	<input type="checkbox"/> Other
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Confirmation Method

<input type="checkbox"/> Active Surveillance	<input type="checkbox"/> Case Outbreak Investigation	<input type="checkbox"/> Clinical Diagnosis	<input type="checkbox"/> Epidemiologically Linked
<input type="checkbox"/> Laboratory Confirmed	<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Local/State Specified	<input type="checkbox"/> Medical Record Review
<input type="checkbox"/> No information given	<input type="checkbox"/> Occupational Disease Surveillance	<input type="checkbox"/> Provider Certified	<input type="checkbox"/> 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**Present Illness**

Brief clinical description (Symptoms and signs, maximum temperature, etc.):

Outcome of case: Died Home Recovered Other**History and Contact Information**

Occupation at date of onset:

Specific work duties:

Indicate which of the following contacts the patient had during the 5 weeks prior to onset

Psittacines; species :

Approximate number of Psittacines:

Pigeons; species:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
Approximate number of Pigeons:	
Domestic fowl; species:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
Approximate number of Domestic fowl:	
Other birds; species:	
Approximate number of other birds:	
Were birds apparently in good health:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
If birds were not in good health elaborate:	
Human case of Psittacosis:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
If yes, name of person with Psittacosis:	
Other contact (specify):	
No known exposure:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
Indicate where exposure occurred	
Type of Establishment:	
Owner and Address of exposure establishment:	
Owner's Name(s): _____	
Establishment's Street Address: _____	
City: _____	State: _____
Zip Code: _____ - _____	County: _____ Country: _____
Exposed to :	
Specify Exposure Indoors or Outdoors:	
Dates of Exposure:	
Investigation of Source	
Other cases of human respiratory illness observed in connection with this possible source:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
If yes, Name (other case of human respiratory illness):	
Age (other case of human respiratory illness):	
Address (other case of human respiratory illness):	
Clinical criteria for case classification	
A. Fever :	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
B. Chills:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
C. Headache:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
D. Photophobia:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
E. Cough:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
F. Myalgia:	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
Laboratory criteria for case classification	
Isolation of Chlamydia psittaci:	<input type="checkbox"/> No <input type="checkbox"/> Not tested <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
Fourfold or greater increase in antibody against C. psittacito a reciprocal titer of greater than or equal to 32:	<input type="checkbox"/> No <input type="checkbox"/> Not tested <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
Presence of IgM antibody against C. psittaci to a reciprocal titer greater than or equal to 16:	<input type="checkbox"/> No <input type="checkbox"/> Not tested <input type="checkbox"/> Unknown <input type="checkbox"/> Yes