

Plague Case Investigation Report



OMB No. 0920-0728

Case ID #: _____

Patient History

Age: _____ years	Sex:	Patient Ethnicity:	Patient race: (select all that apply)	
	<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander
	<input type="checkbox"/> Male	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Unknown/other	

Residence:	Concurrent conditions:
State: _____	<input type="checkbox"/> Pregnant
County: _____	<input type="checkbox"/> Immunocompromised (please specify): _____

Course of Current Illness

Date of initial symptom onset: _____ mm/dd/yyyy	Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Date first seen by a medical person: _____ mm/dd/yyyy	Admit date: _____ Discharge date: _____ mm/dd/yyyy mm/dd/yyyy

Symptoms at presentation:	
Fever/sweats/chills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Confusion/delirium <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Vomiting/diarrhea/abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sore throat <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other: _____

Localized signs:	
Bubo <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, specify: <input type="checkbox"/> Axillary <input type="checkbox"/> Cervical <input type="checkbox"/> Inguinal/Femoral <input type="checkbox"/> Other
Insect bites/skin ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Location/description: _____
Chest X-ray: <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown <input type="checkbox"/> Infiltrates or nodules <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Clear/normal	

Treatment:	Illness outcome:
Receipt of effective antibiotics (check all that were administered):	<input type="checkbox"/> Recovered, no complications
<input type="checkbox"/> Aminoglycosides start date: _____ (e.g., streptomycin, gentamicin) mm/dd/yyyy	<input type="checkbox"/> Recovered, complications (please specify): _____
<input type="checkbox"/> Tetracyclines start date: _____ (e.g., doxycycline) mm/dd/yyyy	<input type="checkbox"/> Recovered, unknown complications
<input type="checkbox"/> Fluoroquinolones start date: _____ (e.g., ciprofloxacin, levofloxacin) mm/dd/yyyy	<input type="checkbox"/> Died (please specify cause and date of death): _____
	<input type="checkbox"/> Unknown

Primary clinical syndrome:	Secondary pneumonic plague:
<input type="checkbox"/> Bubonic <input type="checkbox"/> Septicemic <input type="checkbox"/> Pneumonic <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Pharyngeal <input type="checkbox"/> Meningitic <input type="checkbox"/> Gastrointestinal	

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Laboratory Evidence of Infection

Detection or Isolation

Yersinia pestis cultured? Yes No Unknown

Specimen source Date specimen collected

(e.g., blood, bubo aspirate)

mm/dd/yyyy

If not cultured, presence of *Y. pestis* detected?

Yes No Unknown

Specimen source Date specimen collected

mm/dd/yyyy

Test performed (e.g., DFA or PCR) _____

Serology:

None Single positive titer ≥ 4 -fold change in titer

Serum 1:

Date drawn _____
mm/dd/yyyy

Titer: _____

Serum 2:

Date drawn _____
mm/dd/yyyy

Titer: _____

Plague Case Status

Confirmed A clinically-compatible case with either *Y. pestis* cultured from a clinical specimen or ≥ 4 -fold change in serum antibody titer

Probable A clinically-compatible case with either detection (not isolation) of *Y. pestis* in a clinical specimen or a single positive antibody titer (or < 4 -fold change in titer)

Not a case

Epidemiologic Investigation

Was this illness epi-linked to any other plague cases? Yes No Unknown Specify: _____

Most likely location of exposure: State: _____ County: _____

Likely exposure setting: Around the person's home Recreational (away from home)

Possible routes of exposure: In the 2 weeks preceding illness, did the patient report:

Flea or insect bites? Yes No Unknown

Animal contact? Yes No Unknown

If yes, type of animal Wild (specify: _____) Domestic pet (specify: _____)

What was the nature of the contact? Bitten Scratched Disposed/handled deceased animal
 Cleaned carcass Consumed hunted game meat

Person-to-person transmission from a known plague patient Yes No Unknown

Other possible exposure type: specify _____

Evidence of *Yersinia pestis* infected animals or fleas in the likely exposure location?

Yes No Unknown (If yes, specify: _____)

Additional comments: