

Case ID: _____

First Name: _____

Last Name: _____

PSITTACOSIS HUMAN CASE SURVEILLANCE REPORT

Investigation Information				
Report Date ____/____/____ MM/DD/YYYY	Patient Status <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Deceased	Diagnosis Date ____/____/____ MM/DD/YYYY	Onset Date ____/____/____ MM/DD/YYYY	
Patient Information				
Patient ID (State or Local HD)	Last name	First name	Middle name	
Street Address				
City	County	State	Zip	
Home Phone (Ext.) ###-###-####	Current Occupation	Other Phone <input type="checkbox"/> Work / Business <input type="checkbox"/> Cell ###-###-####	Ext.	
If patient < 18yrs:				
Parent/Guardian Last name		First name		Middle name
Demographics				
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____ MM/DD/YYYY		Age <input type="checkbox"/> Years <input type="checkbox"/> Months	
Race <input type="checkbox"/> Caucasian <input type="checkbox"/> African America <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____				
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown				
If female, pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Report Information				
Person Providing Report				
First	Last	Phone ###-###-####	Ext.	Email
City	County	State	Zip	City
Primary Physician				
First	Last	Phone ###-###-####	Ext.	Email
Street Address				
City	County	State	Zip	

Case ID: _____

First Name: _____

Last Name: _____

Clinical Information**Brief clinical description (Symptoms and signs, note maximum temperature, etc.)**

- ☐ Fever; Maximum temperature: _____ ☐ F ☐ C
☐ Cough ☐ Pneumonia (☐ CXR confirmed or ☐ clinical diagnosis)
☐ Myalgia ☐ Rash
☐ Chills ☐ Photophobia
☐ Headache ☐ Other (describe/details): _____

Specific therapy: (Specify products, dosage, and dates of treatment)**Outcome:**

- ☐ Hospitalized ☐ Required ICU care
☐ Recovered ☐ Unknown
 Date of discharge: ____/____/____
 MM/DD/YYYY

If the patient died, date of death:

____/____/____
 MM/DD/YYYY

Laboratory Information

Test Name/Test Method	Date Specimen Collected MM/DD/YYYY	Test Result	Name of Laboratory
<i>C. psittaci</i> PCR (preferred) <input type="checkbox"/> blood <input type="checkbox"/> sputum <input type="checkbox"/> other (specify): _____	____/____/____		
Respiratory secretions <i>C. psittaci</i> culture (preferred) <input type="checkbox"/> sputum <input type="checkbox"/> BAL <input type="checkbox"/> other (specify): _____	____/____/____		
<i>C. psittaci</i> Fourfold increase in antibody titer Acute-phase serum <input type="checkbox"/> CF <input type="checkbox"/> MIF <input type="checkbox"/> Other (specify)____	____/____/____	IgM: _____ IgG: _____	
Convalescent-phase serum <input type="checkbox"/> CF <input type="checkbox"/> MIF <input type="checkbox"/> Other (specify)____	____/____/____	IgM: _____ IgG: _____	
<i>C. pneumoniae</i> PCR <input type="checkbox"/> blood <input type="checkbox"/> sputum <input type="checkbox"/> other (specify): _____	____/____/____		
<i>C. pneumoniae</i> Fourfold increase in antibody titer Acute-phase serum <input type="checkbox"/> CF <input type="checkbox"/> MIF <input type="checkbox"/> Other (specify)____	____/____/____	IgM: _____ IgG: _____	
Convalescent-phase serum <input type="checkbox"/> CF <input type="checkbox"/> MIF <input type="checkbox"/> Other (specify)____	____/____/____	IgM: _____ IgG: _____	

Case ID: _____

First Name: _____

Last Name: _____

<i>Chlamydia trachomatis</i> [any test(s)]	____/____/____		
Autopsy <input type="checkbox"/> lung <input type="checkbox"/> other: _____	____/____/____		
Chest X-ray done: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, date: ____/____/____ MM/DD/YYYY	If yes, results:	

Epidemiologic Information (*contd. on the next page*)

Occupation at date of onset:	Specific duties:
-------------------------------------	-------------------------

At the time of exposure which of the following personal protective equipment was the patient using?

☐ Respiratory Protective Equipment: ☐ Surgical Mask ☐ Filtering piece/N95
☐ Elastomeric – half face or full face (with cartridges) - specify types of cartridges if known:
☐ N or P 95
☐ N or P 99 or 100
☐ Other: _____

☐ Does the patient get annual respirator fit testing and training? ____Yes ____No

☐ Gloves (if known, specify material by circling the appropriate type from the list below)

- Plastic (latex or nitrile)
- Cloth
- Leather
- Double gloves, i.e. nitrile underneath, leather over (describe) _____

☐ Goggles
☐ Face shield
☐ Rubber boots/disposable overshoes
☐ Disposable surgical cap
☐ Overalls
☐ No personal protective equipment was being used
☐ Other (describe/details): _____

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

(Check all that apply)

- ☐ Birds ☐ Human case of Psittacosis (specify) _____
☐ Other (specify) _____ ☐ No known exposure

If exposure to birds, complete following table:

Type of Bird	Species	Approximate number	Were birds healthy? (Y=Yes N=No UNK=Unknown)
Psittacines*			
Pigeons			
Domestic Fowl			
Other birds			

Case ID: _____

First Name: _____

Last Name: _____

If birds were not healthy, please elaborate:

*Psittacine Birds include: Cockatoos, Cockatiels, Macaws, Parakeets, Conures, Parrots

Indicate where the exposure may have occurred. If the patient had multiple contacts, specify to what they were exposed at each place of exposure.

Type of Establishment	Owner of Establishment	Address of Establishment	Exposure To (Species)	Exposure setting	Date of Exposure
1=Private home 2=Private aviary 3=Commercial aviary 4=Pet shop 5=Pigeon loft 6=Poultry establishment (specify processor or farm) 7=Bird fair/show 8=Backyard poultry 9=Healthcare 10=Long term/Nursing Home 11=Swap meet 12=Other 13=Unknown				I=Indoors O=outdoors	

If other, specify:

If pet birds, domestic pigeons, or fowl are implicated as the source of the human psittacosis, or if any such bird is shown by laboratory methods to be infected, it is important to learn where these birds originated and where they were subsequently purchased or obtained by the present owner. These birds may have acquired a latent form of the infection at any place where they have been detained since hatching.

List the address of every known place where the birds were harbored, including approximate dates.**Additional Relevant Information****Submitted by:****Date:**____/____/____
MM/DD/YYYY**Health Depart.****Phone number:**

###-###-####

Ext.