Unspecified Rash with Fever Syndrome

Revised 02/22/2005

EPIDEMIOLOGY

Several pathogens identified as possible agents of bioterrorism could cause patients to present with a rash and an accompanying fever. Since there is only a small chance of knowing what agent is causing an event there is clearly a need to plan to respond to diseases caused by unknown agents. The list of likely bioterrorism agents that could cause a respiratory type illness includes smallpox and several different viral hemorrhagic fevers (VHF). Additionally some arboviruses and several other diseases of public health concern have the ability to cause syndromes that include a rash and a fever.

CLINICAL FEATURES

Signs and Symptoms: Clinical manifestations of the different diseases that might be considered would present with a rash with accompanying fever. This combination of clinical features is however, not particularly useful without considering the patient demographics, the seasonal and geographic distribution of respiratory diseases, and course that the illness takes. The primary clinical presentation that should alert a clinician is that the case or cases appear to be distinctly unusual in some respect.

DIAGNOSIS

Specific diagnosis for each of the diseases that could be considered likely bioterrorism agents or agents of public health concern will differ depending on the etiologic agent. Although laboratory confirmation will be sought in the event of any disease event reported to the Infectious disease epidemiology section, this particular plan assumes that the laboratory confirmation leading to a definitive diagnosis is delayed or in some other way impeded. As such clinical diagnosis of one or more unusual respiratory infections with the potential to threaten the public’s health will be the basis for follow-up.

SURVEILLANCE

The key to effective surveillance of unusual infectious diseases is the astute clinician. It is through continuing medical education and regular trainings with Louisiana’s medical community that clinicians will be sensitized to and informed about unusual disease events and their role in identifying these events. Furthermore, the Louisiana Sanitary Code requires the reporting of any case of rare or exotic communicable diseases, unexplained death, unusual cluster of disease.
CASE MANAGEMENT

Treatment: Upon determination of the etiology of the disease appropriate case management guidelines will be developed and communicated to the medical community. Additionally, information pertinent to the control of transmission will be communicated to all of the susceptible audiences.

CASE DEFINITION

Following the data gathering interviews that will be conducted early in the investigation a clinical case definition will be developed in order to identify cases that have a common set of signs and symptoms.

PROPHYLAXIS

The administration of prophylaxis will be dependent on the organism that it identified as the causative agent.

ISOLATION

Contact, droplet or airborne precautions will be considered and recommended based on the information available and on the risks and benefits that may accompany the decision.

Isolation = separation and confinement of individuals known or suspected (via signs, symptoms or lab criteria) to be infected with a contagious disease to prevent transmission

Containment measures:
- Travel restrictions: public transportation
- Restrictions on public gatherings
Infectious Disease Epidemiology: Epidemiologic Response Checklist

Consultation/ Confirmation
☑ Discuss bioterrorism event definitions with key public health personnel (health officer, communicable disease control staff, laboratorians, etc.)

Laboratory Confirmation
☑ Identify point of contact (POC) at appropriate state public health laboratory in a potential bioterrorist event

Notification
☑ Establish local notification network to be activated in case of a possible bioterrorist event; disseminate contact information and notification protocol
☑ Establish relationships with local Office of Emergency Preparedness and FBI contacts to be notified in a suspected bioterrorist event and maintain up-to-date contact information

Coordination
☑ Establish Epidemiologic Response as a part of local Incident Command System
☑ Identify personnel available for epidemiologic investigation and perform inventory of skills and duties
☑ Establish contacts at regional and Parrish health units identify potential personnel resources available for epidemiologic “mutual aid”
☑ Establish contacts at the local FBI office for coordination with epidemiologic/ criminal Investigation

Communication
☑ Identify epidemiologic investigation spokesperson and Public Information Officer (PIO)
☑ Establish communication protocol to be implemented during an epidemiologic investigation between PIO and epidemiologic investigation spokesperson
☑ Establish a plan for rapid dissemination of information to key individuals: FAX, Email, website on the internet (if capability exists)

Epidemiologic Investigation
A. Case Finding
☑ Establish plans/ capacity to receive a large number of incoming telephone calls
☑ Develop telephone intake form
☑ Identify individuals available to perform telephone intake duties
☑ Identify potential reporting sources (persons/ facilities) to receive case definition
☑ Establish a plan for rapid dissemination of case definition to potential reporting sources

B. Case Interviews
☑ Obtain appropriate case investigation questionnaires
☑ Identify personnel available to conduct case interviews
☑ Establish a protocol for training case interviewers
☑ Obtain template outbreak disease-specific investigation questionnaires
C. Data Analysis
- Obtain template database for data entry
- Assure Epi Info software is installed on data entry computers
- Identify personnel available for data entry
- Identify personnel with skills to perform descriptive and analytic epidemiologic analysis
- Develop/ obtain data analysis plan
- Develop/ obtain outbreak investigation monitoring tool

Contact Tracing
- Establish a system for locating contacts and familiarize personnel with contact tracing protocol(s)
- Obtain Contact Tracing Forms
- Obtain contact management algorithms for diseases that are communicable from person-to-person
- Obtain treatment/ prophylaxis guidelines
- Develop local drug and vaccine distribution plan
- Establish a system for daily monitoring of all contacts under surveillance

Public Health Recommendations
- Obtain treatment and prophylaxis recommendations for bioterrorist threat agents
- Develop or obtain bioterrorist disease-specific fact sheets
- Establish contact with key health care providers/ facilities and establish protocol for rapid dissemination of recommendations regarding treatment, prophylaxis, personal protective equipment, infection control, and isolation/ quarantine

Consultation / Confirmation
- Disease scenario meets the bioterrorist event definition

Laboratory Confirmation
- Lab specimens are en route to the local public health laboratory/ Laboratory Response Network

Notification
- Department of Health and Human Services
- State Medical Officer
- (225)342-3417 (regular business hours)
- (800)990-5366 pin 6710 (pager for evenings, weekends, holidays)
- State Epidemiologist (504)458-5428 Mobile
- Public Health Lab (504)568-5371
- Public Health Lab Pager (800)538-5388
- OPH Regional Offices (Internal Notification Network)
- Louisiana EOC (225)-925-7500
- Louisiana State Police (800)469-4828 (Crisis Management Center)
**Coordination**
- Epidemiology personnel identified for investigation
- Additional epidemiology personnel support requested (From other regions) Investigation activities coordinated with FBI

**Communication**
- Epidemiology investigation spokesperson identified
- Communication protocol established between epidemiologic investigation spokesperson and Public Information Officer (PIO)

**Epidemiologic Investigation**
- Hypothesis-generating interviews conducted
- Preliminary epidemiologic curve generated
- Case definition established

**A. Case finding**
- Telephone hotline established
- Telephone intake form distributed
- Case definition disseminated to potential reporting sources
  - Hospitals
  - Physicians
  - Laboratories
  - EMS
  - Coroner
  - Media

**B. Case interviews**
- Interviewers trained
- Uniform multi-jurisdictional outbreak investigation form(s) obtained

**C. Data Analysis**
- Uniform multi-jurisdictional database template for data entry obtained
- Epidemiologic curve generated
- Cases line-listed
- Case descriptive epidemiology completed
  - Age
  - Gender
  - Illness onset
  - Clinical profile
  - % Laboratory confirmed
  - Hospitalization rate
  - Case fatality rate
  - Case geographic distribution mapped (GIS mapping if available)
  - Analytic epidemiology completed
  - Disease risk factors identified
  - Mode of transmission identified
  - Source of transmission identified
  - Population at continued risk identified
**Contact Tracing**
- Contact tracing forms distributed
- Health education materials available
- Contact management triage algorithm reviewed with staff
- Treatment/prophylaxis guidelines available
- Treatment/prophylaxis distribution plan in place
- System in place for locating contacts
- Tracking system in place to monitor contacts’ trends/gaps

**Laboratory**
- Establish point of contact (POC) at appropriate Level A and/or Level B public health laboratory to refer queries regarding specimen packaging, storage and shipping guidelines in a potential bioterrorist event [See Laboratory Section’s Bioterrorism Plan]

**Public Health Recommendations**
- See Medical Response Section Bioterrorism Plan
UNSPECIFIED RASH WITH FEVER

Case investigation form

ID NUMBER: _________

INTERVIEWER: ___________________ JOB TITLE: ____________________________

DATE OF INTERVIEW: ___/___/____

PERSON INTERVIEWED: Patient     Other

IF OTHER, NAME OF PERSON __________________________________________

TELEPHONE _____ - _____ - _________

DESCRIBE RELATIONSHIP ____________________________________________

DEMOGRAPHIC INFORMATION

LAST NAME: ___________________________ FIRST NAME: ________________________

DRIVER LICENCE OR SOCIAL SECURITY NUMBER (Circle one): ______________

SEX: Male       Female       DATE OF BIRTH: ___/___/____       AGE____

RACE: White     Black     Asian     Other, specify ________     Unknown

ETHNICITY: Hispanic     Non-Hispanic     Unknown

HOME PHONE: (   ) _____ - ________ WORK/OTHER PHONE: (   ) _____ - ________

HOME ADDRESS STREET: __________________________________________

CITY: ___________________________________ STATE: ___________ ZIP: __________

EMPLOYED: Yes     No     Unknown

BRIEF DESCRIPTION OF JOB: __________________________________________

SCHOOL/PLACE OF EMPLOYMENT: _______________________________________

DEPARTMENT_________________________ FLOOR:_______ ROOM:____________

WORK/SCHOOL ADDRESS: STREET: _________________________ CITY: _________

STATE: ___________ ZIP: ___________
ARE YOU A:

LAB WORKER/TECHNICIAN:  Yes  No  Unknown
TAXIDERMIST:  Yes  No  Unknown
VETERINARIAN:  Yes  No  Unknown
FARMER:  Yes  No  Unknown
ABATTOIR:  Yes  No  Unknown
BUTCHER:  Yes  No  Unknown
OTHER FOOD PREPARATION:  Yes  No  Unknown

HOBBY:

Do you work with fibers/wool/animal skin/or other animal product?  Yes  No  Unknown
Have you been camping in past two months?  Yes  No  Unknown
Have you stayed in cabins in the past two months?  Yes  No  Unknown
Have you been hunting?  Yes  No  Unknown
Have you skinned or dressed and animal?  Yes  No  Unknown
Have you had an animal stuffed or mounted?  Yes  No  Unknown

HOW MANY PEOPLE RESIDE IN THE SAME HOUSEHOLD? __________

LIST NAME(S), AGE(S), AND RELATIONSHIPS (use additional pages if necessary):

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

HOUSEHOLD PETS:

Does your household have any pets (indoor or outdoor)?  Yes  No  Unknown

If so what type of pet: _____________________________________________________________

Have any of the pets been ill or died recently?  Yes  No  Unknown

If so describe: _________________________________________________________________

CLINICAL INFORMATION (as documented in admission history of medical record or from case/proxy interview)

CHIEF COMPLAINT: ________________________________________________________________

DATE OF ILLNESS ONSET: ___/___/___

Briefly summarize History of Present Illness:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
<table>
<thead>
<tr>
<th>SIGNS AND SYMPTOMS</th>
<th>Present at interview?</th>
<th>Present before rash? (Prodromal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>If yes, Maximum temperature____ oF Antipyretics taken Yes No Unknown Date of onset: <em><strong>/</strong>/</em>_</td>
<td></td>
</tr>
<tr>
<td>Chills</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>Headache</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>Malaise/Fatigue</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>Back Pain</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>Muscle tenderness/pain</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>Delirium/confusion</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>Cough</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
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<tr>
<td>Coryza</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
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<tr>
<td>Conjunctivitis</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
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<tr>
<td>Lymphadenopathy</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
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<tr>
<td>Bleeding</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>Other Symptoms/Abnormality</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown Describe:</td>
</tr>
</tbody>
</table>

**PAST MEDICAL HISTORY:**

Do you have a regular physician? Yes No Unknown
If yes, Name: __________________________ Phone Number: (____) ______-_______

Are you currently taking any medication? Yes No Unknown
If yes, list: ____________________________________________________________

Have you had any wound or lesion in the past several months? Yes No Unknown
If yes, where: __________________________________ Appearance: ____________________________

Other Dermatologic condition Yes No Unknown
If yes, describe: __________________________________________________________
<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
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</thead>
<tbody>
<tr>
<td>Food or drug allergies</td>
<td></td>
<td></td>
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<tr>
<td>If yes, specify type:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Malignancy</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Currently pregnant</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>HIV infection</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
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<tr>
<td>Other immunocompromising condition</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Currently on treatment</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If yes, specify disease or drug therapy:</td>
<td></td>
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<tr>
<td>Other underlying condition(s):</td>
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<tr>
<td>Prescription medications:</td>
<td></td>
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<tr>
<td>Were antibiotics taken in the week prior to the onset of the rash?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If yes identify:</td>
<td></td>
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</tbody>
</table>

**SOCIAL HISTORY:**

<table>
<thead>
<tr>
<th>Abuse or drug use</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current alcohol abuse</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Past alcohol abuse</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Current injection drug use</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Past injection drug use</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Current smoker</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Former smoker</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Other illicit drug use</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If yes, specify:</td>
<td></td>
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</tbody>
</table>

**HOSPITAL INFORMATION:**

<table>
<thead>
<tr>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>HOSPITALIZED</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>NAME OF HOSPITAL</td>
<td></td>
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<tr>
<td>DATE OF ADMISSION</td>
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<tr>
<td>DATE OF DISCHARGE</td>
<td></td>
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<tr>
<td>ATTENDING PHYSICIAN</td>
<td></td>
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<tr>
<td>LAST NAME:</td>
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<td>FIRST NAME:</td>
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<tr>
<td>Office Telephone</td>
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<tr>
<td>Pager:</td>
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<tr>
<td>Fax:</td>
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</tr>
</tbody>
</table>
MEDICAL RECORD ABSTRACTION:

MEDICAL RECORD NUMBER: __________________________
WARD/ROOM NUMBER: _______________________________

ADMISSION DIAGNOSIS(ES):
1) ______________________________________
2) ______________________________________
3) ______________________________________

PHYSICAL EXAM:

Admission Vital Signs:
Temp:____ (Oral / Rectal F / C) Heart Rate:______ Resp. Rate:_____ B/P:___/___

Mental Status: Normal Abnormal Not Noted
If abnormal, describe:_____________________________________________________

Respiratory status: Normal spontaneous Respiratory distress Ventilatory support
If abnormal, check all that apply:
Rales Stridor/wheezin Decreased or absent
Other (specify:_________________________________________________________)

Skin rash:
Rash description, check all that apply:
Papular Macular Vesticular
Petechial Bullous Erythematous
Purpuric Pustules Scabs
Other:_______________________________________________________________

Rash location: Check off all areas of the body where rash is/was, check all that apply:
Face Neck Mouth
Chest Abdomen Back
Arms Hands Palms
Legs Feet Soles

Did the rash develop at the same stage on any body area?
Yes No Unknown

Through what order of body parts did the rash spread? (number the following boxes
1=first and 3=last. Multiple boxes can have the same number)

_____ Head _____Trunk _____ Extremities

Is the rash concentrated in one or more areas?
Yes No Unknown
If yes, where?_________________________________________________________
Skin Exam Continued:

Is there flushing?  Yes  No  Unknown
If yes, where?_____________________________________

Is there edema?  Yes  No  Unknown
If yes, where?_____________________________________

Is there Jaundice?  Yes  No  Unknown

Other Findings:
Lymphadenopathy  Yes  No  Unknown
Hepatomegaly  Yes  No  Unknown
Conjunctivitis  Yes  No  Unknown
Pharyngeal inflammation  Yes  No  Unknown
If yes, explain:_____________________________________

Other abnormal physical findings (describe): _________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
## Diagnostic Studies:

<table>
<thead>
<tr>
<th>Test</th>
<th>Results of tests done on Admission (<em><strong>/</strong></em>/___)</th>
<th>Abnormal test result at any time (specify date mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin (Hb)</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
</tr>
<tr>
<td>Hematocrit (HCT)</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
</tr>
<tr>
<td>Platelet (plt)</td>
<td>Thrombocytopenia?</td>
<td>(<em><strong>/</strong></em>/___)</td>
</tr>
<tr>
<td>Total white blood cell (WBC)</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>WBC differential:</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>% granulocytes (PMNs)</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>% bands</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>% lymphocytes</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>Prothrombin Time (PT)</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>Partial Thromboplastin Time (PTT)</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>Renal function: BUN/Cr</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>Liver enzymes: ALT/AST</td>
<td>(<em><strong>/</strong></em>/___)</td>
<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>Blood cultures: (Bacterial)</td>
<td>(specify____________________) positive</td>
<td>(specify____________________) positive</td>
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<td></td>
<td>negative</td>
<td>negative</td>
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<td>pending</td>
<td>pending</td>
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<td>not done</td>
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<td>(<em><strong>/</strong></em>/___)</td>
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<tr>
<td>Test</td>
<td>Results of tests done on Admission (<em><strong>/</strong></em>/___)</td>
<td>Abnormal test result at any time (specify date mm/dd/yy)</td>
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<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------</td>
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<tr>
<td>Blood cultures: (Viral)</td>
<td>positive</td>
<td>positive</td>
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<td>(specify____________________)</td>
<td>(specify____________________)</td>
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<td>negative</td>
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<td>(<strong><strong>/</strong></strong>/____)</td>
<td>(<strong><strong>/</strong></strong>/____)</td>
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<tr>
<td>Viral isolation culture of lesion</td>
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<td>positive</td>
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<td>(specify____________________)</td>
<td>(specify____________________)</td>
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<td>(<strong><strong>/</strong></strong>/____)</td>
<td>(<strong><strong>/</strong></strong>/____)</td>
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<tr>
<td>Tzank smear</td>
<td>positive</td>
<td>positive</td>
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<td>(specify____________________)</td>
<td>(specify____________________)</td>
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<tr>
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<td>pending</td>
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<td>(<strong><strong>/</strong></strong>/____)</td>
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<tr>
<td>Lesion scraping/biopsy</td>
<td>positive</td>
<td>positive</td>
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<td>(specify____________________)</td>
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<td>(<strong><strong>/</strong></strong>/____)</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>positive</td>
<td>positive</td>
</tr>
<tr>
<td></td>
<td>(specify____________________)</td>
<td>(specify____________________)</td>
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<tr>
<td></td>
<td>negative</td>
<td>negative</td>
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<tr>
<td></td>
<td>pending</td>
<td>pending</td>
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<tr>
<td></td>
<td>not done</td>
<td>not done</td>
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<td></td>
<td>(<strong><strong>/</strong></strong>/____)</td>
<td>(<strong><strong>/</strong></strong>/____)</td>
</tr>
<tr>
<td>Hematuria</td>
<td>positive</td>
<td>positive</td>
</tr>
<tr>
<td></td>
<td>negative</td>
<td>negative</td>
</tr>
<tr>
<td></td>
<td>pending</td>
<td>pending</td>
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<tr>
<td></td>
<td>not done</td>
<td>not done</td>
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<tr>
<td></td>
<td>(<strong><strong>/</strong></strong>/____)</td>
<td>(<strong><strong>/</strong></strong>/____)</td>
</tr>
<tr>
<td>Chest radiograph</td>
<td>normal</td>
<td>normal</td>
</tr>
<tr>
<td></td>
<td>unilateral, lobar/consolidation</td>
<td>unilateral, lobar/consolidation</td>
</tr>
<tr>
<td></td>
<td>bilateral, lobar/consolidation</td>
<td>bilateral, lobar/consolidation</td>
</tr>
<tr>
<td></td>
<td>interstitial infiltrates</td>
<td>interstitial infiltrates</td>
</tr>
<tr>
<td></td>
<td>widened mediastinum</td>
<td>widened mediastinum</td>
</tr>
<tr>
<td></td>
<td>pleural effusion</td>
<td>pleural effusion</td>
</tr>
<tr>
<td></td>
<td>other ________________</td>
<td>other ________________</td>
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<tr>
<td></td>
<td>(<strong><strong>/</strong></strong>/____)</td>
<td>(<strong><strong>/</strong></strong>/____)</td>
</tr>
<tr>
<td>Other pertinent study results (e.g.,chest CT, pleural fluid)</td>
<td></td>
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<tr>
<td></td>
<td>(<strong><strong>/</strong></strong>/____)</td>
<td>(<strong><strong>/</strong></strong>/____)</td>
</tr>
</tbody>
</table>
INFECTIOUS DISEASE CONSULT: Yes No Unknown

Date of Exam: ___/___/___

Name of ID physician: Last Name ___________________ First Name ____________________

Telephone or pager number ( ) _____ - _____

HOSPITAL COURSE:

A. antibiotics: Yes No Unknown
   If yes, list all that apply: ______________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

B. antivirals: Yes No Unknown
   If yes, check all that apply:
   Acyclovir (Zovirax)
   Amantadine (Symmetrel)
   Oseltamivir (Tamiflu)
   Rimantidine (Flumadine)
   Zanamivir (Relenza)
   other _________________________________________________________

C. Was the patient placed in a negative pressure room?: Yes No Unknown
   If yes, how soon after admission: Immediately Minutes Hours Days

D. Did patient require intensive care: Yes No Unknown
   If patient was admitted to Intensive Care Unit:
   a. Length of stay in ICU, in days: _______
   b. Was patient on mechanical ventilation: Yes No Unknown

WORKING OR DISCHARGE DIAGNOSIS(ES):

1) ____________________________________________________________________________

2) ____________________________________________________________________________

3) ____________________________________________________________________________

OUTCOME:
Recovered/discharged
Died
Still in hospital: improving ? worsening ?
Risk Exposure Questions

The following questions pertain to the 2 week period prior to the onset of your illness/symptoms:

**Occupation (provide information for all jobs/ volunteer duties)**

1. Please briefly describe your job/ volunteer duties: _________________________________________________

2. Does your job involve contact with the public? : Yes  No
   If “Yes”, specify __________________________________________________________

3. Does anyone else at your workplace have similar symptoms?
   Yes  No  Unknown
   If ”Yes”, name and approximate date on onset (if known) ___________________________

**Knowledge of Other Ill Persons**

4. Do you know of other people with similar symptoms? : Yes  No  Unknown
   (If Yes, please complete the following questions)

<table>
<thead>
<tr>
<th>Name of ill Person</th>
<th>AGE</th>
<th>Sex</th>
<th>Address</th>
<th>Phone</th>
<th>Date of Onset</th>
<th>Relation To you</th>
<th>Did they seek Medical care? Where</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Travel**

*Travel is defined as staying overnight (or longer) at somewhere other than the usual residence

8. Have you traveled anywhere in the last two weeks? : Yes  No  Unknown

   Dates of Travel: ____/____/____ to ____/____/____
   Method of Transportation for Travel: ____________________________
   Where Did You Stay? ____________________________________________
   Purpose of Travel? ____________________________________________
   Did You Do Any Sightseeing on your trip? : Yes  No
   If yes, specify: ________________________________________________
   Did Anyone Travel With You? : Yes  No
   If yes, specify: ________________________________________________
   Are they ill with similar symptoms? : Yes  No  Unknown
   If yes, specify: ________________________________________________
### Public Functions/Venues (during 2 weeks prior to symptom onset)

<table>
<thead>
<tr>
<th>Category</th>
<th>Description of Activity</th>
<th>Location of Activity</th>
<th>Date of Activity</th>
<th>Time of Activity (start, end)</th>
<th>Others ill? (Y/N/U)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Airports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Beaches</td>
<td></td>
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<tr>
<td>11.</td>
<td>Bars/Clubs</td>
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<tr>
<td>12.</td>
<td>Campgrounds</td>
<td></td>
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<tr>
<td>13.</td>
<td>Carnivals/Circus</td>
<td></td>
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</tr>
<tr>
<td>14.</td>
<td>Casinos</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>15.</td>
<td>Family Planning Clinics</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>16.</td>
<td>Government Office</td>
<td>Building</td>
<td></td>
<td></td>
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<tr>
<td>17.</td>
<td>Gym/Workout Facilities</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18.</td>
<td>Meetings or</td>
<td>Conferences</td>
<td></td>
<td></td>
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<tr>
<td>19.</td>
<td>Movie Theater</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20.</td>
<td>Museums</td>
<td></td>
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</tr>
<tr>
<td>21.</td>
<td>Parks</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>22.</td>
<td>Parties (including Raves, Prom, etc)</td>
<td></td>
<td></td>
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<tr>
<td>23.</td>
<td>Performing Arts (ie Concert, Theater, Opera)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>24.</td>
<td>Picnics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Political Events</td>
<td>(including Rallies)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Religious Gatherings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Shopping Malls</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>28.</td>
<td>Sporting Event</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29.</td>
<td>Street Festivals, Flea Markets, Parades</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>30.</td>
<td>Tourist Attractions (ie French Quarter, Aquarium)</td>
<td></td>
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</tr>
</tbody>
</table>
**Transportation**

Have you used the following types of transportation in the 2 weeks prior to onset?

31. Bus/Streetcar: Yes  No  Unknown
   Frequency of this type of transportation: Daily, Weekly, Occasionally, Rarely
   Bus Number: __________________  Origin:______________________________

   Any connections?  Yes  No  (Specify: Location_________ Bus#__________)
   Company Providing Transportation: ______________________  Destination:________

32. Train: Yes  No  Unknown
   Frequency of this type of transportation: Daily, Weekly, Occasionally, Rarely
   Route Number: ________________  Origin:______________________________

   Any connections?  Yes  No  (Specify: Location________________________ Route #__________)
   Company Providing Transportation: ______________________  Destination:________

33. Airplane: Yes  No  Unknown
   Frequency of this type of transportation: Daily, Weekly, Occasionally, Rarely
   Flight Number: ________________  Origin:______________________________

   Any connections?  Yes  No  (Specify: Location_____________ Flight #_________)
   Company Providing Transportation: ______________________  Destination:________

34. Ship/Boat/Ferry: Yes  No  Unknown
   Frequency of this type of transportation: Daily, Weekly, Occasionally, Rarely
   Ferry Number: ________________  Origin:______________________________

   Any connections?  Yes  No  (Specify: Location_____________ Ferry #__________)
   Company Providing Transportation: ______________________  Destination:________

35. Van Pool/Shuttle: Yes  No  Unknown
   Frequency of this type of transportation: Daily, Weekly, Occasionally, Rarely
   Route Number: ________________  Origin:______________________________

   Any connections?  Yes  No  (Specify: Location_________ Route #__________)
   Company Providing Transportation: ______________________  Destination:________
**Food & Beverage**

36. During the 2 weeks before your illness, did you eat at any of the following **food establishments or private gatherings with food or beverages**?

<table>
<thead>
<tr>
<th>Food Establishment</th>
<th>Y/ N/ U</th>
<th>Name of Establishment</th>
<th>Location of Meal</th>
<th>Date of Meal</th>
<th>Time of Meal (start, end)</th>
<th>Food and Drink items consumed</th>
<th>Others ill? (Y/N/U)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cafeteria at School, hospital, or other</td>
<td></td>
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<tr>
<td>Casino or mall food court</td>
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<tr>
<td>Grocery Store or Corner Store</td>
<td></td>
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<tr>
<td>Concert, movie, or other entertainment</td>
<td></td>
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</tr>
<tr>
<td>Dinner party, birthday party or other celebration</td>
<td></td>
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<tr>
<td>Gas station or convenience store</td>
<td></td>
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<tr>
<td>Plane, boat, train, or other</td>
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<tr>
<td>Picnic, Barbecue, Crawfish boil, or potluck</td>
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<tr>
<td>Outdoor farmers market, festival, or swap meet</td>
<td></td>
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<tr>
<td>Restaurant, fast-food, or deli</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Sporting event or snack bar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street vended food</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other food establishment</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Other Private Gathering</td>
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</tbody>
</table>

37. During the 2 weeks before your illness, did you consume any free **food samples** from………?

- Grocery store  Yes, No, Unknown
- Race/competition Yes, No, Unknown
- Public gathering? Yes, No, Unknown
- Private gathering? Yes, No, Unknown
If “YES” for any in question #37, provide date, time, location and list of food items consumed:
Date/Time: __________________________
Location (Name and Address): ____________________________
Food/drink consumed: ____________________________

Others also ill?  Yes  , No  Unknown
(explain): ____________________________________________

38. During the 2 weeks before your illness, did you consume any of the following products?
Vitamins  Yes  , No  Unknown
Specify (Include Brand Name): ____________________________

Herbal remedies  Yes  , No  Unknown
Specify (Include Brand Name): ____________________________

Diet Aids  Yes  , No  Unknown
Specify (Include Brand Name): ____________________________

Nutritional Supplements  Yes  , No  Unknown
Specify (Include Brand Name): ____________________________

Other Ingested non-food  Yes  , No  Unknown
Specify (Include Brand Name): ____________________________

39. During the 2 weeks before your illness, did you consume any unpasteurized products (ie milk, cheese, fruit juices)?
Yes  , No  Unknown
If yes, specify name of item: ____________________________
Date/Time: ____________________________
Location (Name and Address): ____________________________
Others also ill?  Yes  , No  Unknown
(explain): ____________________________________________

40. During the 2 weeks before your illness, did you purchase food from any internet grocers?
Yes  , No  Unknown
If yes, specify date/time of delivery: ____________________________ Store/Site: ____________________________
Items purchased: ____________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
____________________________________

41. During the 2 weeks before your illness, did you purchase any mail order food?
Yes  , No  Unknown
If yes, specify date/time of delivery: ____________________________
Store purchased from: ____________________________________________ Items purchased: ____________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
____________________________________
42. Please check the routine sources for drinking water (check all that apply):
   Community or Municipal
   Well (shared)
   Well (private family)
   Bottled water (Specify Brand: ____________)
   Other (Specify: ______________________)

Aerosolized water
43. During the 2 weeks prior to illness, did you consume water from any of the following sources (check all that apply):
   Wells
   Lakes
   Streams
   Springs
   Ponds
   Creeks
   Rivers
   Sewage-contaminated water
   Street-vended beverages (Made with water or ice and sold by street vendors)
   Ice prepared w/ unfiltered water (Made with water that is not from a municipal water supply or that is not bottled or boiled)
   Unpasteurized milk
   Other (Specify: ________________________________)

If “YES” for any in question #43, provide date, time, location and type of water consumed:
Date/Time: __________________
Location (Name and Address): ____________________________
Type of water consumed: ________________________________
Others also ill?: Yes, No, Unknown
(explain): ____________________________________

44. During the 2 weeks prior to illness, did you engage in any of the following recreational activities (check all that apply):
   Swimming in public pools (e.g., community, municipal, hotel, motel, club, etc)
   Swimming in kiddie/wading pools
   Swimming in sewage-contaminated water
   Swimming in fresh water, lakes, ponds, creeks, rivers, springs, sea, ocean, bay (please circle)
   Wave pools? Water parks? Waterslides? Surfing
   Rafting? Boating?
   Hot tubs (non-private)? Whirlpools (non-private)
   Jacuzzis (non-private)? Other (Specify: ________________________)

If “YES” for any in question #44, provide date, time, location and type of activity:
Date/Time: __________________
Location (Name and Address): ____________________________
Type of water consumed: ________________________________
Others also ill?: Yes, No, Unknown
(explain): ____________________________________
45. During the 2 weeks prior to illness, were you exposed to aerosolized water from any of the following non-private (i.e., used in hospitals, malls, etc) sources (check all that apply):
- Air conditioning at public places
- Respiratory devices
- Vaporizers
- Humidifiers
- Misters
- Whirlpool spas
- Hot tub
- Spa baths
- Creek and ponds
- Decorative fountains
- Other (please explain) ___________________________________________

If “YES” for any in question #45, provide date, time, and location of exposure to aerosolized water:
Date/Time: __________________
Location (Name and Address): _______________________________________
Explanation of aerosolized water: _______________________________________
Others also ill:  Yes  No  Unknown
(explain): ___________________________________________________________

**Recreation** (Activities that are not related to work)

46. In the past two weeks, did you participate in any outdoor activities?
- Yes  No  Unknown

(If “yes”, list all activities and provide locations)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

47. Do you recall any insect or tick bites during these outdoor activities?
- Yes  No  Unknown

(If “yes”, list all activities and provide locations of activities)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

48. Did you participate in other indoor recreational activities (i.e. clubs, crafts, etc that did not occur in a private home)?
- Yes  No  Unknown

(List all activities and provide location)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

State of Louisiana Office of Public Health- Infectious Disease Epidemiology Section

Bioterrorism Manual
Vectors

49. Do you recall any insect or tick bites in the last 2 weeks?
   Yes  No  Unknown

Date(s) of bite(s):____________________________________ Bitten by:  Mosquito
   Tick  Flea  Fly  Other:
Where were you when you were bitten?________________________

50. Have you had any contact with wild or domestic animals, including pets?
   Yes  No  Unknown

Type of Animal: __________________
Explain nature of contact:_____________________
Is / was the animal ill recently:  Yes  No  Unknown
If yes please describe the animal’s symptoms:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Date / Time of contact:_____________________________________
Location of contact:_____________________________________

51. To your knowledge, have you been exposed to rodents/rodent droppings in the last 2 weeks?
   Yes  No  Unknown

If yes, explain type of exposure:______________________________
Date/Time of exposure:____________________________________
Location where exposure occurred:____________________________