Case ID:______________ First Name:___________________ Last Name:__________________

PSITTACOSIS HUMAN CASE SURVEILLANCE REPORT

Investigation Information			
Report Date ____/____/_____ MM/DD/YYYY	**Patient Status** □ Inpatient □ Outpatient □ 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** □ **Work / Business** □ **Cell** ###-###-####	**Ext.**
If patient < 18yrs:			
Parent/Guardian Last name	**First name**	**Middle name**	

Demographics		
Gender □ Male □ Female □ Unknown	**Date of Birth** ____/____/_____ MM/DD/YYYY	**Age** □ **Years** □ **Months**
Race □ Caucasian □ African America □ American Indian/Alaska Native □ Hawaiian/Pacific Islander □ Asian □ Unknown □ Other (Specify)______________________________		
Ethnicity □ Hispanic/Latino □ Non-Hispanic/Latino □ Unknown		
If female, pregnant? □ Yes □ 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**	

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<table>
<tr><th colspan="4">Clinical Information</th></tr>
<tr><td colspan="4">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): ____</td></tr>
<tr><td colspan="4">Specific therapy: (Specify products, dosage, and dates of treatment)</td></tr>
<tr><td colspan="2">Outcome:
□ Hospitalized □ Required ICU care
□ Recovered □ Unknown
Date of discharge: ____/____/____
MM/DD/YYYY</td><td colspan="2">If the patient died, date of death:
____/____/____
MM/DD/YYYY</td></tr>
<tr><th colspan="4">Laboratory Information</th></tr>
<tr><th>Test Name/Test Method</th><th>Date Specimen Collected MM/DD/YYYY</th><th>Test Result</th><th>Name of Laboratory</th></tr>
<tr><td>C. psittaci PCR (preferred)
□ blood □ sputum
□ other (specify): _________</td><td>____/____/_____</td><td></td><td></td></tr>
<tr><td>Respiratory secretions C. psittaci culture (preferred)
□ sputum □ BAL
□ other (specify): _________</td><td>____/____/_____</td><td></td><td></td></tr>
<tr><td>C. psittaci
Fourfold increase in antibody titer
Acute-phase serum
□ CF □ MIF □ Other (specify)____

Convalescent-phase serum
□ CF □ MIF □ Other (specify)____</td><td>____/____/_____

____/____/_____</td><td>IgM:_______
IgG:________

IgM:________
IgG: _______</td><td></td></tr>
<tr><td>C. pneumoniae PCR
□ blood □ sputum
□ other (specify): _________</td><td>____/____/_____</td><td></td><td></td></tr>
<tr><td>C. pneumoniae
Fourfold increase in antibody titer
Acute-phase serum
□ CF □ MIF □ Other (specify)____

Convalescent-phase serum
□ CF □ MIF □ Other (specify)____</td><td>____/____/_____

____/____/_____</td><td>IgM:_______
IgG:________

IgM:________
IgG: _______</td><td></td></tr>
</table>

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Chlamydia trachomatis [any test(s)]	____/____/_____		
Autopsy □ lung □ other: _________	____/____/_____		
Chest X-ray done: □ Yes □ No □ 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			

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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.**	