

# PSITTACOSIS HUMAN CASE SURVEILLANCE REPORT

## Investigation Information

<b>Report Date</b> ____/____/____	<b>Patient Status</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Died	<b>Diagnosis Date</b> ____/____/____	<b>Onset Date</b> ____/____/____
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## Patient Information

<b>Patient ID</b>	<b>First</b>	<b>Last</b>	<b>Middle</b>
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**Street Address**

<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>
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<b>Home Phone</b> ###-###-####	<b>Ext.</b>	<b>Other Phone</b> ###-###-####	<b>Ext.</b>
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Parent/Guardian (if under 18yr.)

<b>First</b>	<b>Last</b>	<b>Middle</b>
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## Demographics

<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<b>Date of Birth</b> ____/____/____	<b>Age</b>
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**Race**  
 Caucasian  African America  American Indian/Alaska Native  Hawaiian/Pacific Islander  Asian  
 Unknown  Other (Specify) \_\_\_\_\_

**Ethnicity**  
 Hispanic/Latino  Non-Hispanic/Latino  Unknown

## Report Information

Person Providing Report

<b>First</b>	<b>Last</b>	<b>Phone</b> ###-###-####	<b>Ext.</b>	<b>Email</b>
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Primary Physician

<b>First</b>	<b>Last</b>	<b>Phone</b> ###-###-####	<b>Ext.</b>	<b>Email</b>
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**Street Address**

<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>
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Case ID

First Name

Last Name

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

- Fever                       Pneumonia  
 Myalgia                       Rash  
 Chills                         Photophobia  
 Headache                     Other (describe/details):  
 Cough

**Specific therapy: (Specify products and dosage)****Outcome:**

- 
- Recovered
- 
- Died
- 
- Unknown

**If the patient died, date of death:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Laboratory Information**

Test Name/Test Method	Date Specimen Collected	Test Result	Name of Laboratory
MIF	____/____/____		
IFA- Acute phase serum	____/____/____		
IFA Convalescent-phase serum	____/____/____		
PCR	____/____/____		
Isolation	____/____/____		

**Chest X-rays done:**

- 
- Yes
- 
- No
- 
- Unknown

**If yes, date:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**If yes, results:****Epidemiologic Information****Occupation at date of onset:****Specific duties:****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			

**If birds were not healthy, please elaborate:**

Case ID

First Name

Last Name

**Epidemiologic Information cont.**

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

Type of Establishment	Owner	Address	Exposure To (Species)	Exposure setting	Date of Exposure
1=Private home 2=Private aviary 3=commercial aviary 4=Pet shop 5=Bird loft 6=Poultry establishment 7=other 8=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**

<b>Submitted by:</b>	<b>Date:</b> ____/____/____	<b>Health Dept.</b>
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<b>Phone number:</b> ### ##-####	<b>Ext.</b>	
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