

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

TULAREMIA

Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 43

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name, First, Middle, Suffix, Maiden/Other, Alias, Birthdate (mm/dd/yyyy), SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Table with 8 columns: Specimen Date, Specimen #, Specimen Source, Type of Test, Test Result(s), Description (comments), Result Date, Lab Name—City/State

CLINICAL FINDINGS
Is/was patient symptomatic for this disease?
Fever
Pulse-temperature dissociation
Fatigue or malaise or weakness
Sweats (diaphoresis)
Chills or rigors
Shock
Swollen lymph nodes
Headache
Stiff neck
Meningitis
Elevated CSF protein
Elevated CSF cell count
Joint pains (arthralgias)
Muscle aches / pains (myalgias)
Skin lesions
Swollen eyelids
Conjunctivitis
Eye pain
Runny nose and/or teary eyes
Oropharyngeal/mucosal lesion(s)
Sore throat
Pharyngitis
Tonsillitis
Cough
Shortness of breath/difficulty breathing/respiratory distress
Acute Respiratory Distress Syndrome (ARDS)
Pneumonia
Chest x-ray
Chest CT scan performed
Other symptoms, signs, clinical findings, or complications consistent with this illness
PREDISPOSING CONDITIONS
Any immunosuppressive conditions?
TREATMENT
Did the patient take an antibiotic for this illness?

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

**HOSPITALIZATION INFORMATION**

Was patient hospitalized for this illness >24 hours?  Y  N  U

Hospital name: \_\_\_\_\_

City, State: \_\_\_\_\_

Hospital contact name: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Admit date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Discharge date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**TRAVEL/IMMIGRATION**

The patient is:

Resident of NC

Resident of another state or US territory

Foreign Visitor

Refugee

Recent Immigrant

Foreign Adoptee

None of the above

Did patient travel during the 14 days prior to onset of symptoms?  Y  N  U

List travel dates and destinations:

From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOOD RISK AND EXPOSURE**

During the 14 days prior to onset of symptoms, did the patient:

Handle raw meat other than poultry?  Y  N  U

If yes, specify and give details: \_\_\_\_\_

**ISOLATION/QUARANTINE/CONTROL MEASURES**

Restrictions to movement or freedom of action?  Y  N

If yes, specify and give details: \_\_\_\_\_

Date control measures issued: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date control measures ended: \_\_\_\_/\_\_\_\_/\_\_\_\_

Was patient compliant with control measures?  Y  N

Did local health director or designee implement additional control measures?  Y  N

If yes, specify: \_\_\_\_\_

\_\_\_\_\_

Were written isolation orders issued?  Y  N  U

If yes, where was the patient isolated? \_\_\_\_\_

\_\_\_\_\_

Date isolation started: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date isolation ended: \_\_\_\_/\_\_\_\_/\_\_\_\_

Was the patient compliant with isolation?  Y  N  U

Does patient know anyone else with similar symptom(s) who had the same or similar travel history?  Y  N  U

List persons and contact information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional travel/residency information: \_\_\_\_\_

**WATER EXPOSURE**

During the 14 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water (natural waters only)?  Y  N  U

If yes, specify and give details: \_\_\_\_\_

Were written quarantine orders issued?  Y  N

If yes, where was the patient quarantined? \_\_\_\_\_

\_\_\_\_\_

Date quarantine started: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date quarantine ended: \_\_\_\_/\_\_\_\_/\_\_\_\_

Was the patient compliant with quarantine?  Y  N

**Notes:**

\_\_\_\_\_

**HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS**

During the 14 days prior to onset of symptoms, did the patient work in a laboratory?  Y  N  U

If yes, specify and give details: \_\_\_\_\_

**OUTDOOR EXPOSURE**

During the 14 days prior to onset of symptoms, did the patient participate in any of the following:

Gardening

Lawn Mowing

Landscaping

If yes, specify and give details: \_\_\_\_\_

Was patient exposed to wild animals?  Y  N  U

Specify animal(s) \_\_\_\_\_

Did patient handle the animal?  Y  N  U

Animal was:

Alive  Dead  Unknown

Was animal sick?  Y  N  U

**CLINICAL OUTCOMES**

Discharge/Final diagnosis: \_\_\_\_\_

Survived?  Y  N  U

Died?  Y  N  U

Died from this illness?  Y  N  U

Date of death (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Autopsy performed?  Y  N  U

Patient autopsied in NC?  Y  N  U

County of autopsy: \_\_\_\_\_

Autopsied outside NC, specify where: \_\_\_\_\_

Source of death information (select all that apply):

Death certificate

Autopsy report final conclusions

Hospital/discharge physician summary

Other

**OTHER EXPOSURE INFORMATION**

Does the patient know anyone else with similar symptoms?  Y  N  U

If yes, specify: \_\_\_\_\_

During the 14 days prior to onset of symptoms, did the patient serve in the U.S. military?  Y  N  U

If yes, specify where and give dates of service: \_\_\_\_\_

**VECTOR EXPOSURE**

During the 14 days prior to onset of symptoms, did the patient have an opportunity for exposure to ticks or deerflies?  Y  N  U

If yes, specify \_\_\_\_\_

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

**ANIMAL EXPOSURE**

During the 14 days prior to onset of symptoms:  
**Did the patient have exposure to rabbits, hares, or other wild animals** (includes animal tissues, animal products, or animal excreta)? .....  Y  N  U  
 Specify animal(s) \_\_\_\_\_  
 \_\_\_\_\_  
**Did patient work at or visit a slaughterhouse (abattoir), meat-packing plant, poultry or wild game processing facility?** .....  Y  N  U  
**Has patient otherwise slaughtered animals or been a butcher, meat cutter, or meat processor?** .....  Y  N  U  
**Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory?** .....  Y  N  U  
**Did the patient skin/eviscerate (gut) wild animal(s) or have contact with wild animal carcass?** .....  Y  N  U  
 Specify animal(s) \_\_\_\_\_  
 \_\_\_\_\_  
 Specify exposure(s) (contact with) - check all that apply:  
 Hide       Bone       Blood  
 Hair       Raw meat       Excreta  
**Did the patient work with tularemia vaccine?** .....  Y  N  U  
 If yes, specify and give details:  
 \_\_\_\_\_  
**Did the patient necropsy animals?** ..  Y  N  U  
 If yes, specify and give details:  
 \_\_\_\_\_  
**Did the patient work with F. tularensis?** .....  Y  N  U  
 If yes, specify and give details:  
 \_\_\_\_\_

Provide the nature of contact, dates, location, and other specifics for any question answered yes.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CASE INTERVIEWS/INVESTIGATIONS**

**Was the patient interviewed?** .....  Y  N  U  
 Date of interview (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Were interviews conducted with others?** .....  Y  N  U  
 Who was interviewed?  
 \_\_\_\_\_  
**Were health care providers consulted?** .....  Y  N  U  
 Who was consulted?  
 \_\_\_\_\_  
**Medical records reviewed (including telephone review with provider/office staff)?** .....  Y  N  U  
**Specify reason if medical records were not reviewed:**  
 \_\_\_\_\_

Notes on medical record verification:  
 \_\_\_\_\_  
 \_\_\_\_\_

**GEOGRAPHICAL SITE OF EXPOSURE**

**In what geographic location was the patient MOST LIKELY exposed?**  
 Specify location:  
 In NC  
 City \_\_\_\_\_  
 County \_\_\_\_\_  
 Outside NC, but within US  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 County \_\_\_\_\_  
 Outside US  
 City \_\_\_\_\_  
 Country \_\_\_\_\_  
 Unknown  
**Is the patient part of an outbreak of this disease?** .....  Y  N

Notes:  
 \_\_\_\_\_  
 \_\_\_\_\_

**VACCINE**

**Has patient/contact ever received tularemia vaccine?** .....  Y  N  U  
 If yes, provide the vaccine name, source of vaccine, date of vaccination, and source of vaccine information:  
 \_\_\_\_\_  
 \_\_\_\_\_

## **Tularemia (*Francisella tularensis*)**

### **1999 CDC Case Definition**

#### **Clinical description**

An illness characterized by several distinct forms, including the following:

- Ulceroglandular: cutaneous ulcer with regional lymphadenopathy
- Glandular: regional lymphadenopathy with no ulcer
- Oculoglandular: conjunctivitis with preauricular lymphadenopathy
- Oropharyngeal: stomatitis or pharyngitis or tonsillitis and cervical lymphadenopathy
- Intestinal: intestinal pain, vomiting, and diarrhea
- Pneumonic: primary pleuropulmonary disease
- Typhoidal: febrile illness without early localizing signs and symptoms

Clinical diagnosis is supported by evidence or history of a tick or deerfly bite, exposure to tissues of a mammalian host of *Francisella tularensis*, or exposure to potentially contaminated water.

#### **Laboratory criteria for diagnosis**

##### *Presumptive*

- Elevated serum antibody titer(s) to *F. tularensis* antigen (without documented fourfold or greater change) in a patient with no history of tularemia vaccination **OR**
- Detection of *F. tularensis* in a clinical specimen by fluorescent assay

##### *Confirmatory*

- Isolation of *F. tularensis* in a clinical specimen **OR**
- Fourfold or greater change in serum antibody titer to *F. tularensis* antigen

#### **Case classification**

*Probable*: a clinically compatible case with laboratory results indicative of presumptive infection

*Confirmed*: a clinically compatible case with confirmatory laboratory results