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

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

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.

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? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
Fever ☐Y ☐N ☐U
☐Yes, subjective ☐No
☐Yes, measured ☐Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):____/____/____
Pulse-temperature dissociation ☐Y ☐N ☐U
Fatigue or malaise or weakness ☐Y ☐N ☐U
Sweats (diaphoresis) ☐Y ☐N ☐U
Chills or rigors ☐Y ☐N ☐U
Shock ☐Y ☐N ☐U
Was systolic BP <90mm Hg ☐Y ☐N ☐U
Shock was: ☐Septic ☐Hypovolemic
Swollen lymph nodes (lymphadenopathy or lymphadenitis) ☐Y ☐N ☐U
Distribution:
☐Generalized ☐Regional ☐Unilateral
☐Bilateral ☐Unknown
Location
☐Preauricular ☐Inguinal
☐Cervical ☐Femoral
☐Axillary ☐Other_____
Tenderness
☐Tender ☐Non-tender
Headache ☐Y ☐N ☐U
Stiff neck ☐Y ☐N ☐U
Meningitis ☐Y ☐N ☐U
Elevated CSF protein ☐Y ☐N ☐U
Elevated CSF cell count ☐Y ☐N ☐U
Joint pains (arthralgias) ☐Y ☐N ☐U
Muscle aches / pains (myalgias) ☐Y ☐N ☐U
Skin lesions ☐Y ☐N ☐U
Describe (check all that apply)
☐Papule ☐Pustule ☐Vesicle ☐Ulcer
Swollen eyelids (periorbital edema) ☐Y ☐N ☐U
Conjunctivitis ☐Y ☐N ☐U
Eye pain ☐Y ☐N ☐U
Runny nose and/or teary eyes (coryza) ☐Y ☐N ☐U
Oropharyngeal/mucosal lesion(s) (stomatitis) ☐Y ☐N ☐U
Sore throat ☐Y ☐N ☐U
Pharyngitis ☐Y ☐N ☐U
Tonsillitis ☐Y ☐N ☐U
Cough ☐Y ☐N ☐U
Shortness of breath/difficulty breathing/ respiratory distress ☐Y ☐N ☐U
Acute Respiratory Distress Syndrome (ARDS) ☐Y ☐N ☐U
Pneumonia ☐Y ☐N ☐U
Chest x-ray ☐Y ☐N ☐U
Describe (check all that apply)
☐Normal
☐Infiltrate
☐Diffuse infiltrates/findings suggestive of ARDS
☐Mediastinal widening
☐Pleural effusion
☐Hilar adenopathy
☐Other_____
Chest CT scan performed ☐Y ☐N ☐U
Date performed(mm/dd/yyyy):____/____/____
Describe (check all that apply):
☐Normal
☐Infiltrate
☐Pleural effusion
☐Hilar adenopathy
☐Mediastinal adenopathy
☐Other _____
Chest pain ☐Y ☐N ☐U
Nausea ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Abdominal pain or cramps ☐Y ☐N ☐U
Diarrhea ☐Y ☐N ☐U
Bacteremia ☐Y ☐N ☐U
Date of positive blood culture____/____/____
Septicemia/sepsis ☐Y ☐N ☐U
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U
Specify _____
Clinical classification
☐Glandular
☐Oculoglandular
☐Oropharyngeal
☐Pneumonic
☐Ulceroglandular
☐Unknown

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U
Specify _____

TREATMENT

Did the patient take an antibiotic for this illness? ☐Y ☐N ☐U
If yes, specify:

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

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

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:

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

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 _____/_____/_____

_____

_____

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:

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:

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:

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:

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 detailis:

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

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 _____

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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