

MELIOIDOSIS INTAKE FORM



Acute Communicable Disease Control
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www.publichealth.lacounty.gov/acd

VCMR ID: _____ Census Tract: _____ Health District: _____

Investigator Name		Report Date	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Reporter Name		<input type="checkbox"/> Call <input type="checkbox"/> Email	Agency Name	
Telephone () ()	Alternate Telephone () ()	Email Address		

INITIAL IMPRESSION: Single Case Laboratory Exposure

DEMOGRAPHIC INFORMATION

Patient Name-Last	First	Middle Initial	Date of Birth	Age	Sex
Address- Number, Street, Apt #		City	State	ZIP Code	
Telephone number					
Home:		Work:	Cell:		
Race (check one)			Ethnicity (check one)		
<input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____			<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
If Asian/Pacific Islander, please check one: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian					
<input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____					
Occupation			Country of birth _____		
Pregnant? (if Female) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, due date: _____			If not U.S. Born - Date of Arrival in U.S. _____		

PRESENT ILLNESS

Symptomatic: Yes No Unknown *If No, Skip this section and go to Epidemiological Risk Factors section.*

	Yes	No	Unk		Yes	No	Unk
Abdominal discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abscess (Specify. _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Localized pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain/tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever (highest temp _____ F°)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss (lbs. _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other symptom(s).			

Onset date	Duration of symptoms (in days)	Date of Diagnosis	Diagnosis		
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Hospital Name	Medical Record Number	Outcome	<input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown	Date of Death
Antibiotics given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Specify Antibiotic(s).	Date Antibiotic Started	No. of Days Taken		

DIAGNOSTIC TESTS

Date Specimen Collected	Specimen Type: <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Urine <input type="checkbox"/> Pus <input type="checkbox"/> Throat swab <input type="checkbox"/> Swabs from organ abscesses/wounds <input type="checkbox"/> Other: Specify. _____				
Lab exam(s) conducted:	<input type="checkbox"/> Culture <input type="checkbox"/> BACTEC/automated system <input type="checkbox"/> PCR <input type="checkbox"/> IHA <input type="checkbox"/> Other: Specify. _____	<input type="checkbox"/> Unknown	Serology (IHA):	<input type="checkbox"/> Acute <input type="checkbox"/> Convalescent	

Laboratory Results

Laboratory Name	Physician Name
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Patient Name (last, first) _____ Date of Birth _____ VCMR ID: _____

EPIDEMIOLOGIC RISK FACTORS

Was this individual part of a recognized cluster or outbreak of melioidosis? Yes No Unk *If Yes, complete page 1 for each case.*

If Yes, please list the name(s) of other associated case(s). _____

Travel **from** the United States **to** another country in the past year? Yes No Unk

If Yes, what country? _____ Dates of travel: _____ to _____

Have any of the following known medical conditions? Check all that apply.

- Diabetes mellitus Alcoholism Renal disease Chronic lung disease Thalassemia Immunosuppression Unknown
 Other: Specify. _____

Have any of the following exposures? Check all that apply.

- Military Service: Specify place: _____ When: _____
 Soil or water contact in endemic country: Specify place: _____ When: _____
 Animal (mammal, reptile, bird) contact: Specify animal: _____ When: _____

LABORATORY EXPOSURE

Was there a laboratory exposure? Yes No Unk *If No, Skip the Laboratory Exposure section.*

If Yes, Date of exposure _____ Total number exposed _____: High Risk _____ Low Risk _____

Laboratory name and location. _____

Activities resulting in exposure. _____

Describe potential exposure. _____

Date post-exposure prophylaxis (PEP) was offered/discussed _____ Risk Status: High Low Unknown

Date PEP initiated _____ PEP regimen used _____

Time between first exposure and start of PEP: _____ Dosing: _____ Duration: _____

Were any side effects reported with the PEP? Yes No Unk

If Yes, Date of onset _____

Describe side effects. _____

Did side effects result in the termination of PEP? Yes No Unk *If Yes, how many days was prophylaxis administered? _____*

Did side effects result in a switch to another antimicrobial agent? Yes No Unk

If Yes, Specify antimicrobial agent. _____

Date started. _____

Are serial serum specimens being collected? Yes No Unk

If Yes, Collection date of "baseline" serum sample? _____

Time between first exposure and initial serum collection: _____ Days Weeks

Dates of serum collection: Week 1 _____ Week 2 _____ Week 4 _____ Week 6 _____

REMARKS

CDPH notified: Contact name _____ Date notified _____ Method: Call Email