NJDOH TULAREMIA INVESTIGATION WORKSHEET

MR #: _____ CDRSS #: _____

DEMOGRAPHICS

Patient Last Name	First Name	DOB:	Phone number
		____ / ____ / ____	
Address		**City**	**Municipality**

Ethnicity
- ○ Hispanic
- ○ Non-Hispanic
- ○ Unknown

Race
☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian or Alaskan Native
☐ Unknown

Pregnancy Status
- ○ Pregnant Due Date: ____ / ____ / ____
- ○ Not pregnant
- ○ Unknown
- ○ N/A

Occupation

Works primarily:
☐ Indoors ☐ Outdoors ☐ Both
☐ Neither ☐ Unknown

PHYSICIAN AND FACILITY INFORMATION

Treating physician

Name:

Address:

Phone: Fax:

Email:

Facility (if hospitalized)

Name of facility:

Date of admission: ___ /___ /_____

Date of discharge: ___ /___ /_____

CLINICAL STATUS

Was an underlying immunosuppressive condition present?
- ○ Yes, specify:
- ○ No
- ○ Unk

Current diagnosis

Primary clinical syndrome
☐ Ulceroglandular ☐ Glandular ☐ Oculoglandular ☐ Oropharyngeal
☐ Typhoidal ☐ Pneumonic ☐ Meningitic

Illness onset date

___ /___ /_____

Sign/Symptom	Response	Onset	Additional information
Abdominal pain	○ Yes ○ No ○ Unk	___ /___ /_____	
Chest pain	○ Yes ○ No ○ Unk	___ /___ /_____	
Chills	○ Yes ○ No ○ Unk	___ /___ /_____	
Confusion/delirium	○ Yes ○ No ○ Unk	___ /___ /_____	
Cough	○ Yes ○ No ○ Unk	___ /___ /_____	
Diarrhea	○ Yes ○ No ○ Unk	___ /___ /_____	
Fever	○ Yes ○ No ○ Unk	___ /___ /_____	TMax: _____F
Headache	○ Yes ○ No ○ Unk	___ /___ /_____	
Lethargy	○ Yes ○ No ○ Unk	___ /___ /_____	
Malaise	○ Yes ○ No ○ Unk	___ /___ /_____	
Myalgia	○ Yes ○ No ○ Unk	___ /___ /_____	
Nausea	○ Yes ○ No ○ Unk	___ /___ /_____	

Shortness of breath	○ Yes ○ No ○ Unk	___ /___ /_____	
Sore throat	○ Yes ○ No ○ Unk	___ /___ /_____	
Sweats	○ Yes ○ No ○ Unk	___ /___ /_____	
Skin ulcer	○ Yes ○ No ○ Unk	___ /___ /_____	Describe:
Skin papules	○ Yes ○ No ○ Unk	___ /___ /_____	Describe:
Lymphadenopathy	○ Yes ○ No ○ Unk	___ /___ /_____	Describe:
Pharyngitis or tonsillitis	○ Yes ○ No ○ Unk	___ /___ /_____	Describe:
Conjunctivitis	○ Yes ○ No ○ Unk	___ /___ /_____	Describe:
Pneumonia	○ Yes ○ No ○ Unk	___ /___ /_____	Describe:

Additional Signs/Symptoms:

Chest X-ray: ☐Not done ☐Unknown ☐Infiltrations Date: ___ /___ /_____ ☐Pleural effusion Date: ___ /___ /_____ ☐Clear/normal Date: ___ /___ /_____	**Did the patient die because of this illness?** ☐Yes, *specify date* _____ / _____ / _____ ☐ No ☐ Unknown

RISK FACTORS

Was there exposure to tick infested areas? ○ Yes ○ No ○ Unk	Location: Date(s):
Did the patient have a recent tick bite? ○ Yes ○ No ○ Unk	Location of tick bite: Date:
Did the patient recently participate in lawn mowing or related activities? ○ Yes ○ No ○ Unk	Describe activity: Location (address): Date(s):
Did patient have contact with a wild rabbit or wild rabbit carcass? ○ Yes ○ No ○ Unk	Describe contact: Location (address): Date(s):

Were dead rabbits found near the patient's property? ○ Yes ○ No ○ Unk	How many? Location (address): Date(s):

TREATMENT INFORMATION

Name of Treatment	Dosage	Dates
☐ Aminoglycosides *(e.g., streptomycin, gentamicin)* Name:		_____ / _____ / _____ to _____ / _____ / _____
☐ Tetracyclines *(e.g., doxycycline)* Name:		_____ / _____ / _____ to _____ / _____ / _____
☐ Fluoroquinolones *(e.g., ciprofloxacin, levofloxacin)* Name:		_____ / _____ / _____ to _____ / _____ / _____
☐ Other:		_____ / _____ / _____ to _____ / _____ / _____
☐ Other:		_____ / _____ / _____ to _____ / _____ / _____
☐ Other:		_____ / _____ / _____ to _____ / _____ / _____
☐ Other:		_____ / _____ / _____ to _____ / _____ / _____
☐ Not treated		_____ / _____ / _____ to _____ / _____ / _____

CASE NOTES