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

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.

### NC EDSS LAB RESULTS

<table>
<thead>
<tr>
<th>Specimen Date</th>
<th>Specimen #</th>
<th>Specimen Source</th>
<th>Type of Test</th>
<th>Test Result(s)</th>
<th>Description (comments)</th>
<th>Result Date</th>
<th>Lab Name—City/State</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### CLINICAL FINDINGS

**Is/was patient symptomatic for this disease?** [Y N U] Y N U

**If yes, symptom onset date (mm/dd/yyyy):** [Y N U]

- **Fever:** [Y N U] Y N U
  - Yes, subjective [Y N U] Y N U
  - Yes, measured [Y N U] Y N U
  - Highest measured temperature [Y N U]
  - Fever onset date (mm/dd/yyyy): [Y N U]
  - Pulse-temperature dissociation [Y N U]

- **Chills or rigors:** [Y N U] Y N U
- **Shock:** [Y N U] Y N U
  - Was systolic BP <90mm Hg [Y N U]
  - Shock was: [Y N U] Septic
  - Hypovolemic

- **Swellen lymph nodes (lymphadenopathy or lymphadenitis):** [Y N U] Y N U
  - Distribution:
    - Generalized [Y N U]
    - Regional [Y N U]
    - Unilateral [Y N U]
    - Bilateral [Y N U]
    - Unknown [Y N U]
  - Location:
    - Preauricular [Y N U]
    - Inguinal [Y N U]
    - Femoral [Y N U]
    - Axillary [Y N U]
    - Other [Y N U]
  - Tenderness:
    - Tender [Y N U]
    - Non-tender [Y N U]

- **Headache:** [Y N U] Y N U
- **Stiff neck:** [Y N U] Y N U
- **Meningitis:** [Y N U] Y N U
- **Elevated CSF protein:** [Y N U] Y N U
- **Joint pains (arthritis):** [Y N U] Y N U
- **Muscle aches / pains (myalgias):** [Y N U] Y N U
- **Skin lesions:** [Y N U] Y N U
  - Describe (check all that apply):
    - Papule [Y N U]
    - Pustule [Y N U]
    - Vesicle [Y N U]
    - Ulcer [Y N U]
  - Swollen eyelids (periorbital edema): [Y N U] Y N U
  - Conjunctivitis [Y N U] Y N U
  - Eye pain [Y N U] Y N U
  - Runny nose and/or teary eyes (coryza): [Y N U] Y N U
  - Oropharyngeal/mucosal lesion(s) (stomatitis): [Y N U] Y N U
  - Sore throat: [Y N U] Y N U
  - Pharyngitis: [Y N U] Y N U
  - Tonsillitis: [Y N U] Y N U
  - Cough: [Y N U] Y N U
  - Shortness of breath/difficulty breathing/ respiratory distress: [Y N U] Y N U
  - Pneumonia: [Y N U] Y N U
  - Chest x-ray:
    - Describe (check all that apply):
      - Normal [Y N U]
      - Infiltrate [Y N U]
      - Diffuse infiltrates/findings suggestive of ARDS [Y N U]
      - Mediastinal widening [Y N U]
      - Pleural effusion [Y N U]
      - Hilar adenopathy [Y N U]
      - Other [Y N U]
    - Chest CT scan performed: [Y N U] Y N U
  - Date performed (mm/dd/yyyy): [Y N U]
  - Describe (check all that apply):
    - Normal [Y N U]
    - Infiltrate [Y N U]
    - Pleural effusion [Y N U]
    - Hilar adenopathy [Y N U]
    - Mediastinal adenopathy [Y N U]
    - Other [Y N U]

- **Other symptoms, signs, clinical findings, or complications consistent with this illness:** [Y N U]
  - Specify [Y N U]

### PREDISPOSING CONDITIONS

**Any immunosuppressive conditions?** [Y N U]

**Specify:** [Y N U]

### TREATMENT

**Did the patient take an antibiotic for this illness?** [Y N U]

**If yes, specify:** [Y N U]
### HOSPITALIZATION INFORMATION

<table>
<thead>
<tr>
<th>Information</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Was patient hospitalized for this illness ≥24 hours?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Hospital name:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>City, State:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital contact name:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Admit date (mm/dd/yyyy):</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Discharge date (mm/dd/yyyy):</strong></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### ISOLATION/QUARANTINE/CONTROL MEASURES

<table>
<thead>
<tr>
<th>Measure</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Restrictions to movement or freedom of action?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>If yes, specify and give details:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Date control measures issued:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Date control measures ended:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Was patient compliant with control measures?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>If yes, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Did local health director or designee implement additional control measures?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>If yes, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TRAVEL/IMMIGRATION

<table>
<thead>
<tr>
<th>Information</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The patient:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>During the 14 days prior to onset of symptoms, did the patient travel?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>List travel dates and destinations:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date quarantine ended:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date quarantine started:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Does patient know anyone else with similar symptom(s) who had the same or similar travel history?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>List persons and contact information:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FOOD RISK AND EXPOSURE

<table>
<thead>
<tr>
<th>Risk/Exposure</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During the 14 days prior to onset of symptoms, did the patient:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Handle raw meat other than poultry?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>If yes, specify and give details:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### WATER EXPOSURE

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During the 14 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water (natural waters only)?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>If yes, specify and give details:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OUTDOOR EXPOSURE

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During the 14 days prior to onset of symptoms, did the patient participate in any of the following:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gardening</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Lawn Mowing</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Landscaping</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Information</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During the 14 days prior to onset of symptoms, did the patient work in a laboratory?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>If yes, specify and give details:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OTHER EXPOSURE INFORMATION

<table>
<thead>
<tr>
<th>Information</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does the patient know anyone else with similar symptoms?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>If yes, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### VECTOR EXPOSURE

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During the 14 days prior to onset of symptoms, did the patient have an opportunity for exposure to ticks or deerflies?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>If yes, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CLINICAL OUTCOMES

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharged/Final diagnosis:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DISCHARGE/OUTCOMES

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Survived?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Died?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Died from this illness?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Date of death (mm/dd/yyyy):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autopsy performed?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Patient autopsied in NC?</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Count of autopsy:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autopsied outside NC, specify where:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Source of death information (select all that apply):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Death certificate</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Autopsy report final conclusions</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td><strong>Hospital/discharge physician summary</strong></td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
</tbody>
</table>
### 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)?  
  - Yes: Y
  - No: N
  - Unknown: U
  - Specify animal(s):

- Did patient work at or visit a slaughterhouse (abattoir), meat-packing plant, poultry or wild game processing facility?  
  - Yes: Y
  - No: N
  - Unknown: U

- Has patient otherwise slaughtered animals or been a butcher, meat cutter, or meat processor?  
  - Yes: Y
  - No: N
  - Unknown: U

- Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory?  
  - Yes: Y
  - No: N
  - Unknown: U

- Did the patient skin/eviscerate (gut) wild animal(s) or have contact with wild animal carcass?  
  - Yes: Y
  - No: N
  - Unknown: 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?  
  - Yes: Y
  - No: N
  - Unknown: U

  If yes, specify and give details:

- Did the patient necropsy animals?  
  - Yes: Y
  - No: N
  - Unknown: U

  If yes, specify and give details:

- Did the patient work with F. tularensis?  
  - Yes: Y
  - No: N
  - Unknown: 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?  
  - Yes: Y
  - No: N
  - Unknown: U

- Date of interview (mm/dd/yyyy):__/__/____

- Were interviews conducted with others?  
  - Yes: Y
  - No: N
  - Unknown: U

  Who was interviewed:

- Were health care providers consulted?  
  - Yes: Y
  - No: N
  - Unknown: U

  Who was consulted:

- Medical records reviewed (including telephone review with provider/office staff)?  
  - Yes: Y
  - No: N
  - Unknown: 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?
  - In NC
  - City ___________________________
  - County _______________________
  - Outside NC, but within US
  - City ___________________________
  - County _______________________
  - Outside US
  - City ___________________________
  - Country _______________________
  - Unknown

- Is the patient part of an outbreak of this disease?  
  - Yes: Y
  - No: N

- Notes:

### VACCINE

- Has patient/contact ever received tularemia vaccine?  
  - Yes: Y
  - No: N
  - Unknown: 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