

MARYLAND TULAREMIA CASE REPORT FORM

Demographic Information:

Name: _____ Date of Birth: ____ / ____ / ____ Age: ____
 Address: _____ City: _____
 County: _____ State: _____ Zip: _____ Occupation: _____
 Sex: Male Female Ethnicity: Is the patient Hispanic or Latino? Yes No Unknown
 Race (Select one or more): American Indian or Alaskan Native Asian Black or African American
 If multiracial, select all that apply): Native Hawaiian or Other Pacific Islander White Unknown Other
 Hospitalized? Yes No Unknown Name of Hospital: _____
 Hospital Address: _____
 Admission date: ____ / ____ / ____ Discharge date: ____ / ____ / ____ Onset date: ____ / ____ / ____
 Outcome of illness: Alive Dead (Date died: ____ / ____ / ____) Unknown

Source of Infection:

History of exposure to: Rabbits/Hares Rodents Ingesting wild meats (Type: _____)
 Skinning/Dressing Animals Mosquito bites Tick attachment (Species, if known: _____)
 Pets owned? _____ Other (specify) _____

Clinical Signs, Symptoms and Outcomes:

Clinical Presentation:

(Please Check all that apply)

Ulceroglandular Glandular Oculoglandular
 Typhoidal Oropharyngeal Pneumonic
 Fever >101°F (38.3°C) Highest Temperature: _____ Chills Headache
 Cough Sore throat Nausea Vomiting
 Pharyngitis Pericarditis Lymphangitis Sporotrichoid nodules
 Sepsis Meningitis Renal failure
 Disseminated intravascular coagulopathy Sterile pyuria Hyponatremia
 Erythema nodosum Erythema multiforme Generalized myalgia Weight loss
 Lymphadenopathy? Yes No Axillary Inguinal Head Cervical
 Respiratory presentation? Yes No Parenchymal infiltrates Pleural effusions Hilar adenopathy
 Local lesion (cracked/dry skin) or Ulcer? Yes No Location and size: _____
 Chest X-ray: _____ Date and other findings: _____
 Creatine kinase elevated serum level? Yes No Value: _____
 History of tularemia vaccination? Yes No Date (s): _____

Laboratory Findings:

PLEASE ATTACH COPIES OF LAB REPORTS

Isolation of *F. tularensis*: Yes No Date: ____ / ____ / ____
 Fourfold or greater change in serum antibody titer to *F. tularensis* antigen: Yes No
 Elevated serum antibody titer(s) to *F. tularensis* antigen (w/o documented fourfold or > change) : Yes No
Date #1: _____ **Result:** _____ **Date #2:** _____ **Result:** _____
Detection of *F. tularensis* in clinical specimen by fluorescent assay: Yes No Date: _____

Source of specimen: _____

Other significant lab tests (specify): _____

Treatment: Antibiotic(s) prescribed _____

Name	Dose	Frequency	Route			Duration
			<input type="checkbox"/> PO	<input type="checkbox"/> IV	<input type="checkbox"/> IM	
			<input type="checkbox"/> PO	<input type="checkbox"/> IV	<input type="checkbox"/> IM	
			<input type="checkbox"/> PO	<input type="checkbox"/> IV	<input type="checkbox"/> IM	
			<input type="checkbox"/> PO	<input type="checkbox"/> IV	<input type="checkbox"/> IM	

Person completing form: _____
 Provider Name: _____
 Address: _____

PLEASE RETURN THIS FORM TO:
 (Name of Local Health Jurisdiction)