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.

Verify if lab results for this event are in NC EDSS. If not present, enter results.

**CLINICAL FINDINGS**

<table>
<thead>
<tr>
<th>Is/was patient symptomatic for this disease?</th>
<th>Y</th>
<th>N</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, symptom onset date (mm/dd/yyyy):</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Yes, subjective</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Yes, measured</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Fatigue or malaise or weakness</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Chill or rigors</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Shock</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Shock was</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Septic</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Hypovolemic</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Swollen lymph nodes</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Pharyngeal</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Meningeal</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Pneumonic</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Predisposing conditions</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Shortness of breath/difficulty breathing/ respiratory distress</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Acute Respiratory Distress Syndrome (ARDS)</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Did the patient have a chest x-ray?</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Chest CT scan performed</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Bacteremia</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Date of positive blood culture (mm/dd/yyyy)</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Septicemia/sepsis</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Disseminated intravascular coagulation (DIC)</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>Other symptoms, signs, clinical findings, or complications consistent with this illness</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
</tbody>
</table>

**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):                         | / | / | / |

**TREATMENT**

Did the patient take an antibiotic as treatment for this illness? Y N U

If yes, specify and give details:

| Did the patient take an antibiotic as prophylaxis secondary to being a contact of a confirmed case? | Y | N | U |
| Antibiotic name:                                  |   |   |   |
| Were antibiotics given in the 24 hours before culture specimen collected? | Y | N | U |
| Specify culture site(s):                          |   |   |   |
| Were antibiotics given in the 24 hours before culture? | Y | N | U |

**PREDISPOSING CONDITIONS**

Any immunosuppressive conditions? Y N U

Specify ________________________________________________

| Productive sputum | Y | N | U |
| Clear fluid       | Y | N | U |
| Purulent fluid    | Y | N | U |
| Bloody (hemoptysis)| Y | N | U |
### CLINICAL OUTCOMES

| Survived? | Y | N | U |
| Status at time of report: |
| □ Fully recovered |
| □ Survived but experiencing sequelae (residual deficit from illness) at time of report |
| Died? | Y | N | U |
| If yes, from this illness? | Y | N | U |
| Patient died in North Carolina? | Y | N | U |

### 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 14 days prior to onset of symptoms? | Y | N | U |
| List travel dates and destinations: |
| From__/__/____ to__/__/____ |

### BEHAVIORAL RISK & CONGREGATE LIVING

| During the 14 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? | Y | N | U |
| Name of facility: |
| Dates of contact: from__/__/____ until__/__/____ |
| During the 14 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? | Y | N | U |
| If yes, specify: |

### 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 | U |
| Did local health director or designee implement additional control measures? | Y | N |
| If yes, specify: |

### TRAVEL IMMIGRATION

| Patient in child care? | Y | N | U |
| Patient a child care worker or volunteer in child care? | Y | N | U |
| Patient a parent or primary caregiver of a child in child care? | Y | N | U |
| Patient a student? | Y | N | U |

### CHILD CARE/SCHOOL/COLLEGE

| Type of school: |
| □ Patient a school WORKER / VOLUNTEER in NC school setting? | Y | N | U |

### 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 |

### OUTDOOR EXPOSURE

| During the 14 days prior to onset of symptoms, did the patient participate in any outdoor activities? | Y | N | U |
| If yes, specify and give details: |

### VECTOR EXPOSURE

| During the 14 days prior to onset of symptoms, did the patient have an opportunity for exposure to fleas? | Y | N | U |
| If yes, specify |
| Exposed on (date) (mm/dd/yyyy):__/__/____ |
| Until (date) (mm/dd/yyyy):__/__/____ |
| Frequency: |
| □ Once |
| □ Multiple times within this time period |

### OTHER EXPOSURE INFORMATION

| Does the patient know anyone else with similar symptoms? | Y | N | U |
| If yes, specify: |
| Has the patient ever served in the U.S. military? | Y | N | U |
### ANIMAL EXPOSURE

During the 14 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)?

- Y N U

If yes, specify and give details:

- Did patient work with plague vaccine?
  - Y N U
  - If yes, specify and give details:

- Did patient necropsy animals?
  - Y N U
  - If yes, specify and give details:

- Did patient work with Y. pestis?
  - Y N U
  - If yes, specify and give details:

- Household pets (especially cats)?
  - Y N U
  - If yes, specify and give details:

- Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor?
  - Y N U
  - If yes, specify and give details:

- Did the patient handle any animals?
  - Y N U
  - If yes, specify and give details:

- Did it/they appear sick?
  - Y N U
  - If yes, specify and give details:

- Did patient/household contact work at, live on, or visit a farm, ranch, or dairy?
  - Y N U
  - If yes, specify and give details:

- Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)?
  - Y N U
  - If yes, specify and give details:

- Did the patient work at or visit a fair with livestock or a petting zoo?
  - Y N U
  - If yes, specify and give details:

- Did the patient work at or visit a zoo, zoological park, or aquarium?
  - Y N U
  - If yes, specify and give details:

- Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory?
  - Y N U
  - If yes, specify and give details:

### CASE INTERVIEWS/INVESTIGATIONS

- Was the patient interviewed?
  - Y N U

- Date of interview (mm/dd/yyyy):
  - Y N U

- 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 reviews 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?

- Specifying 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 plague vaccine?

- Y N U

If yes, provide the vaccine name, source of vaccine, date of vaccination, and source of vaccine information:
Plague (*Yersinia pestis*)

1996 CDC Case Definition

**Clinical description**

Plague is transmitted to humans by fleas or by direct exposure to infected tissues or respiratory droplets; the disease is characterized by fever, chills, headache, malaise, prostration, and leukocytosis that manifests in one or more of the following principal clinical forms:

- Regional lymphadenitis (bubonic plague)
- Septicemia without an evident bubo (septicemic plague)
- Plague pneumonia, resulting from hematogenous spread in bubonic or septicemic cases (secondary pneumonic plague) or inhalation of infectious droplets (primary pneumonic plague)
- Pharyngitis and cervical lymphadenitis resulting from exposure to larger infectious droplets or ingestion of infected tissues (pharyngeal plague)

**Laboratory criteria for diagnosis**

*Presumptive*

- Elevated serum antibody titer(s) to *Yersinia pestis* fraction 1 (F1) antigen (without documented fourfold or greater change) in a patient with no history of plague vaccination or
- Detection of F1 antigen in a clinical specimen by fluorescent assay

*Confirmatory*

- Isolation of *Y. pestis* from a clinical specimen or
- Fourfold or greater change in serum antibody titer to *Y. pestis* F1 antigen

**Case classification**

*Suspected*: a clinically compatible case without presumptive or confirmatory laboratory results

*Probable*: a clinically compatible case with presumptive laboratory results

*Confirmed*: a clinically compatible case with confirmatory laboratory results