|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DepartmenT of Health Services**  Division of Public Health  F-01758 (07/2016) | | | | | | | | | | | | | | | **STATE OF WISCONSIN**  Page 1 of 4 | | | | | | | | | | | | | |
| **BLASTOMYCOSIS CASE WORKSHEET**  **INSTRUCTIONS:** Enter responses in WEDSS or fax completed worksheet to the Bureau of Communicable Diseases at  (608) 261-4976 or submit with Wisconsin Division of Public Health, Acute & Communicable Disease Case Report, F-44151.  \*All information in red is essential for case classification. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DEMOGRAPHIC INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Name *(last, first, middle initial)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent Name *(if patient is a minor)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth | | | | | | | | | | | | Sex | | | | | | | | | | | Pregnant at diagnosis? | | | | | |
|  | | | | | | | | | | | | Male  Female | | | | | | | | | | | Yes  No Due Date: | | | | | |
| Street Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City | | | | | | | | | | | | | | | | Zip Code | | | | | | County | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | |
| Telephone: Home | | | | | | | | | | | | | Work | | | | | | | | | | | Cell | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | |
| Occupation | | | | | | | | | | | | | | | | | | Employer Location | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Race** | | | | | White  Black  Native American/Native Alaskan  Asian *(specify)*: | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Native Hawaiian/Other Pacific Islander  Other: | | | | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity** | | | | | Hispanic  Non-Hispanic | | | | | | | | | | | | | | | | | | | | | | | |
| **SYMPTOM AND SIGNS HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| History from:  Physician or chart/medical record  Patient or relative  Both | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Onset date of first symptoms**:       or  Asymptomatic | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Symptoms or signs** *(check all that apply)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cough | | | | | | | | | | | Headache | | | | | | | Fever | | | | | | | | | Shortness of breath | |
| Coughing up blood | | | | | | | | | | | Back pain | | | | | | | Chills | | | | | | | | | Joint pain | |
| Single skin lesion | | | | | | | | | | | Chest pain | | | | | | | Night sweats | | | | | | | | | Muscle pain/aches | |
| Multiple skin lesions | | | | | | | | | | | Poor appetite | | | | | | | Weight loss | | | | | | | | | Bone pain | |
| Fatigue | | | | | | | | | | | Other | | | | | | | | | | | | | | | | | |
| Was the patient ever diagnosed with pneumonia or other respiratory disease within one year prior to developing current symptoms?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Did the patient’s illness progress to ARDS (acute respiratory distress syndrome)?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Duration of disease** *(check one)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Acute Infection (symptoms present for less than a month before being tested for blastomycosis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chronic Infection (symptoms present for more than a month before being tested for blastomycosis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Site of disease** *(check one)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pulmonary (disease present only in lungs) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Extra-pulmonary (no current or undiagnosed past disease in lungs) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Disseminated (both pulmonary and extra-pulmonary locations) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If disseminated or extra-pulmonary, which sites besides the lungs were affected *(check all that apply)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Skin  Bone  CNS  Eye  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CLINICAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What type of medical care was sought? *(check all that apply)* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Outpatient** | | | | | | | | | | | | | | | | | | **Inpatient** | | | | | | | | | |
|  | | Clinic #1 | | | | | | | | | | | | | | | |  | | Hospital #1 | | | | | | | |
|  | | Date(s) | | | | |  | | | | | | | | | | |  | | Date(s) | | | |  | | | |
|  | | Doctor | | | | |  | | | | | | | | | | |  | | Doctor | | | |  | | | |
|  | | Phone | | | | |  | | | | | | | | | | |  | | Phone | | | |  | | | |
|  | | Clinic name | | | | |  | | | | | | | | | | |  | | Hospital name | | | |  | | | |
|  | |  | | | | |  | | | | | | | | | | |  | | Was the patient ever on a ventilator?  Yes  No | | | | | | | |
|  | | Clinic #2 | | | | | | | | | | | | | | | |  | | Hospital #2 | | | | | | | |
|  | | Date(s) | | | | |  | | | | | | | | | | |  | | Date(s) | | | |  | | | |
|  | | Doctor | | | | |  | | | | | | | | | | |  | | Doctor | | | |  | | | |
|  | | Phone | | | | |  | | | | | | | | | | |  | | Phone | | | |  | | | |
|  | | Clinic name | | | | |  | | | | | | | | | | |  | | Hospital name | | | |  | | | |
|  | |  | | | | |  | | | | | | | | | | |  | | Was the patient ever on a ventilator?  Yes  No | | | | | | | |
| \*If patient was seen at more than two hospitals or clinics please provide the name of the other hospitals or clinics and the dates seen in comments sections at the end of this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Which medication(s) was the patient prescribed to treat the blastomycosis: *(check all that apply)* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Itraconazole (Sporanox®)  Amphotericin B  Fluconazole (Diflucan®)  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What was the duration prescribed? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Outcome** | | | |  | | Alive, include recovery date if symptoms have resolved: | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | Deceased due to blastomycosis on: | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | Deceased due to other cause on:       Cause: | | | | | | | | | | | | | | | | | | | | | |
| **DIAGNOSTIC INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Microscopy** *(smear or wet prep)*  Yes  No | | | | | | | | | | | | | | | | | | | **Serology**  Yes  No | | | | | | | | |
| Date collected: | | | | | | | | | | | | | | | | | | | Date collected: | | | | | | | | |
| Specimen(s): | | | | | | | | | | | | | | | | | | | Lab: | | | | | | | | |
| Lab: | | | | | | | | | | | | | | | | | | | AGID  ELISA  CF | | | | | | | | |
| Result for *Blastomyces*:  Positive  Negative | | | | | | | | | | | | | | | | | | | Result:  Positive  Negative Titer: | | | | | | | | |
| **Culture**  Yes  No | | | | | | | | | | | | | | | | | | | **Urine Antigen**  Yes  No | | | | | | | | |
| Date collected: | | | | | | | | | | | | | | | | | | | Date collected: | | | | | | | | |
| Specimen(s): | | | | | | | | | | | | | | | | | | | Specimen: | | | | | | | | |
| Lab: | | | | | | | | | | | | | | | | | | | Lab: | | | | | | | | |
| Result for *Blastomyces*:  Positive  Negative | | | | | | | | | | | | | | | | | | | Result for *Blastomyces* antigen:  Positive  Negative | | | | | | | | |
| DNA Probe/PCR:  Positive  Negative  Not performed | | | | | | | | | | | | | | | | | | | Antigen level: | | | | | | | | |
| **Histopathology**  Yes  No | | | | | | | | | | | | | | | | | | | **Additional tests to rule out other fungal infections** | | | | | | | | |
| Date collected: | | | | | | | | | | | | | | | | | | | Date of collection: | | | | | | | | |
| Specimen(s): | | | | | | | | | | | | | | | | | | | Specimen: | | | | | | | | |
| Lab: | | | | | | | | | | | | | | | | | | | Lab: | | | | | | | | |
| Result for *Blastomyces*:  Positive  Negative | | | | | | | | | | | | | | | | | | | Test: | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | Result: | | | | | | | | |
| **Radiology** *(check all that apply)* | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| X-ray | | | | | | | | | Date: | | | | | | | MRI | | | | | | | | | Date: | |
| Imaged area:  Chest  Extremity  Spine  Other | | | | | | | | | | | | | | | | Imaged area:  Chest  Extremity  Spine  Other | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | Comments: | | | | | | | | | | |
| CT | | | | | | | | Date: | | | | | | | | Other: | | | | | | | | | Date: | |
| Imaged area:  Chest  Extremity  Spine  Other | | | | | | | | | | | | | | | | Imaged area:  Chest  Extremity  Spine  Other | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | Comments: | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **RISK FACTORS** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Did patient have any of the following chronic/immunosuppressive medical conditions? *(check all that apply)* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| COPD  Diabetes  Cancer  Rheumatoid arthritis  Organ transplant  Steroid treatment  Asthma | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Asplenia  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the patient a smoker or has the patient ever smoked (including but not limited to cigarettes, cigars, pipe)? *(check one)* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Smoker at time of diagnosis  Smoked prior to diagnosis  Never smoked | | | | | | | | | | | | | | | | | | | | | | | | | | |
| For how many years?       Quantity smoked per day (i.e. number of packs or cigars)? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has anyone else in the patient’s household been diagnosed with blastomycosis?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Who/When: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has anyone else that patient knows been recently diagnosed with blastomycosis?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Who/When: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has patient owned a dog that was diagnosed with blastomycosis?  Yes  No  Does not own a dog | | | | | | | | | | | | | | | | | | | | | | | | | | |
| When was the diagnosis made? (Date, or season and year): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Veterinarian’s name:       Telephone: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EXPOSURE HISTORY – Outdoor activities** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Did the patient participate in any of the following recreational outdoor activities during the past 3 months (90 days) before onset of illness? Provide date and specific location information for all yes responses. Y=Yes N=No U=Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | | U | |  | | | | | | | |  | | | | | | | | | | | | | |
|  |  | |  | | Hunting | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | Fishing from shore | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | Visiting a cabin | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | Camping | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | Hiking/cross country running | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | Trail biking | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | ATV usage | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | Visiting parks | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | Kayaking, canoeing, tubing | | | | | | | | When/Where: | | | | | | | | | | | | | |
|  |  | |  | | Other: | | | | | | | | When/Where: | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EXPOSURE HISTORY – Disrupted earth** | | | | |
| Was the patient exposed to disturbed earth from any of the following activities during the 3 months (90 days) before onset of illness? Provide date and specific location information for all yes responses. Y=Yes N=No U=Unknown | | | | |
| Y | N | U |  |  |
|  |  |  | Wood/brush cutting | When/Where: |
|  |  |  | Excavation | When/Where: |
|  |  |  | Gardening/landscaping | When/Where: |
|  |  |  | Mulch exposure | When/Where: |
|  |  |  | Occupational exposures | When/Where: |
|  |  |  | Construction (road/structural) | When/Where: |
|  |  |  | Lawn care (raking, mowing) | When/Where: |
|  |  |  | Composting | When/Where: |
|  |  |  | Other: | When/Where: |
| Did patient travel in-state or out-of-state during the 3 months before the onset of illness?  Yes  No | | | | |
| When/Where | | | | |
| When/Where | | | | |

|  |
| --- |
| Does patient live on or near a lake, river, stream, or wetland?  Yes  No |
| If yes, what is the name of the body of water? |
| If yes, how far away?  Less than 100 feet  Less than ¼ mile  Less than 1 mile  Greater than 1 mile |
| Notes/Remarks: |
|  |