

# PSITTACOSIS CASE REPORT FORM

## Georgia Division of Public Health

(Leave this section blank for state health department use)  Confirmed  Probable  Not a case

**DATE OF INTERVIEW** \_\_\_/\_\_\_/\_\_\_

### A. Demographic Information

Name: _____	DOB: ___/___/___	Age: _____
Address: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City/State/Zip: _____	Occupation: _____	
County: _____	Home Phone: _____	Other Phone: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Unknown		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		

### B. Clinical Information

Name of Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Have you experienced any of the following symptoms?

Fever <input type="checkbox"/> Y <input type="checkbox"/> N (___°F)	Cramps <input type="checkbox"/> Y <input type="checkbox"/> N	Cough <input type="checkbox"/> Y <input type="checkbox"/> N	Sore Throat <input type="checkbox"/> Y <input type="checkbox"/> N
Chills/Shakes <input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N	Chest Pain <input type="checkbox"/> Y <input type="checkbox"/> N	Rash <input type="checkbox"/> Y <input type="checkbox"/> N
Joint Aches <input type="checkbox"/> Y <input type="checkbox"/> N	Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath <input type="checkbox"/> Y <input type="checkbox"/> N	Headache <input type="checkbox"/> Y <input type="checkbox"/> N
Muscle Aches <input type="checkbox"/> Y <input type="checkbox"/> N	Weakness/Fatigue <input type="checkbox"/> Y <input type="checkbox"/> N	Backache <input type="checkbox"/> Y <input type="checkbox"/> N	

Other Symptoms \_\_\_\_\_ Number of stools in the past 24 hours \_\_\_\_\_

What was the first symptom(s)? \_\_\_\_\_ Date of Onset: \_\_\_/\_\_\_/\_\_\_  
 Duration of symptoms? \_\_\_\_\_  Days  Weeks  Months

Did you receive any treatment?  Y  N Date of Diagnosis: \_\_\_/\_\_\_/\_\_\_  
 Treatment (specify products, dosage, and duration): \_\_\_\_\_  
 Dates of treatment: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Were you hospitalized?  Y  N Name of Hospital/Facility: \_\_\_\_\_  
 Dates of hospitalization: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Outcome:  Recovered  Died  Unknown Date of Death (if patient died): \_\_\_/\_\_\_/\_\_\_

Do you have any medical conditions that may suppress your immune system (e.g., diabetes, renal failure, Crohn's disease, HIV infection, lupus)?  Y  N If yes, please specify: \_\_\_\_\_

Do you take any medications that may suppress your immune system?  Y  N  
 If yes, please specify: \_\_\_\_\_

### C. Laboratory Information

Test/Specimen Type	Date Specimen Collected	Results	Name of Laboratory
Acute-phase serum <input type="checkbox"/> CF <input type="checkbox"/> MIF	___/___/___	IgM: _____ IgG: _____	
Convalescent-phase serum <input type="checkbox"/> CF <input type="checkbox"/> MIF	___/___/___	IgM: _____ IgG: _____	
PCR <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____	___/___/___		

Culture <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____	____/____/____		
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**D. Exposure Information**

*Occupational:*

Do you work in a pet store or aviary?   Y   N      Specific duties: \_\_\_\_\_  
 Name of store/aviary: \_\_\_\_\_      Address/City/State/Zip: \_\_\_\_\_

*Home:*

Do you own birds?                      Y   N              What type of birds? \_\_\_\_\_  
 Do you clean the cages?   Y   N              How often do you handle the birds per week? \_\_\_\_\_  
 Do you kiss the birds?           Y   N              Have your birds been tested for Psittacosis?   Y   N      Result: \_\_\_\_\_

Veterinarian: \_\_\_\_\_                      Phone Number: \_\_\_\_\_

Have you recently purchased a new bird?   Y   N              Date of purchase: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Place of purchase: \_\_\_\_\_

*Any:*

Have you been exposed to birds or their housing in the last 2 weeks?   Y   N

Type of Bird	Species	Approximate number	Were birds healthy? If not, describe illness or strange behavior.
Psittacines (e.g., cockatoos, cockatiels, macaws, parakeets, parrots)			
Pigeons			
Domestic fowl			
Other (please specify)			

Where did you have contact with the birds? \_\_\_\_\_

Which of the following activities did you engage in with the birds?

Fed the birds   Y   N              Handled the birds                      Y   N              Kissed the birds                      Y   N  
 If yes, how often per week? \_\_\_\_      If yes, how often per week? \_\_\_\_      Stood inside aviary or coop   Y   N  
 Cleaned the cages   Y   N              Handled any dead birds              Y   N              Watched birds in cage              Y   N  
 If yes, how often per week? \_\_\_\_

**E. Additional Information**

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Submitted by:	Title:	Agency:
Phone:	Fax:	Date: ____/____/____

(Leave this section blank for state health department use)

Reviewed by epidemiologist   Y   N      Name: \_\_\_\_\_                      Date of review: \_\_\_\_/\_\_\_\_/\_\_\_\_