PSITTACOSIS CASE REPORT FORM
Georgia Department of Public Health

DATE OF INTERVIEW _____/_____/_____

A. Demographic Information

Name: ___________________________  DOB: ___/___/___  Age: ______
Address: ________________________  Sex: □ Male □ Female
City/State/Zip: ___________________  Occupation: _______________________
County: ________________________  Home Phone: ________________________
Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Multiracial
□ Native Hawaiian/Pacific Islander □ White/Caucasian □ Other (please specify): ______
Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

B. Clinical Information

Name of Physician: ___________________________  Physician Phone: ________________________
Address: ___________________________________  City/State/Zip: _________________________
Have you experienced any of the following symptoms?
Fever □ Y □ N (___°F)  Cramps □ Y □ N  Cough □ Y □ N  Sore Throat □ Y □ N
Chills/Shakes □ Y □ N  Vomiting □ Y □ N  Chest Pain □ Y □ N  Rash □ Y □ N
Joint Aches □ Y □ N  Diarrhea □ Y □ N  Shortness of Breath □ Y □ N  Headache □ Y □ N
Muscle Aches □ Y □ N  Weakness/Fatigue □ Y □ N  Backache □ Y □ 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

<table>
<thead>
<tr>
<th>Test/Specimen Type</th>
<th>Date Specimen Collected</th>
<th>Results</th>
<th>Name of Laboratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute-phase serum</td>
<td></td>
<td>IgM: __________ IgG: __________</td>
<td></td>
</tr>
<tr>
<td>□ CF □ MIF</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convalescent-phase serum</td>
<td></td>
<td>IgM: __________ IgG: __________</td>
<td></td>
</tr>
<tr>
<td>□ CF □ MIF</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
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<td></td>
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<tr>
<td>PCR</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>□ Blood □ Sputum</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other</td>
<td></td>
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</tbody>
</table>
**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

<table>
<thead>
<tr>
<th>Type of Bird</th>
<th>Species</th>
<th>Approximate number</th>
<th>Were birds healthy? If not, describe illness or strange behavior.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psittacines</td>
<td>(e.g., cockatoos, cockatiels, macaws, parakeets, parrots)</td>
<td></td>
<td></td>
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<tr>
<td>Pigeons</td>
<td></td>
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<td></td>
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<tr>
<td>Domestic fowl</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other (please specify)</td>
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</tr>
</tbody>
</table>

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**

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: ____/_____/_____

(Leave this section blank for state health department use)