

PSITTACOSIS CASE REPORT FORM

Georgia Department 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: ____/____/____