World Health Organization

T1 Case investigation form for investigation of unknown disease

Date* of the day: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Organization/institution*: _____

Country*:_____

Interviewer name _____ **Function / title**_____

Section 1: Patient information

INTERVIEW

Case ID number*: [__][__][__][__][__][__][__]

Date case first reported*: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Case reported by: □ Mobile Team □ Health Center / post □ Hospital □ Other □ Unknown

Name of reporting facility*: _____

If not the case, relation of person interviewed to the case: _____

IDENTIFICATION

Full name of patient*:_____

If child, first and last name of the father/mother/guardian: _____

Telephone number: _____

Birth date*: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] or estimated age*: [_Y_][_Y_] □ in years or □ in months or □ in days

Sex at birth*: □ Male □ Female

Nationality: _____

Residential status: Resident / refugee / displaced (circle the right option)

Living in: camp / settlement / rural / urban (circle the right option)

Residential/street address*: _____

Landmarks to locate the house: _____

Village/town/city*: _____

Admin Level 1*: _____ Admin Level 2*: _____

Admin Level 3*: _____ Admin Level 4*: _____

Residence GPS latitude: ____ . _____ Residence GPS longitude: _____._____

OCCUPATION

Occupation: _____

If working in a health facility, specify name: _____

If working in health facility, specify function/position: _____

List routine activities (outside working hours): _____

_____

** EPI CORE VARIABLES for outbreak investigation.*

*** if the answer is no, go directly to the next box or next question in bold*

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T1 Case investigation form for investigation of unknown disease

Interviewer name _____ **Function / title**_____

Date of medical evaluation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Section 2: Clinical information

COURSE OF DISEASE

Date of onset of first symptoms*: [_D_][_D_]/[_M_][_M_]

For this episode, date first presented to health facility: [_D_][_D_]/[_M_][_M_]

Currently admitted in health facility*: □ No □ Yes, name:_____

Outcome of illness* (circle): still sick / cured / sequelae / defaulter / death

Date outcome was evaluated: [_D_][_D_]/[_M_][_M_]

Date* of default, recovery or death: [_D_][_D_]/[_M_][_M_]

Sequelae after recovery: □ No □ Yes specify: _____

More on course of disease: _____

GENERAL

Onset of disease: □ Acute □ Progressive

History of fever (>38°C): □ Yes □ No □ Unknown

Temperature: [___][___][___] □°C □°F

Chills: □ Yes □ No □ Unknown

Profuse sweating: □ Yes □ No □ Unknown

Intense pain: □ Yes □ No □ Unknown

Sites of pain: □ *Head* □ *Muscular* □ *Chest* □ *Abdominal* □ *Joint* □ *other:* _____

Observed abnormal bleeding: □ Yes □ No

Site(s) of abnormal bleeding: □ At injection sites □ Nose □ Mouth □ Urine □ Stool □ Vagina

Dehydration (thirst, sunken eyes, skinfold): □ Yes □ No □ Unknown

Signs of shock: □ Yes □ No □ Unknown

Intense fatigue or weakness: □ Yes □ No □ Unknown

Height: _____ Weight: _____

Other signs and symptoms, specify:

Main complaints expressed by the patient: _____

** EPI CORE VARIABLES for outbreak investigation.*

*** if the answer is no, go directly to the next box or next question in bold*

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CARDIOLOGY

Heart rate:	_____ beats per minute		
Capillary refill time > 3 seconds:	□ Yes	□ No	□ Unknown
Systolic blood pressure:	_____ mm Hg		
Diastolic blood pressure:	_____ mm Hg		
Observed cardiac disorders:**	□ **Yes**	□ **No**	
Weak pulse:	□ Yes	□ No	□ Unknown
Signs of cardiac failure:	□ Yes	□ No	□ Unknown
Abnormal cardiac auscultation: (murmur, irregular heartbeat, gallop,…)	□ Yes	□ No	□ Unknown
Peripheral oedemas:	□ Yes	□ No	□ Unknown

Other cardiac signs: _____

RESPIRATORY

Respiratory rate (per min): _____

O^2 saturation room air (%): _____

Observed respiratory disorders:**	□ **Yes**	□ **No**	
Cough:	□ Yes	□ No	□ Unknown
Expectoration:	□ Yes	□ No	□ Unknown
Expectoration with blood:	□ Yes	□ No	□ Unknown
Shortness of breath:	□ Yes	□ No	□ Unknown
Respiratory distress:	□ Yes	□ No	□ Unknown
Cyanosis:	□ Yes	□ No	□ Unknown
Abnormal lung auscultation: crackles, murmur,…	□ Yes	□ No	□ Unknown
Signs of pneumonia:	□ Yes	□ No	□ Unknown
Signs of pneumothorax:	□ Yes	□ No	□ Unknown

Other respiratory signs:_____

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

GASTOINTESTINAL	Nausea/vomiting:	□ Yes	□ No	□ Unknown
	Loss of appetite:	□ Yes	□ No	□ Unknown
	Observed gastro intestinal disorders:**	□ Yes	□ No	□ Unknown
	Stomach/abdominal pain:	□ Yes	□ No	□ Unknown
	Hiccups:	□ Yes	□ No	□ Unknown
	Tender abdomen:	□ Yes	□ No	□ Unknown
	Palpable spleen:	□ Yes	□ No	□ Unknown
	Abdominal mass:	□ Yes	□ No	□ Unknown
	Palpable liver:	□ Yes	□ No	□ Unknown
	Diarrhea (≥3 loose/liquid stools per day)	□ Yes	□ No	□ Unknown
	Bloody diarrhea (dysentery):	□ Yes	□ No	□ Unknown
	Passing rice water-like stools:	□ Yes	□ No	□ Unknown
	Dark bloody stools:	□ Yes	□ No	□ Unknown
	Pale stools:	□ Yes	□ No	□ Unknown
	Jaundice:	□ Yes	□ No	□ Unknown
	Other gastro intestinal signs:_____			
NEUROLOGY	**Observed neurological disorders**:**	□ Yes	□ No	
	Paralysis	□ Yes	□ No	□ Unknown
	Flaccid:	□ Yes	Spastic:	□ Yes
	Abnormal movements:	□ Yes	□ No	□ Unknown
	Seizures:	□ Yes	□ No	□ Unknown
	Mental disorder: agitation, confusion, irritability	□ Yes,	□ No	□ Unknown
	Drowsiness, coma:	□ Yes	□ No	□ Unknown
	Neck stiffness:	□ Yes	□ No	□ Unknown
	Other neurological signs: _____			

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

CUTANEOUS

Observed skin disorders**: □ Yes □ No □ Unknown

If yes, date of onset: ___/___/_____

Duration (days): _____

Type: □ rash □ erythematous □ vesicular-pustular □ petechial-purpuric □ maculo-papular

Localization: □ systemic □ localized, specify: _____

Itching skin: □ Yes □ No □ Unknown

Skin necrosis: □ Yes □ No □ Unknown

Ulceration of the skin: □ Yes □ No □ Unknown

Enlarged lymph nodes: □ Yes Where: _____

Photo attached?: □ Yes □ No

Other cutaneous signs:_____

EAR, NOSE AND THROAT (ENT)

Observed ENT disorders**: □ Yes □ No □ Unknown

Conjunctivitis: □ Yes □ No □ Unknown

Bleeding into eyes (conjunctival injections): □ Yes □ No □ Unknown

Runny nose: □ Yes □ No □ Unknown

Ear pain: □ Yes □ No □ Unknown

Hoarseness of voice: □ Yes □ No □ Unknown

Difficulty swallowing: □ Yes □ No □ Unknown

Sore throat: □ Yes □ No □ Unknown

Oral ulcerations: □ Yes □ No □ Unknown

Hypersalivation: □ Yes □ No □ Unknown

Other ENT signs: _____

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

URO-GYNECOLOGY	Recent spontaneous abortion:	□ Yes	□ No	□ Unknown
	Observed uro-gynecological disorders**	□ Yes	□ No	□ Unknown
	Vaginal bleeding outside of menstruation:	□ Yes	□ No	□ Unknown
	Vaginal discharge:	□ Yes	□ No	□ Unknown
	Dark urine:	□ Yes	□ No	□ Unknown
	Pain when passing urine:	□ Yes	□ No	□ Unknown
	Not passing urine in the last 12 hours:	□ Yes	□ No	□ Unknown
	Any other uro-gynecological signs:_____			
UNDERLYING CONDITIONS	Pregnancy:	□ Yes months?_____	□ No	□ Unknown
	Post-partum:	□Yes weeks?_____	□ No	□ Unknown
	Underlying conditions**:	□ Yes	□ No	□ Unknown
	Chronic disease:	□ Yes	□ No	□ Unknown
	specify:_____			
	Associated acute disease:	□ Yes	□ No	□ Unknown
	specify:_____			
	Immunodeficiency:	□ Yes	□ No	□ Unknown
	specify:_____			
	Malnutrition:	□ Yes	□ No	□ Unknown
	MUAC measurement (children only)	_____mm		
	Any other condition impacting health, specify: _____			

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

TREATMENTS

Did the patient receive any (including traditional) treatment for this episode:** □ Yes □ No □ Unknown

Treatments received by the patient for this episode prior to admission: □ Yes, specify in table below □ No

TYPE / NAME	DAILY DOSE	ROUTE	START DATE	END DATE
		□ IV □ IM □ Oral	[_D_][_D_]/[_M_][_M_]	[_D_][_D_]/[_M_][_M_]
		□ IV □ IM □ Oral	[_D_][_D_]/[_M_][_M_]	[_D_][_D_]/[_M_][_M_]
		□ IV □ IM □ Oral	[_D_][_D_]/[_M_][_M_]	[_D_][_D_]/[_M_][_M_]
		□ IV □ IM □ Oral	[_D_][_D_]/[_M_][_M_]	[_D_][_D_]/[_M_][_M_]

Treatments received by the patient for this episode during admission: □ Yes, specify in table below □ No

TYPE / NAME	DAILY DOSE	ROUTE	START DATE	END DATE
		□ IV □ IM □ Oral	[_D_][_D_]/[_M_][_M_]	[_D_][_D_]/[_M_][_M_]
		□ IV □ IM □ Oral	[_D_][_D_]/[_M_][_M_]	[_D_][_D_]/[_M_][_M_]
		□ IV □ IM □ Oral	[_D_][_D_]/[_M_][_M_]	[_D_][_D_]/[_M_][_M_]
		□ IV □ IM □ Oral	[_D_][_D_]/[_M_][_M_]	[_D_][_D_]/[_M_][_M_]

Traditional treatment received? □ Yes □ No □ Unknown

specify: _____

Did the treatment improve the patient medical state? □ Yes □ No □ Unknown

At any time during hospitalization, did the patient receive **blood transfusion?** □ Yes □ No

Other information regarding treatment history?: _____

VACCINATION

Did the patient receive full **vaccination course** according to the national immunization schedule? □ Yes □ No □ Unknown / Not applicable

Date of last dose received: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

For which disease?: _____

Vaccination information obtained via? □ Vaccination Card □ Health services □ Parents or another adult

Copy of vaccination card attached: □ Yes □ No

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

Interviewer name _____ **Function / title**_____

Section 3: Exposure and travel information THREE WEEKS PRIOR TO SYMPTOMS

1. CONTACTS

How many **persons live in the same household** as the patient? _____

Any **household member** presenting similar illness or symptoms?** □ Yes □ No □ Unknown

Date of onset	Name and date of birth	Relationship
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____

Anyone **outside the household** with similar illness or symptoms?** □ Yes □ No □ Unknown

Date of onset	Name and relationship	Place of interaction
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____

2. MASS GATHERING

Did the patient participate in **mass gathering events**** □ Yes □ No □ Unknown

Event date	Location	Type, how many people attended?
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

3. TRAVEL HISTORY

Did the patient **travel** (last 3 weeks), outside her/his residential area**? □Yes □ No □ Unknown

Travel dates	Indicate from where to where	Type of transport used?
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____
[_D_][_D_]/[_M_][_M_]	_____	_____

4. NOSOCOMIAL

Did the patient receive **health care** (last 3 weeks)**?: □ Yes □ No Date _____

Where □ at home □ at health facility □ at traditional clinic

Name of the facility: _____

Type of care:

Invasive care (crossing skin barrier):	□ Yes	Specify: _____
Dental care:	□ Yes	Specify: _____
Delivery or abortion:	□ Yes	Date: _____
Admission in health care facility:	□ Yes	Date admitted: _____Exit date: _____
Blood transfusion:	□ Yes	Date: _____

Did the patient visit a health facility without getting health care (visit a patient or any other reason)?:	□ Yes	Date: _____ Name: _____ Place: _____
Did the patient use or inject illicit drugs?:	□ Yes □ No	Specify:_____
Did the patient come in contact with syringes or needles at his/her workplace?:	□ Yes □ No	Specify: _____
Did the patient donate blood or plasma?:	□ Yes	How many times: _____

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

5. ANIMAL EXPOSURE

Did the patient come into close **proximity with any animal** prior to symptom onset**? □Yes □ No □ Unknown

Specify contact: □ Trading □ Butchering □ Handling □ Consumption of animal products

ANIMAL TYPE			Was the animal dead, sick, had miscarriage or abortion?		
	□ Domestic	□ Wild	□ Yes	□ No	□ Unknown
	□ Domestic	□ Wild	□ Yes	□ No	□ Unknown
	□ Domestic	□ Wild	□ Yes	□ No	□ Unknown
	□ Domestic	□ Wild	□ Yes	□ No	□ Unknown

Any other information regarding animal health events near the patient?:

_____

_____

6. INSECT EXPOSURE

Did the patient get stung/bitten by any **insect, beetle, tick or other**? □ No □ Yes, specify:_____

Did the patient notice an increase in **of the number of insects, ticks, beetles or others**? □ No □ Yes, specify:_____

Did the patient notice any **newly observed insects, ticks, beetles or other** lately? □ No □ Yes, specify:_____

Sources of drinking water	Characteristic of drinking water				Source of non-drinking water
	Clear	Filtered	Treated water	Comments	
	□ Yes □ No	□ Yes □ No	□ Yes □ No		
	□ Yes □ No	□ Yes □ No	□ Yes □ No		
	□ Yes □ No	□ Yes □ No	□ Yes □ No		

Other additional information regarding water source or use:

_____

_____

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

7. WATER AND FOOD

Have you attended an **event** (e.g. festival, wedding, etc.) where food was served and you know of others who are also sick? □ No □ Yes, specify
specify common foods consumed:_____
(please specify details about the event in part 2)

Have you shared a **meal** with others who you know are also experiencing the same symptoms?
□ No □ Yes, specify
specific foods consumed:_____
specify when the meals were shared: _____

Does the patient suspect a specific food or the beverage to be the cause of the disease?: □ No □ Yes, please explain why:_____

Were there any notable changes to the types of sources of food or drinks normally consumed prior to symptom onset?: □ No □ Yes, please specify
_____

Food	Sources of food	Type of food
Morning		
Mid-day		
Evening		
Drink	Sources of beverage	Type of beverage
Morning		
Mid-day		
Evening		

Any other observation to share regarding food and drinks?
(e.g. , risk of food or water contamination stored in re-used containers previously used as chemical containers, food not stored at appropriate temperatures, etc.)

_____

* *EPI CORE VARIABLES for outbreak investigation.*
** *if the answer is no, go directly to the next box or next question in bold*

8. CHEMICAL

Is a **chemical exposure** suspected as the source of the outbreak? □ No □ Yes,

specify suspected product: _____

potential source of exposure?: _____

place of the chemical source?: _____

duration of potential exposure?: _____

List the occupation of adult household members in table below:

Relationship with patient	Occupation	Place of work	Suspected chemical exposure
1.			
2.			
3.			
4.			

9. PERSONAL ASSUMPTION

Any **additional information** to share?

_____

_____

_____

What (and why?) does the patient think might be the **source of this disease or facilitating its spread**?

_____

_____

_____

For how long does the patient think this event has been going on in the community?

_____

_____

Does the patient know about any similar outbreak or event that happened previously?

□ No □ Yes, specify _____

** EPI CORE VARIABLES for outbreak investigation.*

*** if the answer is no, go directly to the next box or next question in bold*

Section 4: Laboratory information

LABORATORY

Laboratory ID: _____Laboratory name: _____

Town (or address) of the laboratory: _____

Did the patient received an antibiotic prior to the collection of specimen? · Yes · No · Unknown

Sample ID	Type of specimen *(blood, stool, CSF, skin smear, ...)*	Collection date / date of test performed	Test performed	Pathogen identified
		[_D_][_D_]/[_M_][_M_] /[_D_][_D_]/[_M_][_M_]		
		[_D_][_D_]/[_M_][_M_]/[_D_][_D_]/[_M_][_M_]		
		[_D_][_D_]/[_M_][_M_]/[_D_][_D_]/[_M_][_M_]		
		[_D_][_D_]/[_M_][_M_]/[_D_][_D_]/[_M_][_M_]		

Blood formula, biochemistry, enzymes test:

Proteinuria: □ Yes □ No □ NA
Haematuria: □ Yes □ No □ NA
Haemoglobin: _____
WBC count: _____
Platelets: _____

CRP: _____
Potassium: _____
ALT/SGPT: _____
AST/SGOT: _____
Lactate: _____

Total Bilirubin: _____
Creatinine: _____
Urea: _____
Creatine kinase (CPK): _____
Other: _____

Blood gases** □ Yes □ No
Arterial blood pH: _____
Bicarbonates: _____
Partial pressure of oxygen): _____
Partial pressure of carbon dioxide: _____
Oxygen saturation: ._____
Other test performed and results (even if negative results): _____
Lab conclusion:
_____

Environmental samples taken**: □ Yes □ No
Products: _____
Date of collection:
_____

Animal samples taken**: □ Yes □ No
Products: _____
Date of collection:
_____

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*

Section 5: Conclusion

List here the diseases you suspected ordered from most to less likely:

Agent or disease suspected	Possible co-factors	Evidence for	Rank of certainty (over/10)	Confirmation action to be taken

** EPI CORE VARIABLES for outbreak investigation.*
*** if the answer is no, go directly to the next box or next question in bold*