Case Report Form – Unexplained Death

Case ID:
Date:

Submitter name and phone number _____

Case reported by: ☐EMS ☐Emergency Department ☐Law Enforcement
☐Local Health Department ☐Hospital Pathologist ☐Medical Examiner
☐Health Care Provider ☐Funeral Director ☐Other:_____

*Does patient meet criteria for an unexplained death with no known cause** ***(check all that apply)****?*

- ☐ Hospital/facility-based death with no known cause, with history of fever (>38.0°C) within 48 hours of death or a temperature of < 36°C;
- ☐ Patient-reported history of fever within 48 hours of death;
- ☐ High clinical suspicion of infectious etiology by health care provider or medical examiner; or
- ☐ Unattended death with no obvious cause of death.

*Deaths due to suicide, homicide, trauma or accidents should be excluded.

Notes:

1. Patient with evidence of acute infectious or inflammatory process (leukocytosis or leukopenia, or signs of inflammation/infection in normally sterile fluid/site) should also be considered febrile, even if temperature was not measured.
2. Any clinical evidence that cause of death is infectious in origin and/or of public health significance should be cause for inclusion.

Was an autopsy performed ☐ Yes ☐ No ☐ Unknown If yes, Date:___/___/_____

Patient Demographics

1. Patient Name: First: _____ Last: _____
2. Age _____
3. Date of birth…… _____/ _____/ _____
4. Gender…… ☐ Male ☐ Female
5. Place of residence:

Street address:_____
City: _____ State: _____ Zip: _____
County: _____ Country: _____
Homeless ☐

6. Country of birth _____ If applicable, year immigrated to US ____

7. Date of illness onset _____/ _____/ _____

8. Presented to Emergency Room ☐ Yes ☐ No ☐ Unknown If yes, Date: __/__/___

9. Hospitalized (admitted) ☐ Yes ☐ No ☐ Unknown If yes, Date: __/__/___

Name of hospital_____ MR# _____

10. Location of Death: ☐ Home ☐Hospital _____
☐Other_____

Reporting Person and Medical Contacts

1. Person reporting case to state or local health department:
Name and Position: _____
Facility/organization: _____
Street address:_____
City: _____ State/Country: _____ Zip: _____
Phone: _____ Pager: _____ Fax: _____
Email: _____

2. Person performing autopsy:
Name and Position: _____
Facility/organization: _____
Street address:_____
City: _____ State/Country: _____ Zip: _____
Phone: _____ Pager: _____ Fax: _____
Email: _____

3. Patient and Family contacts

	Name and Relationship to Patient	Telephone number
a.	_____	_____
b.	_____	_____

Initial medical description

Based on the information available to reporter at this time, classify the patient's primary clinical system involved in the illness:
☐Cardiac ☐Cutaneous/Rash ☐Gastrointestinal ☐Hepatic ☐Neurologic
☐Renal ☐Respiratory ☐Sepsis/Multiorgan failure
☐Other: _____

Any additional systems involved (Check all that apply)
☐Cardiac ☐Cutaneous/Rash ☐Gastrointestinal ☐Hepatic ☐Neurologic
☐Renal ☐Respiratory ☐Sepsis/Multiorgan failure
☐Other: _____

At any time during the current illness, was the patient admitted to an ICU?
☐Yes ☐No ☐Unknown
→ If YES, Date admitted: ___/ ___/ ____ Date discharged (if applicable) ___/ ___/ ____

Hospital admissions for current illness

	Hospital	Patient or Medical Record #	Admission date
a.	_____	_____	___/___/_____
b	_____	_____	___/___/_____
c.	_____	_____	___/___/_____

Risk History: (from medical records or interviews).
If the answer to any question is "Yes", get detailed information.

Recent Travel History
In the ONE MONTH PRIOR to admission/onset (earliest available), did the patient:
1. Travel outside of the United States…… ☐Yes ☐No ☐Unknown
→ If YES, List countries:
2. Travel within the U.S but outside of Arizona……....☐Yes ☐No ☐Unknown
→ If YES, List states:
3. Travel within the state of Arizona……....☐Yes ☐No ☐Unknown
→ If YES, List counties:

Exposures to other ill persons
In the ONE MONTH prior to admission/onset (earliest available), did the patient have:
1. An ill person living in his/her household…… ☐Yes ☐No ☐Unknown
→ If YES, Describe illness:
2. Close contact with someone who had a similar illness…... ☐Yes ☐No ☐Unknown
→ If YES, Describe:

Occupational and Recreational Exposures
In the ONE MONTH prior to admission/onset (earliest available), did the patient:
1. Work outside of the home ……..... ☐Yes ☐No ☐Unknown
→ If YES, List occupation and company name/address
2. Attend school or day care ……..... ☐Yes ☐No ☐Unknown
→ If YES, Name/address of school or day care:
3. Garden/excavate/work with soil; horticulture ……..☐Yes ☐No ☐Unknown
4. Spend time in an infrequently used structure/space, e.g. attic or cabin
……..... ☐Yes ☐No ☐Unknown
5. Perform construction or renovations…….. ☐Yes ☐No ☐Unknown
6. Mow grass or hay……..... ☐Yes ☐No ☐Unknown
7. Go hiking or camping……..... ☐Yes ☐No ☐Unknown
8. Explore caves ……..... ☐Yes ☐No ☐Unknown

9. Participate in water-related recreation (e.g. fishing, boating, swimming)
……..... ☐Yes ☐No ☐Unknown
→ If YES: Type of water:
☐Pool ☐Saltwater (e.g. ocean) ☐Freshwater (e.g. lake, river, stream)
Location:_____
10. Work with any chemicals or toxins……..... ☐Yes ☐No ☐Unknown
→ If YES, List chemicals/toxins:

Food Exposures

Did the patient consume:

1. Rare hamburger or raw beef *in the week before onset of illness*
…….. ☐Yes ☐No ☐Unknown
2. Raw shellfish (e.g. oysters, clams, mussels) *in the 2 months before illness*
…….. ☐Yes ☐No ☐Unknown
3. Raw fish (sushi) *in the 2 months before illness*……..... ☐Yes ☐No ☐Unknown
4. Raw milk/unpasteurized dairy products *in the week before illness*
…….. ☐Yes ☐No ☐Unknown
5. Raw juices (unpasteurized) *in the week before illness* …..... ☐Yes ☐No ☐Unknown

→ **If the patient answered YES to any of the above questions, list detail and contexts of exposure(s)**

Animal and Insect Exposures

<u>In the ONE MONTH PRIOR to admission/onset (earliest available), did the patient:</u>

1. Have animals living in his/her home (including pets)…….. ☐Yes ☐No ☐Unknown
2. Receive an animal bite (wild or domestic animals) in the ONE YEAR prior to admission/onset…….. ☐Yes ☐No ☐Unknown
3. Receive an insect bite (e.g. mosquito, tick, spider)……. ☐Yes ☐No ☐Unknown
4. Have close contact with rodents (e.g. mice, rats, prairie dogs)……..... ……. ☐Yes ☐No ☐Unknown
5. Have close contact with rodent droppings.....……. ☐Yes ☐No ☐Unknown
6. Go hunting or fishing.....……. ☐Yes ☐No ☐Unknown
7. Skin, dress, or eat wild game.....……. ☐Yes ☐No ☐Unknown
8. Spend time on a farm, ranch or petting zoo.....…… ☐Yes ☐No ☐Unknown
9. Have close contact with live birds.....…….. ☐Yes ☐No ☐Unknown
10. Have close contact with dead birds…… ☐Yes ☐No ☐Unknown
11. Have close contact with bird droppings.....……. ☐Yes ☐No ☐Unknown
12. Perform or assist with an animal necropsy.....…… ☐Yes ☐No ☐Unknown
13. Have close contact with animals in any other setting..... ☐Yes ☐No ☐Unknown

→ **If the patient answered YES to any of the above questions, list animal(s)/insect(s) and type of exposure(s)**

Description of Current Illness

Chief complaint: (Why did the patient seek health care?)

History of presenting illness: (Chronology from onset of illness to death)

Severity of illness

Supplemental oxygen used…… ☐Yes ☐No ☐Unknown

→ If YES, Date started: ___/ ___/ _____ Date stopped: ____/ ____/ _____

Vasopressor medications (e.g. dopamine, epinephrine).....… ☐Yes ☐No ☐Unknown

→ If YES, Date started: ___/ ___/ _____ Date stopped: ____/ ____/ _____

Mechanical ventilation…….…… ..... ☐Yes ☐No ☐Unknown

→ If YES, Date started: ___/ ___/ _____ Date stopped: ____/ ____/ _____

Cardiopulmonary arrest.....……. ☐Yes ☐No ☐Unknown

→ If YES, Date: ___/ ___/ _____

Medications: (For current illness, on or before hospital admission, including any herbal or non-traditional medications)

Received antimicrobials …….……..……... ☐Yes ☐No ☐Unknown

→If yes, list:

Name	Date 1st Received
_____	_____/ _____/ _____
_____	_____/ _____/ _____
_____	_____/ _____/ _____
_____	_____/ _____/ _____
_____	_____/ _____/ _____
_____	_____/ _____/ _____

Past medical history: (Any chronic illness, immunosuppression, splenectomy, receipt of blood products at any time, immunization history)

Past surgical history:

Social history: (Anything else that might seem relevant to the particular case)

Marital status: (Married, single, divorced, widowed)
Alcohol use: (what, how much, for how long)
Smoking: (what, how much, for how long)
Illicit drugs: (what, how much, for how long, route used)
Sexual history

Please attach all tests and results/findings, including:

- Labs
- Cultures
- Pathology including histopathology
- Imaging studies
- Procedures

Additional comments:

Completed forms should be submitted to the Arizona Department of Health Services within 30 days of death, or earlier if consultation with ADHS UNEX team is needed.

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