CRYPTOCOCCOSIS CASE INVESTIGATION - Page 1 of 3

Indiana State Department of Health
State Form 52276 (8-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name | **ISDH Action:** ○ A case ○ Not a case

First Name | **MI** | **Phone Number** ___ - ___ - ____

Number & Street Address

City | **State** | **ZIP Code** ____ - ____

County | **Date of Birth** __ / __ / ____ | **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation | **Phone of Employer/School/Day Care** ___ - ___ - ____

Name of ○ Employer ○ School ○ Day Care

Address of Employer/School/Day Care

City | **State** | **ZIP Code** ____ - ____

Section 2. Clinical Information

Symptoms (check all that apply):
- ○ Fever ___.___ *(degrees)*
- ○ Chest Pain
- ○ Coughing
- ○ Hemoptysis
- ○ Confusion
- ○ Headache
- ○ Nausea
- ○ Arthritis/Arthralgia
- ○ Dizziness
- ○ Weight Loss
- ○ Irritability
- ○ Night Sweats
- ○ Visual Loss
- ○ Brain Swelling
- ○ Seizure
- ○ Impaired Memory/Judgment
- ○ Behavorial Changes
- ○ Other, specify:

Extrapulmonary site:
- ○ Blood
- ○ Eye
- ○ Bone
- ○ Lesions (face, scalp, skin)
- ○ Other, specify:

Date of chest x-ray __ / __ / ____

Chest X-ray:
- ○ Normal
- ○ Cavitation
- ○ Calcification
- ○ Pulmonary Infiltrates
- ○ Mediastinal Adenopathy
- ○ Other, specify:

Immunocompromised*
- ○ Yes
- ○ No

*Need not specify immuno-compromised disorder involved.

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Section 2. Clinical Information (continued)

__ __ / __ __ / __ __
Date of Onset

Was the patient hospitalized?
○ Yes ○ No

If Yes, admission date: __ __ / __ __ / __ __

Discharge date: __ __ / __ __ / __ __

Hospital:

Patient chart number:

Physician:

E-mail address:

Physician phone: ___ - ___ - ____

Section 3. Environmental Risk Factors

○ Occupation, specify:

○ Building Demolition, specify:

○ Pigeon Raising

○ Poultry Raising

○ Gardening

○ Laboratory Worker

○ Excavation or Decayed Wood Chips

○ Cave Exploration

○ Tobacco Smoking (check one):
- ○ Active
- ○ Passive
- ○ Unknown

○ Other, specify:

Section 4. Diagnostic Laboratory Testing

Culture for *Cryptococcus neoformans:*

__ __ / __ __ / __ __
Specimen date

○ Positive
○ Negative
○ Unknown/Pending

Anatomical site:

○ Blood
○ Lung Biopsy
○ Sputum
○ Tissue Specimen
○ Lesion Biopsy
○ Broncho Pulmonary
○ CSF
○ Other, specify:

Biopsy for *Cryptococcus neoformans:*

__ __ / __ __ / __ __
Specimen date

○ Positive
○ Negative
○ Unknown/Pending

Anatomical site:

○ Lung Biopsy
○ Other, specify:

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Section 4. Diagnostic Laboratory Testing (continued)

THERAPY

Treatment for Cryptococcosis:

○ Yes ○ No

Drug given:

○ Amphotericin-B

○ Ketoconazole

○ Other, specify: _____

OUTCOME

○ Recovery without medication probable

○ Recovery with medication probable

○ Death

__ __ / __ __ / __ __
Date of death

_____
Cause of death

○ Unknown

Section 5. Comments/Follow-up

Comments:

_____
Investigator Name

_____
Agency

___ - ___ - ____ **Phone Number**

__ __ / __ __ / __ __ **Date**