

California Department of Public Health  
 Center for Infectious Diseases  
 Division of Communicable Disease Control  
 Infectious Diseases Branch  
 Surveillance and Statistics Section  
 MS 7306, P.O. Box 997377  
 Sacramento, CA 95899-7377

Local ID Number \_\_\_\_\_

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

## PSITTACOSIS CASE REPORT

PATIENT INFORMATION						
Last Name	First Name	Middle Name	Suffix	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk	
Address Number & Street - Residence			Apartment/Unit Number			
City/Town			State	Zip Code		
Census Tract	County of Residence		Country of Residence			
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)				
Home Telephone		Cellular Phone/Pager		Work/School Telephone		
E-mail Address		Other Electronic Contact Information				
Work/School Location		Work/School Contact				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____						
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, Est. Delivery Date (mm/dd/yyyy)				
Medical Record Number		Patient's Parent/Guardian Name				
Occupation Setting (see list on page 6)		Other Describe/Specify				
Occupation (see list on page 6)		Other Describe/Specify				
*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.						
CLINICAL INFORMATION						
Physician Name - Last Name			First Name		Telephone Number	

First three letters of  
patient's last name:

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<b>SIGNS AND SYMPTOMS</b>						
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)			Date First Sought Medical Care (mm/dd/yyyy)	
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted		
Fever				Highest temperature (specify °F/°C)		
Chills						
Headache						
Photophobia						
Cough						
Myalgia						
Other symptom (specify)						
<b>HOSPITALIZATION</b>						
Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, how many total hospital nights?	
Was patient placed in respiratory isolation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			If there were any ER or hospital stays related to this illness, specify details below.			
<b>HOSPITALIZATION - DETAILS</b>						
Hospital Name 1	Street Address			Admission Date (mm/dd/yyyy)		
	City			Discharge / Transfer Date (mm/dd/yyyy)		
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis	
Hospital Name 2	Street Address			Admission Date (mm/dd/yyyy)		
	City			Discharge / Transfer Date (mm/dd/yyyy)		
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis	
<b>TREATMENT / MANAGEMENT</b>						
Received treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, specify the treatments below.				
<b>TREATMENT / MANAGEMENT - DETAILS</b>						
Antibiotic 1	Dose		Date Started (mm/dd/yyyy)		Days Prescribed	
Antibiotic 2	Dose		Date Started (mm/dd/yyyy)		Days Prescribed	
Antibiotic 3	Dose		Date Started (mm/dd/yyyy)		Days Prescribed	
<b>OUTCOME</b>						
Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk		If Survived, Survived as of _____ (mm/dd/yyyy)			Date of Death (mm/dd/yyyy)	

First three letters of patient's last name:

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**LABORATORY INFORMATION**

**LABORATORY RESULTS SUMMARY**

<i>Specimen Type 1</i> <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Other: _____	<i>Type of Test</i> <input type="checkbox"/> MIF <input type="checkbox"/> CF <input type="checkbox"/> Culture <input type="checkbox"/> Other: _____	If Serum (acute) is submitted, then Serum (convalescent) must also be submitted	
	<i>C. psittaci IgM Titer</i>	<i>C. psittaci IgG Titer</i>	
	<i>Results</i>	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	
	<i>Laboratory Name</i>	<i>Telephone Number</i>	
<i>Specimen Type 2</i> <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Other: _____	<i>Type of Test</i> <input type="checkbox"/> MIF <input type="checkbox"/> CF <input type="checkbox"/> Culture <input type="checkbox"/> Other: _____	If Serum (acute) is submitted, then Serum (convalescent) must also be submitted	
	<i>C. psittaci IgM Titer</i>	<i>C. psittaci IgG Titer</i>	
	<i>Results</i>	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	
	<i>Laboratory Name</i>	<i>Telephone Number</i>	

**IMAGING SUMMARY**

<i>Anatomic site</i>	<i>Date (mm/dd/yyyy)</i>	<i>Type of Imaging</i> <input type="checkbox"/> X-Ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____
	<i>Result</i>	<i>Interpretation</i>
	<i>Laboratory Name</i>	<i>Telephone Number</i>

**EPIDEMIOLOGIC INFORMATION**

INCUBATION PERIOD IS 1 - 4 WEEKS PRIOR TO ILLNESS ONSET

**EXPOSURES / RISK FACTORS**

**DID THE PATIENT HAVE CONTACT WITH ANY OF THE FOLLOWING DURING THE MONTH PRIOR TO ILLNESS ONSET?**

Exposure	Yes	No	Unk	If Yes, Specify as Noted
Bird(s)				<i>Type of Bird</i> <input type="checkbox"/> Psittacines <input type="checkbox"/> Pigeons <input type="checkbox"/> Poultry <input type="checkbox"/> Other: _____
				<i>Type of Bird Exposure</i> <input type="checkbox"/> Household pet <input type="checkbox"/> Aviary <input type="checkbox"/> Pet store <input type="checkbox"/> Other: _____
				<i>Contact Dates (mm/dd/yyyy)</i> From ____/____/____ to ____/____/____
				<i>Source of Birds</i>
				<i>Date Birds Acquired (mm/dd/yyyy)</i>
				<i>Any birds ill?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<i>Any birds die?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
<i>Any birds tested?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Results</i>			
Human psittacosis case				Specify
Other contact or exposure				Specify

First three letters of patient's last name:

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**CONTACTS / OTHER ILL PERSONS**

Any contacts with similar illness?  
 Yes  No  Unk If Yes, specify details below.

**ILL CONTACTS - DETAILS**

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship		
	Street Address			Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)	
	City		State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	

Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship		
	Street Address			Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)	
	City		State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	

**NOTES / REMARKS**


**REPORTING AGENCY**

Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
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First Reported By  
 Clinician  Laboratory  Other (specify): \_\_\_\_\_

**EPIDEMIOLOGICAL LINKAGE**

Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number
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**DISEASE CASE CLASSIFICATION**

Case Classification (see case definition page 5)  
 Confirmed  Probable

**STATE USE ONLY**

Case Classification  
 Confirmed  Probable  Not a case  Need additional information

**CASE DEFINITION****PSITTACOSIS (2010)****CLINICAL DESCRIPTION**

An illness characterized by fever, chills, headache, myalgia, and a dry cough with pneumonia often evident on chest x-ray. Severe pneumonia requiring intensive-care support, endocarditis, hepatitis, and neurologic complications occasionally occur.

**LABORATORY CRITERIA FOR DIAGNOSIS**

- Isolation of *Chlamydophila psittaci* from respiratory specimens (e.g., sputum, pleural fluid, or tissue), or blood, or
- Fourfold or greater increase in antibody (Immunoglobulin G [IgG]) against *C. psittaci* by complement fixation (CF) or microimmunofluorescence (MIF) between paired acute- and convalescent-phase serum specimens obtained at least 2-4 weeks apart, or
- Supportive serology (e.g. *C. psittaci* antibody titer [Immunoglobulin M (IgM)] of greater than or equal to 32 in at least one serum specimen obtained after onset of symptoms), or
- Detection of *C. psittaci* DNA in a respiratory specimen (e.g. sputum, pleural fluid or tissue) via amplification of a specific target by polymerase chain reaction (PCR) assay.

**CASE CLASSIFICATION**

**Probable:** An illness characterized by fever, chills, headache, cough and myalgia that has either:

- Supportive serology (e.g. *C. psittaci* antibody titer [Immunoglobulin M, IgM] of greater than or equal to 32 in at least one serum specimen obtained after onset of symptoms), or
- Detection of *C. psittaci* DNA in a respiratory specimen (e.g. sputum, pleural fluid or tissue) via amplification of a specific target by polymerase chain reaction (PCR) assay.

**Confirmed:** An illness characterized by fever, chills, headache, cough and myalgia, and laboratory confirmed by either:

- Isolation of *Chlamydophila psittaci* from respiratory specimens (e.g., sputum, pleural fluid, or tissue), or blood, or
- Fourfold or greater increase in antibody (Immunoglobulin G [IgG]) against *C. psittaci* by complement fixation (CF) or microimmunofluorescence (MIF) between paired acute- and convalescent-phase serum specimens obtained at least 2-4 weeks apart.

**COMMENT**

Although MIF has shown greater specificity to *C. psittaci* than CF, positive serologic findings by both techniques may occur as a result of infection with other Chlamydia species and should be interpreted with caution. To increase the reliability of test results, acute- and convalescent-phase serum specimens should be analyzed at the same time in the same laboratory. A realtime polymerase chain reaction (rtPCR) has been developed and validated in avian specimens but has not yet been validated for use in humans (1).

**REFERENCES**

1. Mitchell, S.L., Wolff, B.J., Thacker, W.L., Ciombor, P.G., Gregory, C.R., Everett, K.D., Ritchie, B.W., & Winchell, J.M. (2009). Genotyping of *Chlamydophila psittaci* by real-time PCR and high-resolution melt analysis. *J Clin Microbiol*, 47(1),175-181.

<b>RACE DESCRIPTIONS</b>	
<b>Race</b>	<b>Description</b>
American Indian or Alaska Native	Patient has origins in <b>any</b> of the original peoples of North and South America (including Central America).
Asian	Patient has origins in <b>any</b> of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in <b>any</b> of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in <b>any</b> of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in <b>any</b> of the original peoples of Europe, the Middle East, or North Africa.
<b>OCCUPATION SETTING</b>	
<ul style="list-style-type: none"> <li>• Childcare/Preschool</li> <li>• Correctional Facility</li> <li>• Drug Treatment Center</li> <li>• Food Service</li> <li>• Health Care - Acute Care Facility</li> <li>• Health Care - Long Term Care Facility</li> <li>• Health Care - Other</li> </ul>	<ul style="list-style-type: none"> <li>• Homeless Shelter</li> <li>• Laboratory</li> <li>• Military Facility</li> <li>• Other Residential Facility</li> <li>• Place of Worship</li> <li>• School</li> <li>• Other</li> </ul>
<b>OCCUPATION</b>	
<ul style="list-style-type: none"> <li>• Adult film actor/actress</li> <li>• Agriculture - farmworker or laborer (crop, nursery, or greenhouse)</li> <li>• Agriculture - field worker</li> <li>• Agriculture - migratory/seasonal worker</li> <li>• Agriculture - other/unknown</li> <li>• Animal - animal control worker</li> <li>• Animal - farm worker or laborer (farm or ranch animals)</li> <li>• Animal - veterinarian or other animal health practitioner</li> <li>• Animal - other/unknown</li> <li>• Clerical, office, or sales worker</li> <li>• Correctional facility - employee</li> <li>• Correctional facility - inmate</li> <li>• Craftsman, foreman, or operative</li> <li>• Daycare or child care attendee</li> <li>• Daycare or child care worker</li> <li>• Dentist or other dental health worker</li> <li>• Drug dealer</li> <li>• Fire fighting or prevention worker</li> <li>• Flight attendant</li> <li>• Food service - cook or food preparation worker</li> <li>• Food service - host or hostess</li> <li>• Food service - server</li> <li>• Food service - other/unknown</li> <li>• Homemaker</li> <li>• Laboratory technologist or technician</li> <li>• Laborer - private household or unskilled worker</li> <li>• Manager, official, or proprietor</li> <li>• Manicurist or pedicurist</li> <li>• Medical - emergency medical technician or paramedic</li> <li>• Medical - health care worker</li> </ul>	<ul style="list-style-type: none"> <li>• Medical - medical assistant</li> <li>• Medical - pharmacist</li> <li>• Medical - physician assistant or nurse practitioner</li> <li>• Medical - physician or surgeon</li> <li>• Medical - nurse</li> <li>• Medical - other/unknown</li> <li>• Military</li> <li>• Police officer</li> <li>• Professional, technical, or related profession</li> <li>• Retired</li> <li>• Sex worker</li> <li>• Stay at home parent/guardian</li> <li>• Student - preschool or kindergarten</li> <li>• Student - elementary or middle school</li> <li>• Student - high school</li> <li>• Student - college or university</li> <li>• Student - other/unknown</li> <li>• Teacher/employee - preschool or kindergarten</li> <li>• Teacher/employee - elementary or middle school</li> <li>• Teacher/employee - high school</li> <li>• Teacher/instructor/employee - college or university</li> <li>• Teacher/instructor/employee - other/unknown</li> <li>• Unemployed - seeking employment</li> <li>• Unemployed - not seeking employment</li> <li>• Unemployed - other/unknown</li> <li>• Volunteer</li> <li>• Other</li> <li>• Refused</li> <li>• Unknown</li> </ul>