State of California—Health and Human Services Agency

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

COCCIDIOIDOMYCOSIS
CASE REPORT

Please complete this form only for laboratory confirmed cases of coccidioidomycosis that meet at least one of the case definition clinical conditions. For case definition, see page 5.

***Completion of this form is not required** but encouraged to improve surveillance and understanding of this disease. Jurisdictions not participating in CalREDIE should **securely** email the completed form to IDB-SSS@cdph.ca.gov; otherwise, mail the completed form to IDB-SSS at the address above. Jurisdictions participating in CalREDIE should create a CalREDIE incident and enter the information directly into the CalREDIE system.*

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*
Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ *Years* ☐ *Months* ☐ *Days*
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 ☐ Male ☐ Female ☐ Other: ______________			
Pregnant? ☐ Yes ☐ No ☐ 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*		

Primary Language
☐ English
☐ Spanish
☐ Other:____________________

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unk

*Race**
(check all that apply, race descriptions on page 6)
☐ African-American/Black
☐ American Indian or Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Japanese
- ☐ Cambodian ☐ Korean
- ☐ Chinese ☐ Laotian
- ☐ Filipino ☐ Thai
- ☐ Hmong ☐ Vietnamese
- ☐ Other:____________________

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian
- ☐ Other:____________________

☐ White
☐ Other:____________________
☐ Unk

*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: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unk	*Onset Date (mm/dd/yyyy)*	*Date First Sought Medical Care (mm/dd/yyyy)*

Duration of Acute Symptoms	*Specify Units* ☐ Days ☐ Weeks ☐ Months	*Did the patient miss school or work due to illness?* ☐ Yes ☐ No ☐ Unk ☐ N/A	*If Yes, specify number of days*

Clinical Conditions	Yes	No	Unk	Clinical Conditions	Yes	No	Unk
Influenza-like signs and symptoms (e.g., fever, chest pain, cough, myalgia, arthralgia, headache, and fatigue)				Dissemination to bones (specify): ___________________			
Pneumonia, diagnosed by chest radiograph or CT				Dissemination to joints (specify): ___________________			
Other pulmonary lesion, diagnosed by chest radiograph or CT (specify type of lesion): ______________________				Meningitis			
Rash (specify) ☐ Erythema multiforme ☐ Erythema nodosum ☐ Other				*Other disseminated site (specify)*			
Skin lesions (dissemination to skin)				*Other disseminated site (specify)*			

EXISTING MEDICAL CONDITIONS/PAST MEDICAL HISTORY

At the time of disease onset, did the patient have any of the following conditions or treatments? (check all that apply)

☐ Asthma
☐ Cancer (type): _________________
☐ Chemotherapy
☐ COPD/emphysema
☐ Corticosteroid
☐ Diabetes
☐ Immunocompromised
☐ Organ recipient
☐ Tuberculosis
☐ Other: ________________________

HOSPITALIZATION

Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unk	*Was patient hospitalized?* ☐ Yes ☐ No ☐ Unk	*If Yes, how many total hospital nights?*

If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION - DETAILS

Hospital Name 1	*Street Address*			*Admit 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*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*

TREATMENT / MANAGEMENT

Received treatment? ☐ Yes ☐ No ☐ Unk	*If Yes, specify the treatments below.*

TREATMENT / MANAGEMENT - DETAILS

Treatment Type 1 ☐ Antifungal ☐ Other	*Treatment Name*	*Date Started (mm/dd/yyyy)*
Treatment Type 2 ☐ Antifungal ☐ Other	*Treatment Name*	*Date Started (mm/dd/yyyy)*

First three letters of patient's last name: | | | |

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unk	*If Survived,* Survived as of ______________________(mm/dd/yyyy)	
	If Died, Date of Death (mm/dd/yyyy)	*Was death caused by coccidioidomycosis?* ☐ Yes ☐ No ☐ Unk

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY - BLOOD SPECIMENS (results from the time of diagnosis)

Reason for Testing
☐ Symptomatic ☐ Screening ☐ Other (specify):______________________________

Test Type	Done	Not Done	Unk	If Test Done, Specify as Noted		
IgM enzyme immunoassay (EIA)				*Collection Date (mm/dd/yyyy)*	*Laboratory Name*	*Telephone Number*
				Interpretation ☐ Positive ☐ Negative ☐ Equivocal ☐ Unk ☐ Pending ☐ Other: ____________		
IgG enzyme immunoassay (EIA)				*Collection Date (mm/dd/yyyy)*	*Laboratory Name*	*Telephone Number*
				Interpretation ☐ Positive ☐ Negative ☐ Equivocal ☐ Unk ☐ Pending ☐ Other: ____________		
IgM immunodiffusion (ID)				*Collection Date (mm/dd/yyyy)*	*Laboratory Name*	*Telephone Number*
				Interpretation ☐ Positive ☐ Negative ☐ Equivocal ☐ Unk ☐ Pending ☐ Other: ____________		
IgG immunodiffusion (ID)				*Collection Date (mm/dd/yyyy)*	*Laboratory Name*	*Telephone Number*
				Interpretation ☐ Positive ☐ Negative ☐ Equivocal ☐ Unk ☐ Pending ☐ Other: ____________		
IgG complement fixation (CF)				*Collection Date (mm/dd/yyyy)*	*Laboratory Name*	*Telephone Number*
				Interpretation ☐ Positive ☐ Negative ☐ Equivocal ☐ Unk ☐ Pending ☐ Other: ____________		*Titer*

LABORATORY RESULTS SUMMARY - OTHER SPECIMENS

Specimen Type 1	*Type of Test*		*Collection Date (mm/dd/yyyy)*
☐ CSF ☐ Tissue: __________ ☐ Other: __________	☐ IgM EIA ☐ IgM ID ☐ IgG CF ☐ Histopathology ☐ IgG EIA ☐ IgG ID ☐ Culture ☐ Other (specify):______________		
	Results	*Laboratory Name*	*Telephone Number*
Specimen Type 2	*Type of Test*		*Collection Date (mm/dd/yyyy)*
☐ CSF ☐ Tissue: __________ ☐ Other: __________	☐ IgM EIA ☐ IgM ID ☐ IgG CF ☐ Histopathology ☐ IgG EIA ☐ IgG ID ☐ Culture ☐ Other (specify):______________		
	Results	*Laboratory Name*	*Telephone Number*

First three letters of patient's last name: | | | |

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 1 TO 3 WEEKS PRIOR TO ONSET OF PULMONARY ILLNESS

DUST EXPOSURES (If patient has no history of pulmonary illness, please skip DUST EXPOSURES section.)

DID THE PATIENT HAVE EXPOSURE TO EXCESSIVE VISIBLE DUST (e.g., DUE TO SOIL DISTURBANCE, CONSTRUCTION ACTIVITY, DUST STORM, ETC.) AT ANY OF THE FOLLOWING SETTINGS DURING THE INCUBATION PERIOD?

Setting of Exposure 1
☐ Home
☐ School
☐ Worksite
☐ Prison or jail
☐ Long term care facility
☐ Outdoor event or facility
☐ Other (specify): ____________________

Name and Address of Facility, Worksite, or Event

Source of Dust
☐ Dust generating activity (soccer game, outdoor vehicle riding, gardening) ☐ Construction
☐ Wind/dust storm/earthquake ☐ Unknown
☐ Other (specify): ________________

Date(s) of Exposure (mm/dd/yyyy)

Similar illness in others at facility, worksite, or event?
☐ Yes ☐ No ☐ Unk

Setting of Exposure 2
☐ Home
☐ School
☐ Worksite
☐ Prison or jail
☐ Long term care facility
☐ Outdoor event or facility
☐ Other (specify): ____________________

Name and Address of Facility, Worksite, or Event

Source of Dust
☐ Dust generating activity (soccer game, outdoor vehicle riding, gardening) ☐ Construction
☐ Wind/dust storm/earthquake ☐ Unknown
☐ Other (specify): ________________

Date(s) of Exposure (mm/dd/yyyy)

Similar illness in others at facility, worksite, or event?
☐ Yes ☐ No ☐ Unk

OTHER EPIDEMIOLOGIC INFORMATION

Is the patient a current or former cigarette smoker?
☐ Current ☐ Former ☐ Never smoked cigarettes ☐ Unk

If current or former cigarette smoker, describe frequency of use (pack years)

Had the patient heard of coccidioidomycosis or Valley Fever prior to diagnosis?
☐ Yes ☐ No ☐ Unk

If Yes, source of information?
☐ News source ☐ Website ☐ Other (specify): ________________
☐ Friend/word-of-mouth ☐ Provider

PLACE OF RESIDENCE

Did patient reside ***outside of current county of residence*** *in the year before illness onset?*
☐ Yes ☐ No ☐ Unk

If Yes, specify all locations and dates below.

PLACE OF RESIDENCE - DETAILS

Location (city, county, state, country)	Type of Residence	Month and Year Residence Started	Month and Year Residence Ended
	☐ Permanent residence / home ☐ School / university campus ☐ Temporary work residence ☐ Long term care facility ☐ Prison / jail ☐ Other:_________________		
	☐ Permanent residence / home ☐ School / university campus ☐ Temporary work residence ☐ Long term care facility ☐ Prison / jail ☐ Other:_________________		

TRAVEL HISTORY

Did patient travel ***outside of county of residence*** *during the incubation period?*
☐ Yes ☐ No ☐ Unk

Has the patient traveled outside the U.S. during the incubation period?
☐ Yes ☐ No ☐ Unk

If Yes for either of these questions, specify all locations and dates below.

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

First three letters of patient's last name: ☐☐☐

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*

First Reported By
☐ Clinician ☐ Laboratory ☐ Other (specify):______________________

Source of Information (check all that apply)
☐ Healthcare provider/medical record ☐ Patient interview
☐ Other (specify):_________________

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐ Confirmed

OUTBREAK

Part of known outbreak?
☐ Yes ☐ No ☐ Unk

If Yes, extent of outbreak:
☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unk ☐ Other (specify):___________

STATE USE ONLY

Case Classification
☐ Confirmed ☐ Not a case ☐ Need additional information

CASE DEFINITION

COCCIDIOIDOMYCOSIS (2011)

CLINICAL CRITERIA

Infection may be asymptomatic or may produce an acute or chronic disease. Although the disease initially resembles an influenza-like or pneumonia-like febrile illness primarily involving the bronchopulmonary system, dissemination can occur to multiple organ systems. An illness is typically characterized by one or more of the following:

- Influenza-like signs and symptoms (e.g., fever, chest pain, cough, myalgia, arthralgia, and headache)
- Pneumonia or other pulmonary lesion, diagnosed by chest radiograph
- Erythema nodosum or erythema multiforme rash
- Involvement of bones, joints, or skin by dissemination
- Meningitis
- Involvement of viscera and lymph nodes

LABORATORY CRITERIA FOR DIAGNOSIS

A confirmed case must meet at least one of the following laboratory criteria for diagnosis:

- Cultural, histopathologic, or molecular evidence of presence of *Coccidioides* species; OR
- Positive serologic test for coccidioidal antibodies in serum, cerebrospinal fluid, or other body fluids by:
  - Detection of coccidioidal immunoglobulin M (IgM) by immunodiffusion, enzyme immunoassay (EIA), latex agglutination, or tube precipitin, OR
  - Detection of coccidioidal immunoglobulin G (IgG) by immunodiffusion, EIA, or complement fixation, OR
  - Coccidioidal skin-test conversion from negative to positive after onset of clinical signs and symptoms

CASE CLASSIFICATION

Confirmed: A case that meets the clinical criteria and is laboratory confirmed.

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** 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 **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Adult film actor/actress
- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - server
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - nurse
- Medical - other/unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent/guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Volunteer
- Other
- Refused
- Unknown