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

TULAREMIA
CASE REPORT

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 7)	*Other Describe/Specify*

Occupation (see list on page 7)	*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 7)
☐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)*

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Fever				*Highest temperature (specify °F/°C)*
Cutaneous ulcer				*Location*
Other skin lesion				*Location*
Lymphadenopathy				*Location*
Sepsis				
Pharyngitis				
Pleuropneumonia				
Cough				
Conjunctivitis				
Stomatitis				
Tonsilitis				
Abdominal pain				
Vomiting				
Diarrhea				

Other signs / symptoms (specify)

PAST MEDICAL HISTORY

Mucous membrane/skin cut or abrasion? ☐Yes ☐No ☐Unk	*If Yes, specify location*
Immunocompromised? ☐Yes ☐No ☐Unk	*If Yes, specify condtion*

Other (specify)

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

HOSPITALIZATION

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

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

TREATMENT / MANAGEMENT DETAILS

Treatment Type 1 ☐Antibiotic ☐Other	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Treatment Type 2 ☐Antibiotic ☐Other	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)

OUTCOME

Outcome?	If Survived,	Date of Death (mm/dd/yyyy)
☐Survived ☐Died ☐Unk	Survived as of _____(mm/dd/yyyy)	

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1	Type of Test	Collection Date (mm/dd/yyyy)
☐Blood ☐Biopsy or scraping of ulcer ☐Swab of ulcer ☐Tissue aspirate ☐Serum (acute) IgM ☐Serum (convalescent) IgM ☐Serum (acute) IgG ☐Serum (convalescent) IgG ☐Isolate☐Other:_____ If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.	☐Culture ☐PCR ☐ELISA ☐Immunofluorescence antibody ☐Agglutination ☐CF ☐DFA ☐Other:_____	
Result	Specify (if applicable) Result Unit: ☐Titer ☐O.D. Result Type: ☐DNA ☐mRNA	Interpretation ☐Positive ☐Equivocal ☐Negative
Laboratory Name		Telephone Number

Specimen Type 2	Type of Test	Collection Date (mm/dd/yyyy)
☐Blood ☐Biopsy or scraping of ulcer ☐Swab of ulcer ☐Tissue aspirate ☐Serum (acute) IgM ☐Serum (convalescent) IgM ☐Serum (acute) IgG ☐Serum (convalescent) IgG ☐Isolate ☐Other:_____ If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.	☐Culture ☐PCR ☐ELISA ☐Immunofluorescence antibody ☐Agglutination ☐CF ☐DFA ☐Other:_____	
Result	Specify (if applicable) Result Unit: ☐Titer ☐O.D. Result Type: ☐DNA ☐mRNA	Interpretation ☐Positive ☐Equivocal ☐Negative
Laboratory Name		Telephone Number

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

LABORATORY RESULTS SUMMARY - OTHER			
Was the biotype identified? ☐Yes ☐No ☐Unk	*If Yes, specify biotype* ☐Type A ☐Type B ☐Other_____	*Laboratory Name*	*Telephone Number*

IMAGING SUMMARY				
Anatomic Site 1	*Type of Imaging* ☐X-ray ☐CT ☐MRI ☐Other:_____			*Date (mm/dd/yyyy)*
	Result	*Interpretation*	*Facility Name*	*Telephone Number*
Anatomic Site 2	*Type of Imaging* ☐X-ray ☐CT ☐MRI ☐Other:_____			*Date (mm/dd/yyyy)*
	Result	*Interpretation*	*Facility Name*	*Telephone Number*

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 3 WEEKS PRIOR TO ILLNESS ONSET

FOOD HISTORY

DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?

Food Item	Yes	No	Unk	If Yes, Specify as Noted
Undercooked meat				*Animal species and meat product*
Untreated water				*Location*

Other (specify)

OCCUPATIONAL / RECREATIONAL EXPOSURE

DID THE PATIENT EXPERIENCE ANY OF THE FOLLOWING EVENTS OR OCCUPATIONS DURING THE INCUBATION PERIOD?

Event / Occupation	Yes	No	Unk	If Yes, Specify as Noted
Known tick contact				*Address where tick contact occurred*
Known deerfly contact				*Address where deerfly contact occurred*
Contact with untreated water				*Location*
Microbiology laboratory				*Laboratory name and location*
Veterinary medicine				*Animal species and location*
Farmer / livestock owner				*Animal species and location*
Hunting / animal trapping / fishing				*Animal species and location*
Landscape / gardening				*Location*
Hiking / camping				*Location*

Other (specify)

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

ANIMAL EXPOSURES

DID THE PATIENT HAVE CONTACT WITH ANY OF THE FOLLOWING ANIMALS DURING THE INCUBATION PERIOD?

Animal Exposures	Yes	No	Unk	If Yes, Specify as Noted	
Wild rabbit				*Species*	*Contact type(s)* ☐Handling ☐Skinning ☐Bite ☐Other:_____
Domestic rabbit				*Breed*	*Contact type(s)* ☐Handling ☐Skinning ☐Bite ☐Other:_____
Wild rodent				*Species*	*Contact type(s)* ☐Handling ☐Skinning ☐Bite ☐Other:_____
Domestic rodent				*Species*	*Contact type(s)* ☐Handling ☐Skinning ☐Bite ☐Other:_____
Other wild animal(s)				*Species*	*Contact type(s)* ☐Handling ☐Skinning ☐Bite ☐Other:_____
Other domestic animal(s)				*Species*	*Contact type(s)* ☐Handling ☐Skinning ☐Bite ☐Other:_____

TRAVEL HISTORY (INCUBATION PERIOD IS 7 DAYS PRIOR TO ILLNESS ONSET)

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

ILL CONTACTS

Any contacts with similar illness (including household contacts)? ☐Yes ☐No ☐Unk	*If Yes, specify details below.*

ILL CONTACTS - DETAILS

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

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case?	Contact Name / Case Number
☐Yes ☐No ☐Unk	

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐Confirmed ☐Probable ☐Suspect

Disease Type
☐Ulceroglandular ☐Glandular ☐Oculoglandular ☐Oropharyngeal ☐Intestinal ☐Pneumonic ☐Typhoidal ☐Other:_____

OUTBREAK

Part of known outbreak?	If Yes, extent of outbreak
☐Yes ☐No ☐Unk	☐One CA jurisdiction ☐Multiple CA jurisdictions ☐Multistate ☐International ☐Unk ☐Other (specify):_____

Mode of Transmission	Vehicle of Outbreak	Pattern 1 ID number	Pattern 2 ID number
☐Point source ☐Person-to-person ☐Unk ☐Other:_____			

STATE USE ONLY

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

CASE DEFINITION

TULAREMIA (2010)

CLINICAL DESCRIPTION

An illness characterized by several distinct forms, including the following:
- Ulceroglandular: cutaneous ulcer with regional lymphadenopathy
- Glandular: regional lymphadenopathy with no ulcer
- Oculoglandular: conjunctivitis with preauricular lymphadenopathy
- Oropharyngeal: stomatitis or pharyngitis or tonsillitis and cervical lymphadenopathy
- Intestinal: intestinal pain, vomiting, and diarrhea
- Pneumonic: primary pleuropulmonary disease
- Typhoidal: febrile illness without early localizing signs and symptoms

Clinical diagnosis is supported by evidence or history of a tick or deerfly bite, exposure to tissues of a mammalian host of *Francisella tularensis*, or exposure to potentially contaminated water.

LABORATORY CRITERIA FOR DIAGNOSIS

- Presumptive: Elevated serum antibody titer(s) to *F. tularensis* antigen (without documented fourfold or greater change) in a patient with no history of tularemia vaccination or detection of *F. tularensis* in a clinical specimen by fluorescent assay
- Confirmatory: Isolation of *F. tularensis* in a clinical specimen or fourfold or greater change in serum antibody titer to *F. tularensis* antigen

CASE CLASSIFICATION

- **Confirmed:** a clinically compatible case with confirmatory laboratory results
- **Probable:** a clinically compatible case with laboratory results indicative of presumptive infection

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