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

LEPTOSPIROSIS 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 ☐Unknown	*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
☐Unknown

*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:____________________
☐Unknown

*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 ☐Unknown	*Onset Date (mm/dd/yyyy)*	*Date First Sought Medical Care (mm/dd/yyyy)*

Signs and Symptoms	Yes	No	Unk	Signs and Symptoms	Yes	No	Unk
Fever *If Yes, highest temperature:_______ specify °F/°C*				Icterus			
Headache				Uremia			
Chills				Abdominal pain			
Myalgia				Vomiting			
Conjunctivitis				Diarrhea			
Photophobia, uveitis				Hemorrhage			
Meningitis				Respiratory insufficiency			
Rash *If Yes, location of rash: ____________________*				*Other signs / symptoms (specify)*			

HOSPITALIZATION

Did patient visit emergency room for illness? ☐Yes ☐No ☐Unknown	*Was patient hospitalized?* ☐Yes ☐No ☐Unknown	*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*			*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*

TREATMENT / MANAGEMENT

Received Treatment? ☐Yes ☐No ☐Unknown	*If Yes, specify the treatment below.*

TREATMENT / MANAGEMENT - DETAILS

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

OUTCOME

Outcome? ☐Survived ☐Died ☐Unknown	*If Survived, Alive as of ______________________________(mm/dd/yyyy)*	*Date of Death (mm/dd/yyyy)*

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

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 ☐Serum ☐Other: ________	*Collection Date (mm/dd/yyyy)*	*Laboratory Name*	*Telephone Number*
If Serum, Type of Test 1 ☐Microscopic Agglutination Test (MAT) ☐Indirect Immunofluorescence (IFA) ☐Complement Fixation (CF) ☐Indirect Hemagglutination Assay (IHA) ☐ELISA/EIA ☐Unspecified/Other: ________	*Antibody type and titer* ☐IgG ________ ☐IgM ________ ☐Unspecified: ________ *Interpretation* ☐Positive ☐Negative ☐Equivocal *Serovar?* ☐Canicola ☐Icterohemorrhagiae ☐Pomona ☐Other serovar: ________ ☐Unspecified		
If Other specimen, Type of Test 1 ☐Direct Immunofluorescence (DFA) ☐Darkfield Microscopy ☐Polymerase Chain Reaction (PCR) ☐Culture ☐Other: ________	*Result?* *Interpretation* ☐Positive ☐Negative ☐Equivocal		
Specimen Type 2 ☐Serum ☐Other: ________	*Collection Date (mm/dd/yyyy)*	*Laboratory Name*	*Telephone Number*
If Serum, Type of Test 2 ☐Microscopic Agglutination Test (MAT) ☐Indirect Immunofluorescence (IFA) ☐Complement Fixation (CF) ☐Indirect Hemagglutination Assay (IHA) ☐ELISA/EIA ☐Unspecified/Other: ________	*Antibody type and titer* ☐IgG ________ ☐IgM ________ ☐Unspecified: ________ *Interpretation* ☐Positive ☐Negative ☐Equivocal *Serovar?* ☐Canicola ☐Icterohemorrhagiae ☐Pomona ☐Other serovar: ________ ☐Unspecified		
If Other specimen, Type of Test 2 ☐Direct Immunofluorescence (DFA) ☐Darkfield Microscopy ☐Polymerase Chain Reaction (PCR) ☐Culture ☐Other: ________	*Result?* *Interpretation* ☐Positive ☐Negative ☐Equivocal		
Specimen Type 3 ☐Serum ☐Other: ________	*Collection Date (mm/dd/yyyy)*	*Laboratory Name*	*Telephone Number*
If Serum, Type of Test 3 ☐Microscopic Agglutination Test (MAT) ☐Indirect Immunofluorescence (IFA) ☐Complement Fixation (CF) ☐Indirect Hemagglutination Assay (IHA) ☐ELISA/EIA ☐Unspecified/Other: ________	*Antibody type and titer* ☐IgG ________ ☐IgM ________ ☐Unspecified: ________ *Interpretation* ☐Positive ☐Negative ☐Equivocal *Serovar?* ☐Canicola ☐Icterohemorrhagiae ☐Pomona ☐Other serovar: ________ ☐Unspecified		
If Other specimen, Type of Test 3 ☐Direct Immunofluorescence (DFA) ☐Darkfield Microscopy ☐Polymerase Chain Reaction (PCR) ☐Culture ☐Other: ________	*Result?* *Interpretation* ☐Positive ☐Negative ☐Equivocal		

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

EPIDEMIOLOGIC INFORMATION

EXPOSURES / RISK FACTORS

CONTACT WITH THE FOLLOWING DURING THE 30 DAYS PRIOR TO ONSET

	Yes	No	Unk	If Yes, Specify as Noted	
Bodies of water, natural (e.g., lakes, rivers)				*Activity*	*Location*
Bodies of water, temporary (e.g., lagoons, flood waters)				*Activity*	*Location*
Other untreated water (e.g., sewage)				*Activity*	*Location*
Farm, agriculture				*Activity*	*Location*
Farm, livestock				*Activity*	*Location*
Other exposure or activity				*Activity*	*Location*

Occupation at Date of Onset	*Kind of Business or Industry*

ANIMAL CONTACTS

Animal Contact 1 ☐Cattle ☐Dogs ☐Rats/rodents ☐Other: ________	*Type of Exposure*		*Place of Exposure*
	Date of Exposure (mm/dd/yyyy)	*Was the animal ill?* ☐Yes ☐No ☐Unknown	*Illness Summary*
	Seen by Veterinarian? ☐Yes ☐No ☐Unknown	*Name of Veterinarian*	*Address of Veterinarian*
Animal Contact 2 ☐Cattle ☐Dogs ☐Rats/rodents ☐Other: ________	*Type of Exposure*		*Place of Exposure*
	Date of Exposure (mm/dd/yyyy)	*Was the animal ill?* ☐Yes ☐No ☐Unknown	*Illness Summary*
	Seen by Veterinarian? ☐Yes ☐No ☐Unknown	*Name of Veterinarian*	*Address of Veterinarian*

TRAVEL HISTORY

*Did patient travel **outside county of residence** during the month preceding illness onset?*
☐Yes ☐No ☐Unknown

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)

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

CONTACTS / OTHER ILL PERSONS	
Any contacts with similar illness? ☐Yes ☐No ☐Unknown	*If Yes, specify details below.*

ILL CONTACTS - DETAILS					
Name 1	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Illness Onset Date (mm/dd/yyyy)*
	Street Address			*Exposure Dates Shared with Index Case (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*	*Illness Onset Date (mm/dd/yyyy)*
	Street Address			*Exposure Dates Shared with Index Case (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)*
First Reported By ☐Clinician ☐Laboratory ☐Other (specify):______________________			

EPIDEMIOLOGICAL LINKAGE	
Epi-linked to known case? ☐Yes ☐No ☐Unknown	*Contact Name / Case Number*

DISEASE CASE CLASSIFICATION

Case Classification (see case definition on page 6)

☐Confirmed ☐Probable

OUTBREAK				
Part of known outbreak? ☐Yes ☐No ☐Unk	*If Yes, extent of outbreak* ☐One CA jurisdiction ☐Multiple CA jurisdictions ☐Multistate ☐International ☐Unk ☐Other (specify):_______________			
Mode of Transmission ☐Point source ☐Person-to-person ☐Unk ☐Other (specify):____________	*Vehicle of Outbreak*	*Pattern 1 ID Number*	*Pattern 2 ID Number*	

STATE USE ONLY

State Case Classification

☐Confirmed ☐Probable ☐Not a case ☐Need additional information

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

CASE DEFINITION

LEPTOSPIROSIS (2013)

CLINICAL CRITERIA

An illness characterized by fever, headache, and myalgia, and less frequently by conjunctival suffusion, meningitis, rash, jaundice, or renal insufficiency. Symptoms may be biphasic.

Clinical presentation includes history of fever within the past two weeks and at least two of the following clinical findings: myalgia, headache, jaundice, conjunctival suffusion without purulent discharge, or rash (i.e. maculopapular or petechial); OR at least one of the following clinical findings:

- Aseptic meningitis
- GI symptoms (e.g., abdominal pain, nausea, vomiting, diarrhea)
- Pulmonary complications (e.g., cough, breathlessness, hemoptysis)
- Cardiac arrhythmias, ECG abnormalities
- Renal insufficiency (e.g., anuria, oliguria)
- Hemorrhage (e.g., intestinal, pulmonary, hematuria, hematemesis)
- Jaundice with acute renal failure

LABORATORY CRITERIA FOR DIAGNOSIS

Diagnostic testing should be requested for patients in whom there is a high index of suspicion for leptospirosis, based either on signs and symptoms, or on occupational, recreational or vocational exposure to animals or environments contaminated with animal urine.

Supportive:

- *Leptospira* agglutination titer of ≥ 200 but < 800 by Microscopic Agglutination Test (MAT) in one or more serum specimens, or
- Demonstration of anti-*Leptospira* antibodies in a clinical specimen by indirect immunofluorescence, or
- Demonstration of *Leptospira* in a clinical specimen by darkfield microscopy, or
- Detection of IgM antibodies against *Leptospira* in an in acute phase serum specimen.

Confirmed:

- Isolation of *Leptospira* from a clinical specimen, or
- Fourfold or greater increase in *Leptospira* agglutination titer between acute- and convalescent-phase serum specimens studied at the same laboratory, or
- Demonstration of *Leptospira* in tissue by direct immunofluorescence, or
- *Leptospira* agglutination titer of ≥ 800 by Microscopic Agglutination Test (MAT) in one or more serum specimens, or
- Detection of pathogenic *Leptospira* DNA (e.g., by PCR) from a clinical specimen.

EPIDEMIOLOGIC LINKAGE

Involvement in an exposure event (e.g., adventure race, triathlon, flooding) with associated laboratory-confirmed cases.

CASE CLASSIFICATION

Probable**:** A clinically compatible case with at least one of the following:

- Involvement in an exposure event (e.g., adventure race, triathlon, flooding) with known associated cases, or
- Presumptive laboratory findings, but without confirmatory laboratory evidence of *Leptospira* infection.

Confirmed**:** A case with confirmatory laboratory results, as listed above.

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