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 ☐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	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 ☐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 treatment below.

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? ☐Survived ☐Died ☐Unk	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 (acute) ☐Serum (convalescent) ☐Other (specify):_____ _____	*Collection Date (mm/dd/yyyy)*	*Type of Test* ☐ELISA ☐IFA ☐Microscopic agglutination ☐CF ☐Isolation / Culture	
	L. icterohemorrhagiae Titer	*L. canicola Titer*	*L. pomona Titer*
	Other Leptospira Serovar		*Other Leptospira Serovar Titer*
	Interpretation ☐Positive ☐Negative ☐Equivocal	*Laboratory Name*	*Telephone*
Specimen Type 2 ☐Serum (acute) ☐Serum (convalescent) ☐Other (specify):_____ _____	*Collection Date (mm/dd/yyyy)*	*Type of Test* ☐ELISA ☐IFA ☐Microscopic agglutination ☐CF ☐Isolation / Culture	
	L. icterohemorrhagiae Titer	*L. canicola Titer*	*L. pomona Titer*
	Other Leptospira Serovar		*Other Leptospira Serovar Titer*
	Interpretation ☐Positive ☐Negative ☐Equivocal	*Laboratory Name*	*Telephone*

EPIDEMIOLOGIC INFORMATION

EXPOSURES / RISK FACTORS

CONTACT WITH FOLLOWING DURING THE MONTH PRECEDING 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 CONTACT

Animal Contact 1 ☐Cats ☐Rats/rodents ☐Cattle ☐Other: _____ ☐Dogs	*Type of Exposure*	
	Place of Exposure	*Date of Exposure (mm/dd/yyyy)*
Animal Contact 2 ☐Cats ☐Rats/rodents ☐Cattle ☐Other _____ ☐Dogs	*Type of Exposure*	
	Place of Exposure	*Date of Exposure (mm/dd/yyyy)*

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

ILL ANIMAL EXPOSURE

Animal Contact 1 ☐Cats ☐Cattle ☐Dogs ☐Rats/rodents ☐Other: _____	*Type of Exposure*		*Place of Exposure*
	Date of Exposure (mm/dd/yyyy)	*Illness Summary*	
	Seen by Veterinarian ☐Yes ☐No ☐Unk	*Name of Veterinarian*	*Address of Veterinarian*
Animal Contact 2 ☐Cats ☐Cattle ☐Dogs ☐Rats/rodents ☐Other: _____	*Type of Exposure*		*Place of Exposure*
	Date of Exposure (mm/dd/yyyy)	*Illness Summary*	
	Seen by Veterinarian ☐Yes ☐No ☐Unk	*Name of Veterinarian*	*Address of Veterinarian*

ANIMAL DIAGNOSTIC TESTS AND IDENTIFICATION

Serology Test 1 ☐ELISA ☐IFA ☐CF ☐Agglutination ☐Titer ☐Other (specify test and tissue or material): _____ _____ ☐None	*Collection Date (mm/dd/yyyy)*	*L. icterohemorrhagiae Titer*	*L. canicola Titer*
	L. pomona Titer	*Other Leptospira Serovar*	*Other Leptospira Serovar Titer*
	Interpretation ☐Positive ☐Negative ☐Equivocal	*Laboratory Name*	
	Laboratory Location		*Telephone*
Serology Test 2 ☐ELISA ☐IFA ☐CF ☐Agglutination ☐Titer ☐Other (specify test and tissue or material): _____ _____ ☐None	*Collection Date (mm/dd/yyyy)*	*L. icterohemorrhagiae Titer*	*L. canicola Titer*
	L. pomona Titer	*Other Leptospira Serovar*	*Other Leptospira Serovar Titer*
	Interpretation ☐Positive ☐Negative ☐Equivocal	*Laboratory Name*	
	Laboratory Location		*Telephone*

TRAVEL HISTORY

*Did patient travel **outside county of residence** during the month preceding illness onset?*
☐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)

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

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	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 ☐Unk	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 (1997)

CLINICAL DESCRIPTION

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

LABORATORY CRITERIA FOR DIAGNOSIS

- Isolation of *Leptospira* from a clinical specimen, or
- Fourfold or greater increase in *Leptospira* agglutination titer between acute-phase and convalescent-phase serum specimens obtained ≥ 2 weeks apart and studied at the same laboratory, or
- Demonstration of *Leptospira* in a clinical specimen by immunofluorescence

CASE CLASSIFICATION

Probable: a clinically compatible case with supportive serologic (i.e., a *Leptospira* agglutination titer of ≥ 200 in one or more serum specimens)

Confirmed: a clinically compatible illness that 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