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

SPOTTED FEVER RICKETTSIOSES CASE REPORT

Check one: ☐ Rocky Mountain spotted fever (*Rickettsia rickettsii*)

☐ Pacific Coast tick fever, caused by *Rickettsia* species 364D

☐ Other spotted fever rickettsiosis (including *Rickettsia parkeri, etc.*)

This form should be completed only for cases of Rocky Mountain spotted fever and other spotted fever rickettsioses. Ehrlichiosis and anaplasmosis cases should be reported on the Ehrlichiosis/Anaplasmosis Case Report form. Cases of typhus and other non-spotted fever rickettsioses should be reported on the Typhus and Other Non-Spotted Fever Rickettsioses Case Report form.

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

☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male / transman ☐ Identity not listed ☐ Declined to answer

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(s)
(check all that apply, race descriptions on page 6)

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.

☐ American Indian or Alaska Native

☐ Asian *(check all that apply)*
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ Other:_____

☐ Black or African-American

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

☐ White

☐ Other:_____

☐ Unk

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth

☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation

☐ Heterosexual or straight
☐ Gay, lesbian, or same-gender loving
☐ Bisexual
☐ Questioning, unsure, or patient doesn't know
☐ Orientation not listed
☐ Declined to answer
☐ Unknown

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

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

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)*	
Muscle pain					
Headache					
Nausea or vomiting					
Rash or other cutaneous lesion				*Location / size / appearance*	
Chills					
Sweats					
Joint pain				*Joint(s)*	
Eye pain					
Abdominal pain					
Diarrhea					
Cough					
Hypotension				*Date measured (mm/dd/yyyy)*	*Systolic / Diastolic*

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*

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

TREATMENT / MANAGEMENT

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

TREATMENT / MANAGEMENT DETAILS

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

OUTCOME

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

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY - SEROLOGY

Specimen Type 1	Collection Date (mm/dd/yyyy)	Type of Test	Antigen
	Results	Laboratory Name	Telephone Number
Specimen Type 2	Collection Date (mm/dd/yyyy)	Type of Test	Antigen
	Results	Laboratory Name	Telephone Number

LABORATORY RESULTS SUMMARY - OTHER

Hematology? ☐ Yes ☐ No ☐ Unk	Collection Date (mm/dd/yyyy)	WBC	HCT	Hb	Platelets
Serum chemistry? ☐ Yes ☐ No ☐ Unk	Collection Date (mm/dd/yyyy)	ALT		AST	
Other laboratory diagnostics performed (e.g., PCR, buffy coat smear)? ☐ Yes ☐ No ☐ Unk		If Yes, describe			

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: UP TO 14 DAYS BEFORE ILLNESS ONSET

ANIMAL AND INSECT EXPOSURES

Observe any of the following during incubation period at or around home? ☐ Dogs ☐ Cats ☐ Rodents ☐ Opossums ☐ Fleas ☐ Ticks	Describe	
If pets in the home, how often are they treated with flea prevention medication?	Type(s) of Treatment	Date(s) of Last Treatment (mm/dd/yyyy)
Observe any of the following during incubation period away from home? ☐ Dogs ☐ Cats ☐ Rodents ☐ Opossums ☐ Fleas ☐ Ticks	Describe	
If any cats were observed, were they feral / stray, indoor, or outdoor cats? ☐ Feral / stray ☐ Indoor ☐ Outdoor ☐ Other:_____		
Did the patient spend any nights living outside, without shelter, in the past 21 days (including in a car, unsheltered on the street, or in a temporary shelter)? ☐ Yes ☐ No ☐ Unk	Describe	
Did patient recall any insect bites in the 10 days prior to illness? ☐ Yes ☐ No ☐ Unk	If Yes, specify all locations, type of insect bite, and dates on page 4.	

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

INSECT BITE HISTORY - DETAILS

Bite 1	*Location (city, county, state, country)*	*Date of Insect Bite (mm/dd/yyyy)*	*Type of Insect Bite* ☐ Flea ☐ Tick ☐ Other:_____
Bite 2	*Location (city, county, state, country)*	*Date of Insect Bite (mm/dd/yyyy)*	*Type of Insect Bite* ☐ Flea ☐ Tick ☐ Other:_____

TRAVEL HISTORY

*Did patient travel **out of county of residence** during the **incubation period** ?* ☐ Yes ☐ No ☐ Unk	*If Yes, specify all locations and dates in the Travel History - Details Table.*

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*	*Occupation*	
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*	*Occupation*	

EPIDEMIOLOGICAL LINKAGE

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

NOTES / REMARKS

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

REPORTING AGENCY

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

First Reported By

☐ Clinician ☐ Laboratory ☐ Other (specify):_____

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)

☐ Confirmed ☐ Probable ☐ Suspect

STATE USE ONLY

State Case Classification

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

CASE DEFINITION

SPOTTED FEVER RICKETTSIOSES (INCLUDING ROCKY MOUNTAIN SPOTTED FEVER) (SFR, INCLUDING RMSF) (2020)

BACKGROUND

Spotted fever rickettsioses (SFR), which captures cases of Rocky Mountain spotted fever (RMSF), *Rickettsia parkeri* rickettsiosis, Pacific Coast tick fever (caused by infection with *Rickettsia* species 364D), and others, are a group of diseases caused by spotted fever group *Rickettsiae* (SFGR). These pathogens cause acute febrile illnesses, with headache, malaise, thrombocytopenia, rash, and occasionally eschars (dark necrotic scabs at the site of tick or mite bite). RMSF, caused by *R. rickettsii*, is well recognized as the most severe rickettsial illness.

Currently, only 3% of SFR cases are reported as confirmed, with most probable cases supported by a single serology titer. Antibodies to SFGR can rise in the first week of illness and stay elevated for months to years following infection. Data suggest that the prevalence of IgG antibodies reactive to SFGR in asymptomatic individuals may be more common than previously thought. The use of a single elevated IgG titer result for diagnosis may produce a skewed understanding of SFR epidemiology and national disease burden.

CLINICAL CRITERIA

Fever as reported by the patient or a healthcare provider, **AND one** or more of the following: rash, eschar, headache, myalgia, anemia, thrombocytopenia, or any hepatic transaminase elevation.

LABORATORY CRITERIA FOR DIAGNOSIS

Confirmatory laboratory evidence:

- Detection of SFGR nucleic acid in a clinical specimen via amplification of a *Rickettsia* genus- or species-specific target by Polymerase Chain Reaction (PCR) assay, **OR**
- Serological evidence of a fourfold increase in IgG-specific antibody titer reactive with SFGR antigen by indirect immunofluorescence antibody assays (IFA) between paired serum specimens (one taken in the first two weeks after illness onset and a second taken two to ten weeks after acute specimen collection)*, **OR**
- Demonstration of SFGR antigen in a biopsy or autopsy specimen by immunohistochemical methods (IHC), **OR**
- Isolation of SFGR from a clinical specimen in cell culture and molecular confirmation (e.g., PCR or sequence).

Presumptive laboratory evidence:

- Serologic evidence of elevated IgG antibody at a titer ≥1:128 reactive with SFGR antigen by IFA in a sample taken within 60 days of illness onset.**

Supportive laboratory evidence:

- Serologic evidence of elevated IgG antibody at a titer <1:128 reactive with SFGR antigen by IFA in a sample taken within 60 days of illness onset.

* A four-fold rise in titer should not be excluded (as confirmatory laboratory criteria) if the acute and convalescent specimens are collected within two weeks of one another.

** This includes paired serum specimens without evidence of fourfold rise in titer, but with at least one single titer ≥1:128 in IgG-specific antibody titers reactive with SFGR antigen by IFA.

EPIDEMIOLOGIC LINKAGE

None.

Criteria to distinguish a new case of this disease or condition from reports or notifications which should not be enumerated as a new case for surveillance

A person previously reported as a probable or confirmed case-patient may be counted as a new case-patient when there is an episode of new clinically compatible illness with confirmatory laboratory evidence.

CASE CLASSIFICATION

Confirmed

- A clinically compatible case (meets clinical evidence criteria) that is laboratory confirmed.

Probable

- A clinically compatible case (meets clinical criteria) that has presumptive laboratory evidence.

Suspect

- A case with confirmatory or presumptive laboratory evidence of infection with no clinical information available, **OR**
- A clinically compatible case (meets clinical criteria) that has supportive laboratory evidence.

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