

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	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence			Apartment/Unit Number		
City/Town		State	Zip Code		
Census Tract	County of Residence		Country		
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		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
E-mail Address			Other Electronic Contact Information		
Work/School Location			Work/School Contact		
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Occupation Setting (see list on page 7)			Other Describe/Specify		
Occupation (see list on page 7)			Other Describe/Specify		
*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:

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SIGNS AND SYMPTOMS

<i>Symptomatic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Onset Date (mm/dd/yyyy)</i>			<i>Date First Sought Medical Care (mm/dd/yyyy)</i>
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Fever				<i>Highest temperature (specify °F/°C)</i>
Cutaneous ulcer				<i>Location</i>
Other skin lesion				<i>Location</i>
Lymphadenopathy				<i>Location</i>
Sepsis				
Pharyngitis				
Pleuropneumonia				
Cough				
Conjunctivitis				
Stomatitis				
Tonsillitis				
Abdominal pain				
Vomiting				
Diarrhea				
<i>Other signs / symptoms (specify)</i>				

PAST MEDICAL HISTORY

<i>Mucous membrane/skin cut or abrasion?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, specify location</i>
<i>Immunocompromised?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, specify condition</i>
<i>Other (specify)</i>	

First three letters of patient's last name:

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HOSPITALIZATION

Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, how many total hospital nights?
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify the treatments below.
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TREATMENT / MANAGEMENT DETAILS

Treatment Type 1 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Treatment Type 2 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)

OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 <input type="checkbox"/> Blood <input type="checkbox"/> Biopsy or scraping of ulcer <input type="checkbox"/> Swab of ulcer <input type="checkbox"/> Tissue aspirate <input type="checkbox"/> Serum (acute) IgM <input type="checkbox"/> Serum (convalescent) IgM <input type="checkbox"/> Serum (acute) IgG <input type="checkbox"/> Serum (convalescent) IgG <input type="checkbox"/> Isolate <input type="checkbox"/> Other: _____ If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.	Type of Test <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> ELISA <input type="checkbox"/> Immunofluorescence antibody <input type="checkbox"/> Agglutination <input type="checkbox"/> CFB <input type="checkbox"/> DFA <input type="checkbox"/> Other: _____		Collection Date (mm/dd/yyyy)
	Result	Specify (if applicable) Result Unit: <input type="checkbox"/> Titer <input type="checkbox"/> O.D. Result Type: <input type="checkbox"/> DNA <input type="checkbox"/> mRNA	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Negative
	Laboratory Name		Telephone Number
	If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.		
Specimen Type 2 <input type="checkbox"/> Blood <input type="checkbox"/> Biopsy or scraping of ulcer <input type="checkbox"/> Swab of ulcer <input type="checkbox"/> Tissue aspirate <input type="checkbox"/> Serum (acute) IgM <input type="checkbox"/> Serum (convalescent) IgM <input type="checkbox"/> Serum (acute) IgG <input type="checkbox"/> Serum (convalescent) IgG <input type="checkbox"/> Isolate <input type="checkbox"/> Other: _____ If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.	Type of Test <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> ELISA <input type="checkbox"/> Immunofluorescence antibody <input type="checkbox"/> Agglutination <input type="checkbox"/> CFB <input type="checkbox"/> DFA <input type="checkbox"/> Other: _____		Collection Date (mm/dd/yyyy)
	Result	Specify (if applicable) Result Unit: <input type="checkbox"/> Titer <input type="checkbox"/> O.D. Result Type: <input type="checkbox"/> DNA <input type="checkbox"/> mRNA	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Negative
	Laboratory Name		Telephone Number
	If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.		

First three letters of patient's last name:

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LABORATORY RESULTS SUMMARY - OTHER

Was the biotype identified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify biotype <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Other: _____	Laboratory Name	Telephone Number
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IMAGING SUMMARY

Anatomic Site 1	Type of Imaging <input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____			Date (mm/dd/yyyy)
	Result	Interpretation	Facility Name	Telephone Number
Anatomic Site 2	Type of Imaging <input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> 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:

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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) <input type="checkbox"/> Handling <input type="checkbox"/> Skinning <input type="checkbox"/> Bite <input type="checkbox"/> Other: _____
Domestic rabbit				Breed	Contact type(s) <input type="checkbox"/> Handling <input type="checkbox"/> Skinning <input type="checkbox"/> Bite <input type="checkbox"/> Other: _____
Wild rodent				Species	Contact type(s) <input type="checkbox"/> Handling <input type="checkbox"/> Skinning <input type="checkbox"/> Bite <input type="checkbox"/> Other: _____
Domestic rodent				Species	Contact type(s) <input type="checkbox"/> Handling <input type="checkbox"/> Skinning <input type="checkbox"/> Bite <input type="checkbox"/> Other: _____
Other wild animal(s)				Species	Contact type(s) <input type="checkbox"/> Handling <input type="checkbox"/> Skinning <input type="checkbox"/> Bite <input type="checkbox"/> Other: _____
Other domestic animal(s)				Species	Contact type(s) <input type="checkbox"/> Handling <input type="checkbox"/> Skinning <input type="checkbox"/> Bite <input type="checkbox"/> Other: _____

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

Did patient travel outside county of residence during the incubation period ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates below.
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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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify details below.
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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:

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NOTES / REMARKS

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REPORTING AGENCY

<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
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First Reported By
 Clinician Laboratory Other (specify): _____

EPIDEMIOLOGICAL LINKAGE

<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Contact Name / Case Number</i>
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DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
 Confirmed Probable Suspect

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

OUTBREAK

<i>Part of known outbreak?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, extent of outbreak</i> <input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____
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<i>Mode of Transmission</i> <input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	<i>Vehicle of Outbreak</i>	<i>Pattern 1 ID number</i>	<i>Pattern 2 ID number</i>
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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	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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