

Brucellosis

COUNTY

FOR STATE USE ONLY

#

Although always a good idea, case investigations are required only when there is suspicion of an outbreak or there are an unusual number of cases

Date investigation initiated _____

___/___/___ case report

___/___/___ interstate

- confirmed
- presumptive
- suspect

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____ e-mail address _____
Street City County Zip

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)
Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

- Lab
- Infection Control Practitioner
- Physician
- _____

Name _____

Phone _____ Date ___/___/___
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX
 female male

HISPANIC yes no unknown

RACE

- White
- American Indian
- Black
- Asian/Pacific Islander
- unknown
- refused to answer
- other _____

DATE OF BIRTH ___/___/___
m d y

or, if unknown, AGE _____

Worksites/school/day care center _____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

(Laboratory Data on page 2)

Date of current ONSET ___/___/___ Onset was: acute insidious

Duration of current illness _____ not stated

Date of ORIGINAL ONSET (if recurrence) ___/___/___
weeks

Onset was: acute insidious not stated

Symptoms _____ Duration or Severity _____

Fever, Intermittent

Fever, Constant

Chills

Weight Loss

Sweating

Body Ache

Weakness

Headache

Malaise

Anorexia

Abscess (bone, joint, muscle)

Orchitis

Epididymitis

Arthralgia

Endocarditis

Other (specify) _____

Remarks _____

EPI-LINKAGE

During the exposure period, was the patient... associated with a known outbreak? yes no unk

Does the case know about anyone else with a similar illness?

yes no could not be interviewed

If yes, provide additional information below about recrudescence cases or those with insidious onset — type of work or activity, contact with animals, species and frequency, place of contact /dates:

TREATMENT Type, Duration and Route of Administration of:

Tetracycline

Streptomycin

Sulfanomides

Other (specify) _____

Bed Rest (duration) _____

Patient education provided

Remarks _____

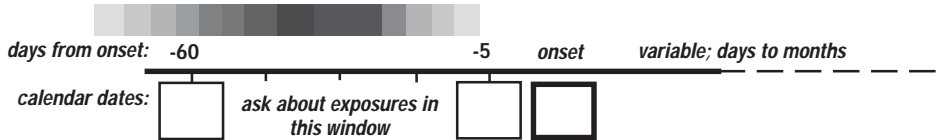


PATIENT'S NAME ▶

INFECTION TIMELINE

EXPOSURE PERIOD

Enter onset date in heavy box.
Count back to figure the probable exposure period.



POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Skip this section if case is already epi-linked. no risk factors could be identified patient could not be interviewed

BRUCELLOSIS STATUS IN ANIMAL CONTACTS

Animal contact Within 6 Months Prior to Onset No Yes Dates, from _____ to _____

Commercial Establishments

(Includes stockyards, slaughterhouses, abattoirs, dairies, packinghouses, meathandlers, laboratories etc.)

Family-Owned Animals

	Cattle					Cattle					Place of Exposure
	Beef	Dairy	Swine	Sheep	Other (specify)	Beef	Dairy	Swine	Sheep	Other / Wild (Specify)	
Present	yes <input type="checkbox"/>	yes <input type="checkbox"/>	yes <input type="checkbox"/>	yes <input type="checkbox"/>	yes <input type="checkbox"/>	yes <input type="checkbox"/>	yes <input type="checkbox"/>	yes <input type="checkbox"/>	yes <input type="checkbox"/>	yes <input type="checkbox"/>	<input type="checkbox"/> Slaughterhouse
Not Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Laboratory
Status Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other
Under Investigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

USE OF RAW MILK OR MILK PRODUCTS

Describe Type of Product _____

Pasteurized? yes no unknown

Date of Last Consumption Prior to Onset _____

Source of Milk _____

EXPOSURE TO BRUCELLA VACCINE: yes no
If yes, date and type of exposure _____

COUNTY UNDER CONTROL PROGRAM: yes no
If yes, check Modified Certified (Bovine) Certified Free (Bovine) Validated (Swine)

LABORATORY DATA

Blood	Other Specimens (specify)	Date Collected	Date Examined	Isolation Results			Species Isolated	Culture Media	Laboratory
				Pos.	Neg.	Unsat.			

SEROLOGY Sera positive by tube agglutination may be sent to the CDC for mercaptoethanol-resistant agglutins test.

Std. Tube Agglutination	Other Tests (specify)	Date Collected	Date Examined	Results (Titre, etc.)	Producer of Test Antigen	Laboratory

SKIN

Date Performed	Results		Degree of Reaction	Producer of Test Antigen	Laboratory
	Pos	Neg			

Other Comments: _____



ADMINISTRATION

Brucellosis/June 2003

Remember to copy patient's name to the top of this page.

Completed by _____ Date _____ Phone _____ Case report sent to OHS on ___/___/___ Investigation sent to OHS on ___/___/___