Leptospirosis Case Report Form

Instructions

Please complete as much of the form as possible. The instructions below explain each variable. If you have questions, please contact Bacterial Special Pathogens Branch at (404) 639-1711 or bspb@cdc.gov.

Send the completed form with all personal identifiers removed to CDC either by:

Email: bspb@cdc.gov

Fax: (404) 929-1590

DCIPHER: contact bspb@cdc.gov for more information

Reporting Information	Description
Date of Notification	Date case was first reported to jurisdiction (mm/dd/yyyy).
Reporting Jurisdiction	State, territory, or jurisdiction reporting case to CDC.
State Case ID	Unique identifier given by the state health department.
NNDSS Case ID	If different from State Case ID, provide the Case Identifier transmitted in NNDSS. This ID will be used to link the case report form with NNDSS.
Reporter Name, Phone Number, and Email	Contact information for person reporting case to CDC.
Outbreak	Denote if this case is part of a cluster or outbreak.

Case Demographic Information	Description
Sex	Genetic sex of patient.
Pregnant	Pregnancy status at onset of current illness.
Age	Age of patient at onset of current illness.
Residence	State, county, and zip code of patient's current residence.
Race and Ethnicity	Race and ethnicity of patient as noted in the chart or reported by physician or infection control personnel (ICP). Multiple boxes for race may be checked. Do not make assumptions based on name or native language. If race or ethnicity is unknown, please select "Unknown."
Occupation	Indicate occupation at time of disease onset. Specify past occupation(s) in the 30 days prior to symptom onset, if relevant (i.e., occupations with environmental, animal, or travel related exposures).

Case Exposure Information	Description
Animal Contact	Indicate any contact with animals or their bodily fluids the patient had in the 30 days prior to onset of current illness, the type of animal, where the exposure occurred, and if the animal was sick at the time of exposure.
Environmental Exposures	Indicate any water, mud, or sewage contact the patient had in the 30 days prior to onset of current illness and the locations where this contact occurred.
Indirect Rodent Exposure	Indicate if the patient has visited or lived in any locations with a known or observed rodent infestation in the 30 days prior to onset of current illness.
Significant Weather	Indicate any significant weather events (e.g., monsoon, typhoon, cyclone, hurricane, flooding) experienced by the patient in the 30 days prior to onset of current illness.
Travel	Indicate any travel the patient conducted in the 30 days prior to onset of current illness.

Case Clinical and Treatment Information	Description
Symptomatic	Indicate if the patient experienced any symptoms associated with this illness.
Illness Onset	Date of the beginning of this illness (mm/dd/yyyy) or date of the onset of symptoms of this illness as reported to the public health system.
Symptoms and Conditions	Select patient-described symptoms or medically identified conditions associated with this illness.
Hospitalization	Indicate whether the patient was admitted to a hospital for this illness. Enter admission and discharge dates, if applicable.
Treatment	Select the prescribed antibiotic(s) and start date for each. If prescribed antibiotics not listed, enter the generic name and start date, if known.
Outcome	Indicate the outcome of the patient following this illness. If the patient died of this illness, enter date of death.

NOTE: Complete a new test block (4 available on the form) for each test performed.

Laboratory Testing Information	Description
Test Type	Indicate the laboratory test performed.
Performing Laboratory	Indicate the laboratory that performed the test.
Specimen Type	Indicate the type of specimen collected.
Specimen Collection Date	Indicate the date the specimen was collected (mm/dd/yyyy).
Results	Indicate if the test was positive, any applicable qualitative results associated with the test (e.g., titer), the organism and serovar identified if applicable, and the test result date (mm/dd/yyyy).

Case Classification and Comments	Description
Case Classification	Indicate the patient's case classification based on the leptospirosis case definition. Confirmed and Probable leptospirosis cases must be reported to CDC following the notification criteria outlined in the CSTE position statement (12-ID-02).
Comments	List any other pertinent information about the case not provided elsewhere on the form.

DOB: date of birth

PCR: polymerase chain reaction

MAT: microscopic agglutination test

IHC: immunohistochemistry

SPHL: state public health laboratory

LRN: laboratory response network

LEPTOSPIROSIS CASE REPORT FORM

Form Version Apr 2023

REPORTING INFORMATION

Date of Notification: ______________ State Case ID: ________________________ NNDSS Case ID: ________________________

Reporter Name: ________________________________ Reporter Phone Number: ______________ Reporter Email: ______________________________

Reporting Jurisdiction: ____________ Part of an outbreak? Yes No Unknown

DEMOGRAPHIC INFORMATION

Sex: Male Female Refused Unknown DOB: _____________ Age: ________ Years Months Days

Pregnant: Yes No Unknown RESIDENCE: State: ________ County: ____________________________________ Zip Code: ________

Race:

- American Indian or Alaskan Native
- Asian
- White
- Black or African American
- Native Hawaiian or Pacific Islander
- Unknown
- Other race: ____

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Occupation: ____ Other: ____

ANIMAL AND ENVIRONMENTAL EXPOSURES

In the 30 days prior to illness onset, did the patient have contact with any animals or their body fluids? Yes No Unknown

If yes, select all that apply:

Animal	Location of exposure				
Rat/mouse	Home	Work	Travel	Recreational	Other
Dog	Home	Work	Travel	Recreational	Other
Cow	Home	Work	Travel	Recreational	Other
Horse	Home	Work	Travel	Recreational	Other
Domestic pig	Home	Work	Travel	Recreational	Other
Goat or sheep	Home	Work	Travel	Recreational	Other
Other:	Home	Work	Travel	Recreational	Other
Unknown animal					

Specify additional location details (e.g., name of facility, park, or zoo) where animal exposure(s) occurred:

Any animals sick or dead due to illness at the time of contact? Yes No Unknown *If yes, specify sick animals:* ______________________

In the 30 days prior to illness onset, did the patient have contact with any fresh water or mud? Yes No Unknown

If yes, select all that apply:

Water exposures	Location of exposure				
River/stream (running water)	Home	Work	Travel	Recreational	Other
Lake/pond (still water)	Home	Work	Travel	Recreational	Other
Flood water	Home	Work	Travel	Recreational	Other
Rainwater run-off/puddles	Home	Work	Travel	Recreational	Other
Mud or wet soil	Home	Work	Travel	Recreational	Other
Other:	Home	Work	Travel	Recreational	Other
Unknown type					

Specify additional location details (e.g., name of park or river/lake) where water or mud water occurred:

In the 30 days prior to illness onset, did the patient have any contact with sewage? Yes No Unknown

If yes, where did the exposure occur? Home Work Travel Recreational Other

What activities led to the indicated environmental or animal exposure(s)? (select all that apply)

- Swimming or bathing
- Fresh water fishing
- Adventure race, triathlon, or mud run
- Biking/motorcycle riding
- Pet or livestock ownership
- Boating, kayaking, or rafting
- Camping or hiking
- Playing sports in yard or park
- Gardening or yard work
- Petting/touching animals at farm/zoo/other location
- Drinking water
- Hunting
- Maintenance or house cleaning
- Washing dishes or laundry
- Occupational
- Other: ______________________
- Unknown

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329-4027; ATTN: PRA (0920-0728).

In the 30 days prior to illness onset, has the patient lived or spent time in a location with evidence of rodents (e.g. seen/heard rodents, seen rodent droppings, burrows, or gnawed materials)? Yes No Unknown

If yes, location with evidence of rodents: Home Work Travel Recreational Other

In the 30 days prior to illness onset, has the patient been in any areas experiencing significant weather? Yes No Unknown

If yes, select all that apply:

Hurricane, cyclone, or typhoon
Windstorm or tornado
Flooding/heavy rain
Earthquake
Mudslide
Other: ____________________

If yes, location of severe weather event:

Home Travel Other
Work Recreational

TRAVEL HISTORY

In the 30 days prior to illness onset, did the patient travel 50 miles or more from their normal residence? Yes No Unknown

If yes, US state: __________ OR Country: ____________________

If yes, US state: __________ OR Country: ____________________

If yes, US state: __________ OR Country: ____________________

- CLINICAL INFORMATION AND PRESENTATION –

Was the patient symptomatic? Yes No **Unknown** **Date of Illness Onset:** __________

Select all clinical manifestations associated with this illness:

Fever
Chills
Headache
Malaise/fatigue
Myalgia (muscle aches)
Calf pain
Abdominal pain
Diarrhea
Vomiting/nausea
Skin rash
Shortness of breath
Conjunctival suffusion
Jaundice
Acutely elevated liver enzymes
Acute liver failure
Acute renal insufficiency or failure
Respiratory insufficiency or failure
Thrombocytopenia
Aseptic meningitis
Pulmonary hemorrhage/coughing blood
Other hemorrhage
Other, specify: ____________________

- TREATMENT AND OUTCOME –

Was the patient hospitalized for this illness? Yes No Unknown

1st Admission Date: __________ 1st Discharge Date: __________

2nd Admission Date: __________ 2nd Discharge Date: __________

Were antibiotics prescribed or administered to the patient? Yes No Unknown

Doxycycline Start Date: __________ Ceftriaxone Start Date: __________ Amoxicillin Start Date: __________

Penicillin Start Date: __________ Ampicillin Start Date: __________ Azithromycin Start Date: __________

Other: ____________________ Start Date: __________ Other: ____________________ Start Date: __________

Clinical outcome:

Died
Still hospitalized
Still sick (outpatient)
Recovered
Long-term disability
Unknown

Date of Death: __________ **Illness Duration (days):** ______

LABORATORY TESTING INFORMATION

1st Test & Specimen

Test type:	MAT, PCR, ImmunoDot/DotBlot IgM, Other ELISA IgM, BioFire, Culture, IHC, Sequencing, Other: ____________
Performing lab:	CDC, SPHL, Commercial Lab, Other LRN, Other, Unknown **Specimen collection date:** ________
Specimen type:	Whole blood, Serum, Isolate, Urine, Cerebrospinal fluid, Tissue, Swab, Other: ____________
Qualitative result:	Positive, Negative, Borderline, Indeterminate **Serology Titer:** ________ **Serovar Name:** ____________ **Organism name:** ____________ **Lab result date:** ________

2nd Test & Specimen

Test type:	MAT, PCR, ImmunoDot/DotBlot IgM, Other ELISA IgM, BioFire, Culture, IHC, Sequencing, Other: ____________
Performing lab:	CDC, SPHL, Commercial Lab, Other LRN, Other, Unknown **Specimen collection date:** ________
Specimen type:	Whole blood, Serum, Isolate, Urine, Cerebrospinal fluid, Tissue, Swab, Other: ____________
Qualitative result:	Positive, Negative, Borderline, Indeterminate **Serology Titer:** ________ **Serovar Name:** ____________ **Organism name:** ____________ **Lab result date:** ________

3rd Test & Specimen

Test type:	MAT / PCR / ImmunoDot/DotBlot IgM / Other ELISA IgM / BioFire / Culture / IHC / Sequencing / Other: ________
Performing lab:	CDC / SPHL / Commercial Lab / Other LRN / Other / Unknown — **Specimen collection date:** ________
Specimen type:	Whole blood / Serum / Isolate / Urine / Cerebrospinal fluid / Tissue / Swab / Other: ________
Qualitative result:	Positive / Negative / Borderline / Indeterminate — **Serology Titer:** ________ **Serovar Name:** ________ **Organism name:** ________ **Lab result date:** ________

4th Test & Specimen

Test type:	MAT / PCR / ImmunoDot/DotBlot IgM / Other ELISA IgM / BioFire / Culture / IHC / Sequencing / Other: ________
Performing lab:	CDC / SPHL / Commercial Lab / Other LRN / Other / Unknown — **Specimen collection date:** ________
Specimen type:	Whole blood / Serum / Isolate / Urine / Cerebrospinal fluid / Tissue / Swab / Other: ________
Qualitative result:	Positive / Negative / Borderline / Indeterminate — **Serology Titer:** ________ **Serovar Name:** ________ **Organism name:** ________ **Lab result date:** ________

CASE CLASSIFICATION

Confirmed   Probable   Not a case   Unknown

ADDITIONAL COMMENTS