

Brucellosis

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case
 Reviewer initials: _____
 Referred to another state: _____

CASE

Last name: _____
 First and middle name: _____
 Maiden name: _____ Suffix: _____
 Address line: _____
 Zip: _____ City: _____
 State: _____ County: _____
 Phone: (____) - ____ - ____ Type: _____
 Long-term care resident: Yes No Unknown
 Facility name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____
 Gender: Female Male Other _____
 Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____
 Marital status: Single Married Separated
 Divorced Parent with partner Widowed
 Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian
 Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
 Parent/Guardian name: _____
 Parent/Guardian phone: (____) - ____ - ____ Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____
 Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown
 Date of death: ____ / ____ / ____
 Event exception: Case could not be found
 Case could not be interviewed
 Case refused interview
 Other – see notes
 Outbreak related: Yes No Unknown
 Outbreak name: _____
 Exposure setting: _____
 Epi-linked: Yes No Unknown
 Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown
 State: _____ Country: _____

Healthcare provider information

Last name: _____
 First name: _____
 Provider title: ARNP MD PA
 DO NP
 Facility name: _____
 Address line 1: _____
 Address line 2: _____
 Zip code: _____ City: _____
 State: _____ County: _____
 Phone: (____) - ____ - ____ Type: _____

LABORATORY FINDINGS

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: _____	Type: _____	biovar: _____

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Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: _____	Type: _____	biovar: _____

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Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____

Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: _____	Type: biovar	<input type="checkbox"/> Other _____

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Health care worker type: _____

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HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

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Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

CLINICAL INFO & DIAGNOSIS

- | | | | |
|---------------------------------------|-----------------------------------|-----------------------------------|--|
| Episode Type: | Episode Severity: | Symptoms: | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> First attack | <input type="checkbox"/> Mild | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Recurrence | <input type="checkbox"/> Moderate | <input type="checkbox"/> Chills | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Chronic | <input type="checkbox"/> Severe | <input type="checkbox"/> Headache | |

Date Returned to Normal Activities: ____ / ____ / ____

TREATMENT

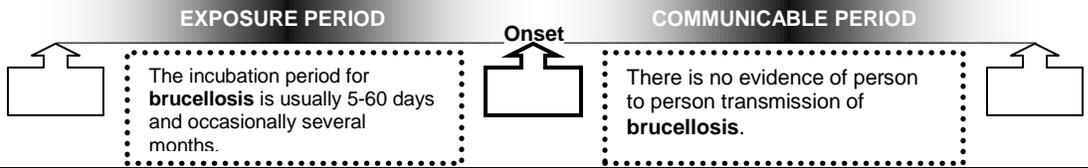
Antibiotics prescribed? Yes No Unknown

Antibiotic: _____	Antibiotic: _____	Antibiotic: _____
Date started: ____ / ____ / ____	Date started: ____ / ____ / ____	Date started: ____ / ____ / ____
Dose: _____	Dose: _____	Dose: _____

Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU	Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU	Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU
Number of times a day: _____	Number of times a day: _____	Number of times a day: _____
Number of days: _____	Number of days: _____	Number of days: _____
Route: _____	Route: _____	Route: _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

In the 60 days before the onset of symptoms did the case:

Travel within Iowa? Yes No Unk City in Iowa: _____ Departure date: ____/____/____ Return date: ____/____/____

Travel within U.S.? Yes No Unk State: _____ City: _____ Departure date: ____/____/____ Return date: ____/____/____

Travel outside U.S.? Yes No Unk Country: _____ Departure date: ____/____/____ Return date: ____/____/____

Give birth: Yes No Unknown

Have animal contact: Yes No Unknown

Animal type: Deer Elks Horses Rabbits Sheep
 Dogs Goats Pigs Rats Other

Were any of these animals birthing: Yes No Unknown

Exposed to potential Infection sources: Yes No Unknown

Check all possible sources: Aborted animal fetuses or placentas Livestock Vaccine
 Laboratory Packing Plant
 Livestock Handling Unpasteurized dairy product

CONTACTS

Others with the same exposures? Yes No Unknown

Others with the same exposures

Name	DOB	Gender	Address/Phone
_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Zip code: _____ Phone: ____-____-____
Relationship to case	List symptoms	Symptom onset date	Is contact a case?
<input type="checkbox"/> Spouse <input type="checkbox"/> Sexual contact <input type="checkbox"/> Child <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Sibling <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Roommate <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Unknown/Other	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Zip code: _____ Phone: ____-____-____
Relationship to case	List symptoms	Symptom onset date	Is contact a case?
<input type="checkbox"/> Spouse <input type="checkbox"/> Sexual contact <input type="checkbox"/> Child <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Sibling <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Roommate <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Unknown/Other	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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