Rocky Mountain Spotted Fever

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: Long-term care resident: ☐ Yes ☐ No ☐ Unknown Facility name: Facility phone: ( )- - Type:

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

Onset date: / / Diagnosis date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom:
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 type: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
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: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Rickettsia rickettsii***

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Rickettsia rickettsii***

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Rickettsia rickettsii***

OCCUPATIONS

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

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / Discharge date: / / Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Fever: ☐ Yes ☐ No ☐ Unk Onset Date: / / Duration (days): _____ Highest known fever: _____ °F/C

Other symptoms:
☐ Anemia
☐ Fatigue
☐ Headache
☐ Muscle pain
☐ Nausea
☐ Rash
☐ vomiting

Life threatening complications:
☐ Adult respiratory distress syndrome
☐ Disseminated intravascular coagulopathy
☐ Meningitis/Encephalitis
☐ Renal failure

The following questions are relevant for Lyme disease only.

Did the health care provider for the case diagnose Lyme disease? ☐ Yes ☐ No ☐ Unk

Erythema migrans diagnosed by physician present: ☐ Yes ☐ No ☐ Unk Onset Date: / / Lesion greater than or equal to 5 cm: ☐ Yes ☐ No ☐ Unk

Late manifestations:
☐ 2nd/3rd degree atrioventricular (AV) block
☐ Bilateral facial palsy
☐ Encephalitis/Encephalomyelitis
☐ Cranial neuritis
☐ Recurrent, brief attacks of joint swelling
☐ Lymphocytic meningitis
☐ Radiculoneuropathy

OTHER LAB FINDINGS

Higher antibody result in CSF than in serum: ☐ Yes ☐ No ☐ Unknown

Leukopenia: ☐ Yes ☐ No ☐ Unknown

Thrombocytopenia: ☐ Yes ☐ No ☐ Unknown

Elevated hepatic transaminases: ☐ Yes ☐ No ☐ Unknown

TREATMENT

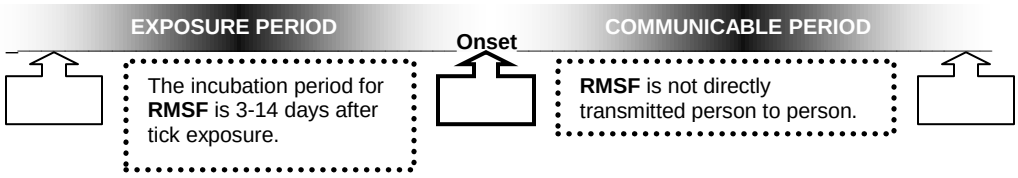
Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic: _____	Antibiotic: _____	Antibiotic: _____
Date started: ___/___/___	Date started: ___/___/___	Date started: ___/___/___
Dose: _____	Dose: _____	Dose: _____
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of times a day: _____ Route: _____	# of times a day: _____ Route: _____	# of times a day: _____ Route: _____

Therapeutic medications prescribed: ☐ Yes ☐ No ☐ Unknown List medications:

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

Did the case spend time in a wooded, brushy, or grassy area within 14 days of the onset of symptoms?

Location name: _____

Address: _____

City/State/County: _____ Zip: _____ Is Lyme disease endemic in this county? ☐ Yes ☐ No ☐ Unk

Location name: _____

Address: _____

City/State/County: _____ Zip: _____ Is Lyme disease endemic in this county? ☐ Yes ☐ No ☐ Unk

In the 14 days prior to onset of symptoms did the case find a tick on his/her body? ☐ Yes ☐ No ☐ Unk Date found: ___/___/___

NOTES: