



Q Fever Case Report

Centers for Disease Control and Prevention Fax: (404) 639-2778

CDC# (1-4)

- PATIENT/PHYSICIAN INFORMATION -

Patient's name: _____ **Date submitted:** ____/____/____ (mm/dd/yyyy)
Address: _____ **Physician's name:** _____ **Phone no.:** _____
 (number, street) _____
City: _____ **NETSS ID No.:** (if reported)
Case ID (13-18) Site (19-21) State (22-23)

- DEMOGRAPHICS -

1. State of residence: <input type="text"/> <input type="text"/> <small>(24-25)</small>	2. County of residence: _____ <small>(26-50)</small>	3. Zip code: _____ <small>(51-59)</small>	4. Date of birth: ____/____/____ <small>(60-61) (62-63) (64-67)</small>	5. Sex: (68) 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Not specified	6. Race: (69) 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black 3 <input type="checkbox"/> American Indian Alaskan Native 4 <input type="checkbox"/> Asian 5 <input type="checkbox"/> Pacific Islander 9 <input type="checkbox"/> Not specified	7. Hispanic ethnicity: 1 <input type="checkbox"/> Yes (70) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	
8. Occupation at date of onset of illness (Check all that apply)					9. Any contact with animals within 2 months prior to onset? (check all that apply)		
1 <input type="checkbox"/> wool or felt plant (71) 2 <input type="checkbox"/> tannery or rendering plant (72) 3 <input type="checkbox"/> dairy (73) 4 <input type="checkbox"/> veterinarian (74) 5 <input type="checkbox"/> medical research (75)			6 <input type="checkbox"/> animal research (76) 7 <input type="checkbox"/> slaughterhouse worker (77) 8 <input type="checkbox"/> laboratory worker (78) 9 <input type="checkbox"/> rancher (79)		10 <input type="checkbox"/> live in household with person occupationally related to above? (80) 8 <input type="checkbox"/> other (please specify) (81)		
10. Any exposure to birthing animals? (89) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If yes, which animal _____				11. Exposure to unpasteurized milk? (90) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If yes, which animal _____		12. Any travel in last year? (91-92) If yes, State <input type="text"/> <input type="text"/> County _____ Foreign Country _____	
						13. Other family member with similar illness in last year? (93) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	

- CLINICAL FINDINGS -

14. Date of Onset of Symptoms: ____/____/____ <small>(94-95) (96-97) (98-101)</small> (mm/dd/yyyy)	15. Clinical Signs and syndromes (check all that apply)		
	1 <input type="checkbox"/> fever (>100.5) (102)	4 <input type="checkbox"/> malaise (105)	7 <input type="checkbox"/> headache (108)
	2 <input type="checkbox"/> myalgia (103)	5 <input type="checkbox"/> rash (106)	8 <input type="checkbox"/> splenomegaly (109)
	3 <input type="checkbox"/> retrobulbar pain (104)	6 <input type="checkbox"/> cough (107)	9 <input type="checkbox"/> hepatomegaly (110)
			10 <input type="checkbox"/> pneumonia (111)
			8 <input type="checkbox"/> Other (please specify) (114)
			11 <input type="checkbox"/> hepatitis (112)
			12 <input type="checkbox"/> endocarditis (113)
16. Any pre-existing medical conditions? (check all that apply)		17. Was patient hospitalized because of this illness? (119)	
1 <input type="checkbox"/> immunocompromised (115) 3 <input type="checkbox"/> valvular heart disease or vascular graft (117) 2 <input type="checkbox"/> pregnancy (116) 8 <input type="checkbox"/> Other _____ (118)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	
		18. Did patient die from complications of this illness? (120) (If yes, date) (mm/dd/yyyy)	
		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk <small>(121-22) (123-24) (125-28)</small>	

- LABORATORY DATA -

19. Name of laboratory: _____ **City:** _____ **State:** ____ **Zip:** _____

20. Serology <small>(Check only if specific assay was performed)</small>	Phase I Antigen		Phase II Antigen		22. Other Diagnostic Tests ?*	Positive?
	Serology 1 (mm/dd/yyyy)	Serology 2 (mm/dd/yyyy)	Serology 1 (mm/dd/yyyy)	Serology 2 (mm/dd/yyyy)		
IFA - IgG	<small>(129-30) (131-32) (133-36)</small> Titer or OD* Positive? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (137)	<small>(141-42) (143-44) (145-48)</small> Titer or OD* Positive? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (149)	<small>(153-54) (155-56) (157-60)</small> Titer or OD* Positive? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (161)	<small>(165-66) (167-68) (169-72)</small> Titer or OD* Positive? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (173)	PCR Immunostain Culture	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (178) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (179) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (180)
IFA - IgM	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (138)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (150)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (162)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (174)	Sample(s) tested: _____ _____ _____ _____	
Complement Fixation	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (139)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (151)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (163)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (175)		
Other test:	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (140)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (152)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (164)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (176)		
21. Was there a fourfold change in antibody titer between the two serum specimens? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (177)						

*IFA or CF "Titer" or Other test: ELISA (EIA) Optical Density "OD" value.

- FINAL DIAGNOSIS -

23. Classify case based on the CDC case definition (see criteria below):
 1 **CONFIRMED** 2 **PROBABLE** (181)

Confirmed Q fever: A clinically compatible case that is laboratory confirmed with 1) a fourfold change in antibody titer to *Coxiella burnetii* antigen by IFA or CF antibody test, or 2) a positive PCR assay, or 3) culture of *C. burnetii* from a clinical specimen, or 4) positive immunostaining of *C. burnetii* in tissue.

Probable Q Fever: A clinically compatible case with single supportive IgG or IgM titer as defined by testing lab.

State Health Department Official who reviewed this report:
 Name: _____
 Title: _____ Date: ____/____/____
(mm/dd/yyyy)



Q Fever Case Report

Centers for Disease Control and Prevention Fax: (404) 639-2778



Form Approved
OMB 0920-0009

CDC# [][][][] (1-4)

- PATIENT/PHYSICIAN INFORMATION -

Date submitted: ___/___/___ (mm/dd/yyyy)
 Physician's name: _____ Phone no.: _____
 NETSS ID No.: (if reported) [][][][][][] - [][] - [][]
Case ID (13-18) Site (19-21) State (22-23)

- DEMOGRAPHICS -

1. State of residence: [][] (24-25)	2. County of residence: _____ (26-50)	3. Zip code: _____-_____-____ (51-59)	4. Date of birth: (mm/dd/yyyy) ____/____/____ (60-61) (62-63) (64-67)	5. Sex: (68) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not specified	6. Race: (69) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Not specified	7. Hispanic ethnicity: (70) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
8. Occupation at date of onset of illness (Check all that apply)				9. Any contact with animals within 2 months prior to onset? (check all that apply)		
<input type="checkbox"/> wool or felt plant (71) <input type="checkbox"/> animal research (76) <input type="checkbox"/> live in household with person occupationally related to above? (80) <input type="checkbox"/> tannery or rendering plant (72) <input type="checkbox"/> slaughterhouse worker (77) <input type="checkbox"/> laboratory worker (78) <input type="checkbox"/> other (please specify) (81) <input type="checkbox"/> dairy (73) <input type="checkbox"/> veterinarian (74) <input type="checkbox"/> rancher (79) <input type="checkbox"/> medical research (75)				<input type="checkbox"/> Cattle (82) <input type="checkbox"/> Goats (84) <input type="checkbox"/> Cats (86) <input type="checkbox"/> Sheep (83) <input type="checkbox"/> Pigeons (85) <input type="checkbox"/> Rabbits (87) <input type="checkbox"/> Other (please specify) (88)		
10. Any exposure to birthing animals? (89) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, which animal _____		11. Exposure to unpasteurized milk? (90) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, which animal _____		12. Any travel in last year? (91-92) If yes, State [][] County _____ Foreign Country _____		13. Other family member with similar illness in last year? (93) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

- CLINICAL FINDINGS -

14. Date of Onset of Symptoms: ____/____/____ (mm/dd/yyyy) <small>(94-95) (96-97) (98-101)</small>	15. Clinical Signs and syndromes (check all that apply)				
<input type="checkbox"/> fever (>100.5) (102) <input type="checkbox"/> malaise (105) <input type="checkbox"/> headache (108) <input type="checkbox"/> pneumonia (111) <input type="checkbox"/> Other (please specify) (114) <input type="checkbox"/> myalgia (103) <input type="checkbox"/> rash (106) <input type="checkbox"/> splenomegaly (109) <input type="checkbox"/> hepatitis (112) <input type="checkbox"/> retrobulbar pain (104) <input type="checkbox"/> cough (107) <input type="checkbox"/> hepatomegaly (110) <input type="checkbox"/> endocarditis (113)					
16. Any pre-existing medical conditions? (check all that apply)		17. Was patient hospitalized because of this illness? (119)		18. Did patient die from complications of this illness? (120) (If yes, date) (mm/dd/yyyy)	
<input type="checkbox"/> immunocompromised (115) <input type="checkbox"/> valvular heart disease or vascular graft (117) <input type="checkbox"/> pregnancy (116) <input type="checkbox"/> Other _____ (118)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <small>(121-22) (123-24) (125-28)</small>	

- LABORATORY DATA -

19. Name of laboratory: _____ **City:** _____ **State:** _____ **Zip:** _____

20. Serology <small>(Check only if specific assay was performed)</small>	Phase I Antigen		Phase II Antigen		22. Other Diagnostic Tests ?* <small>* Check only if specific assay was performed.</small>
	Serology 1 (mm/dd/yyyy) <small>(129-30) (131-32) (133-36)</small>	Serology 2 (mm/dd/yyyy) <small>(141-42) (143-44) (145-48)</small>	Serology 1 (mm/dd/yyyy) <small>(153-54) (155-56) (157-60)</small>	Serology 2 (mm/dd/yyyy) <small>(165-66) (167-68) (169-72)</small>	
IFA - IgG	<input type="checkbox"/> Yes <input type="checkbox"/> No (137)	<input type="checkbox"/> Yes <input type="checkbox"/> No (149)	<input type="checkbox"/> Yes <input type="checkbox"/> No (161)	<input type="checkbox"/> Yes <input type="checkbox"/> No (173)	PCR <input type="checkbox"/> Yes <input type="checkbox"/> No (178)
IFA - IgM	<input type="checkbox"/> Yes <input type="checkbox"/> No (138)	<input type="checkbox"/> Yes <input type="checkbox"/> No (150)	<input type="checkbox"/> Yes <input type="checkbox"/> No (162)	<input type="checkbox"/> Yes <input type="checkbox"/> No (174)	Immunostain <input type="checkbox"/> Yes <input type="checkbox"/> No (179)
Complement Fixation	<input type="checkbox"/> Yes <input type="checkbox"/> No (139)	<input type="checkbox"/> Yes <input type="checkbox"/> No (151)	<input type="checkbox"/> Yes <input type="checkbox"/> No (163)	<input type="checkbox"/> Yes <input type="checkbox"/> No (175)	Culture <input type="checkbox"/> Yes <input type="checkbox"/> No (180)
Other test: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No (140)	<input type="checkbox"/> Yes <input type="checkbox"/> No (152)	<input type="checkbox"/> Yes <input type="checkbox"/> No (164)	<input type="checkbox"/> Yes <input type="checkbox"/> No (176)	Sample(s) tested:

21. Was there a fourfold change in antibody titer between the two serum specimens? Yes No (177)

*IFA or CF "Titer" or Other test: ELISA (EIA) Optical Density "OD" value.

- FINAL DIAGNOSIS -

23. Classify case based on the CDC case definition (see criteria below):
 CONFIRMED **PROBABLE** (181)

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Probable Q Fever: A clinically compatible case with single supportive IgG or IgM titer as defined by testing lab.

State Health Department Official who reviewed this report:
Name: _____
Title: _____ Date: ____/____/____ (mm/dd/yyyy)



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Form Approved
OMB 0920-0009

CDC# [] [] [] [] (1-4)

- PATIENT/PHYSICIAN INFORMATION -

Patient's name: _____ Date submitted: ____/____/____ (mm/dd/yyyy)
Address: (number, street) _____ Physician's name: _____ Phone no.: _____
City: _____ NETSS ID No.: (if reported) [][] - [][] - [][]
Case ID (13-18) Site (19-21) State (22-23)

- DEMOGRAPHICS -

1. State of residence: [][] (24-25)	2. County of residence: _____ (26-50)	3. Zip code: ____-____ (51-59)	4. Date of birth: (mm/dd/yyyy) ____/____/____ (60-61) (62-63) (64-67)	5. Sex: (68) 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Not specified	6. Race: (69) 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black 3 <input type="checkbox"/> American Indian Alaskan Native 4 <input type="checkbox"/> Asian 5 <input type="checkbox"/> Pacific Islander 9 <input type="checkbox"/> Not specified	7. Hispanic ethnicity: 1 <input type="checkbox"/> Yes (70) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
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8. Occupation at date of onset of illness (Check all that apply) 1 <input type="checkbox"/> wool or felt plant (71) 2 <input type="checkbox"/> tannery or rendering plant (72) 3 <input type="checkbox"/> dairy (73) 4 <input type="checkbox"/> veterinarian (74) 5 <input type="checkbox"/> medical research (75) 6 <input type="checkbox"/> animal research (76) 7 <input type="checkbox"/> slaughterhouse worker (77) 8 <input type="checkbox"/> laboratory worker (78) 9 <input type="checkbox"/> rancher (79) 10 <input type="checkbox"/> live in household with person occupationally related to above? (80) 8 <input type="checkbox"/> other (please specify) (81)	9. Any contact with animals within 2 months prior to onset? (check all that apply) 1 <input type="checkbox"/> Cattle (82) 2 <input type="checkbox"/> Sheep (83) 8 <input type="checkbox"/> Other (please specify) (88) 3 <input type="checkbox"/> Goats (84) 4 <input type="checkbox"/> Pigeons (85) 6 <input type="checkbox"/> Rabbits (87) 5 <input type="checkbox"/> Cats (86)
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10. Any exposure to birthing animals? (89) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If yes, which animal _____	11. Exposure to unpasteurized milk? (90) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If yes, which animal _____	12. Any travel in last year? (91-92) If yes, State [][] County _____ Foreign Country _____	13. Other family member with similar illness in last year? (93) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
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- CLINICAL FINDINGS -

14. Date of Onset of Symptoms: ____/____/____ (mm/dd/yyyy) (94-95) (96-97) (98-101)	15. Clinical Signs and syndromes (check all that apply) 1 <input type="checkbox"/> fever (>100.5) (102) 2 <input type="checkbox"/> myalgia (103) 3 <input type="checkbox"/> retrobulbar pain (104) 4 <input type="checkbox"/> malaise (105) 5 <input type="checkbox"/> rash (106) 6 <input type="checkbox"/> cough (107) 7 <input type="checkbox"/> headache (108) 8 <input type="checkbox"/> splenomegaly (109) 9 <input type="checkbox"/> hepatomegaly (110) 10 <input type="checkbox"/> pneumonia (111) 11 <input type="checkbox"/> hepatitis (112) 12 <input type="checkbox"/> endocarditis (113) 8 <input type="checkbox"/> Other (please specify) (114)
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16. Any pre-existing medical conditions? (check all that apply) 1 <input type="checkbox"/> immunocompromised (115) 2 <input type="checkbox"/> pregnancy (116) 3 <input type="checkbox"/> valvular heart disease or vascular graft (117) 8 <input type="checkbox"/> Other (118)	17. Was patient hospitalized because of this illness? (119) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	18. Did patient die from complications of this illness? (120) (If yes, date) (mm/dd/yyyy) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
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- LABORATORY DATA -

19. Name of laboratory: _____ City: _____ State: _____ Zip: _____

20. Serology (Check only if specific assay was performed)	Phase I Antigen		Phase II Antigen		22. Other Diagnostic Tests ?*	Positive?
	Serology 1 (mm/dd/yyyy)	Serology 2 (mm/dd/yyyy)	Serology 1 (mm/dd/yyyy)	Serology 2 (mm/dd/yyyy)		
IFA - IgG	<input type="checkbox"/> Yes <input type="checkbox"/> No (137)	<input type="checkbox"/> Yes <input type="checkbox"/> No (149)	<input type="checkbox"/> Yes <input type="checkbox"/> No (161)	<input type="checkbox"/> Yes <input type="checkbox"/> No (173)	PCR	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (178)
IFA - IgM	<input type="checkbox"/> Yes <input type="checkbox"/> No (138)	<input type="checkbox"/> Yes <input type="checkbox"/> No (150)	<input type="checkbox"/> Yes <input type="checkbox"/> No (162)	<input type="checkbox"/> Yes <input type="checkbox"/> No (174)	Immunostain	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (179)
Complement Fixation	<input type="checkbox"/> Yes <input type="checkbox"/> No (139)	<input type="checkbox"/> Yes <input type="checkbox"/> No (151)	<input type="checkbox"/> Yes <input type="checkbox"/> No (163)	<input type="checkbox"/> Yes <input type="checkbox"/> No (175)	Culture	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (180)
Other test:	<input type="checkbox"/> Yes <input type="checkbox"/> No (140)	<input type="checkbox"/> Yes <input type="checkbox"/> No (152)	<input type="checkbox"/> Yes <input type="checkbox"/> No (164)	<input type="checkbox"/> Yes <input type="checkbox"/> No (176)	Sample(s) tested:	

* IFA or CF "Titer" or Other test: ELISA (EIA) Optical Density "OD" value.

21. Was there a fourfold change in antibody titer between the two serum specimens? 1 Yes 2 No (177)

- FINAL DIAGNOSIS -

23. Classify case based on the CDC case definition (see criteria below):
1 CONFIRMED 2 PROBABLE (181)

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Probable Q Fever: A clinically compatible case with single supportive IgG or IgM titer as defined by testing lab.

State Health Department Official who reviewed this report:
Name: _____
Title: _____ Date: ____/____/____ (mm/dd/yyyy)

Public reporting burden of this collection of information is estimated to average 10 minutes per response. 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. Please send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Rd., NE (MS D-74); Atlanta, GA 30333; ATTN: PRA (0920-0009).