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| **DHHS**  **logo** | **Department of Health and Human Services**  **Centers for Disease Control and Prevention**  **Atlanta, GA 30033** | **Brucellosis Case Report Form** | **OMB number** |

**Brucellosis Case Report Form General 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.

Send the completed form with all personal identifiers removed to:

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| Mail: | Centers for Disease Control & Prevention  ATTN: Bacterial Special Pathogens Branch  Mailstop C09  1600 Clifton Rd NE  Atlanta, GA 30333 |
| Fax: | (404) 639-7080 |

**Patient identifier information (NOT transmitted to CDC)**

|  |  |
| --- | --- |
| Patient Name | Patient’s full name |
| Phone | Patient’s phone number |
| Patient Chart Number | Medical chart number for patient |
| Address | Patient’s address including street and city |
| State, Zip | Patient’s state of residence and zip code |
| Hospital Name | Name of the hospital where the patient is admitted or seen |

**Information obtained for confirmed and probable brucellosis cases**

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| --- | --- | --- | --- | --- |
| **Patient & Physician Information** | | | | |
| State Case ID | | Unique identifier given by the state health department. | |
| Investigator | | State health department investigator name. | |
| Date Reported | | Date the case was reported to state. | |
| Physician | | Primary health care provider name. | |
| Phone | | Primary health care provider phone number and/or pager. | |
| NETSS Number | | If case submitted to NETSS, include the NETSS-generated Case ID number. | |
| **Demographics** | | | |
| State of Residence | | Use the 2 letter postal abbreviation (e.g., NY) of patient’s state of residence. | |
| County of Residence | | Patient’s county of residence. | |
| Age | | Age of patient at time of diagnosis; indicate age unit as months or years. | |
| Sex | | Genetic sex of patient (i.e., male or female). | |
| Pregnant | | Pregnancy status at time of diagnosis. | |
| Country of Birth | | Indicate original country of birth, including U.S. born. If unknown, please enter “Unknown”. | |
| Ethnicity | | Indicate ethnicity of patient. | |
| Race | | Race of patient as noted in the chart or reported by physician or infection control personnel (ICP). Multiple boxes may be checked. Do not make assumptions based on name or native language. If race is unknown, please check “Unknown”. | |
| Occupation | | Indicate occupation at time of disease onset. Specify past occupation(s) if relevant. | |
| **Clinical Information And Treatment** | | | |
| Disease Presentation | | Disease presentation- a date determined by duration from onset of symptoms to date of diagnosis. | |
| Symptoms and Associated Diagnoses | | Select patient-described symptoms. Enter date of onset if known. If approximate date is known, enter rounded date (e.g., fever two weeks prior to seeking medical care on 9/17—enter 9/1). | |
| Signs and Associated Diagnoses | | Select signs identified upon examination. Enter date of diagnosis where known. Enter an approximate date if a precise date is unknown. | |
| Hospitalized? | | Indicate whether the patient was admitted to a hospital due to this illness. Enter admission and discharge date, if applicable. | |
| Deceased? | | Indicate if the patient died of this illness. Enter date if applicable. | |
| Treatment and Duration | | Select whether the patient has completed their treatment. Select the prescribed antimicrobial agents, amount, and duration for each. If prescribed other antimicrobials, enter the generic name, amount, and duration, if known. NOTE: If an agent is taken twice daily, enter the total prescribed mg/day (e.g., 100 mg BID- enter 200 mg/day). | |
| **Risk Factors** | | | |
| Travel | | | Select whether the patient traveled out of state or country in the past six months, and where and when if applicable. |
| Animal Contact | | | Select which animals and type of contact, if any, the patient had in the past 6 months. |
| Unpasteurized Dairy | | | Select if the patient consumed unpasteurized (raw) dairy in the past six months. Choose type of animal, owner of the animal the dairy came from, what products were eaten, and location of product. |
| Confirmed Case | | | Select if the patient is linked to a confirmed case. If yes, select the relationship to the patient. |
| Similar Illness | | | Select if the patient is aware of a contact having a similar illness. If yes, select the relationship to the patient. |
| Risk Status | | | If the patient had a known exposure to *Brucella*, indicate the exposure source and the location of exposure. Also indicate the assessed risk status of the exposure. Finally, if exposed to a *Brucella* vaccine, indicate to which vaccine the case was exposed.  The CDC exposure guidelines are available at [www.cdc.gov/mmwr/preview/mmwrhtml/mm5702a3.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5702a3.htm). If a laboratory exposure did occur, review these assessment, monitoring, and prophylaxis recommendations. For assistance, contact CDC at the phone number listed on page one. |
| Received Post-Exposure Prophylaxis (PEP) | | | If the patient was exposed to *Brucella*, indicate if the patient took PEP, or reasons for not taking PEP. |
| Completed PEP | | | If exposed, indicate if the patient completed the entire course of PEP as prescribed. CDC recommended PEP regimen is doxycycline 100 mg orally twice a day plus rifampin 600 mg orally once a day for 21 days. |
| **Laboratory Data** | | | |
| NOTE: Complete a new Laboratory Data section for each laboratory receiving and processing patient samples. Leave the test field blank for each test not performed. | | | |
| Case Status | Indicate case classification. Confirmed and Probable cases must be reported to NETSS by the next regularly scheduled transmission cycle.CDC must be notified of multiple cases which are temporal/spatial clusters within 24 hours of the cases meeting the notification criteria (CSTE Position Statement 09-SI-04). | | |
| Laboratory Name | Enter the laboratory name and address which processed the sample. For each laboratory that processed the sample, start a new laboratory section. Submit a copy of page four for each laboratory involved in testing. | | |
| Received From | Enter the name, city, and state of the laboratory from which the specimen is received; include date of receipt. | | |
| Paired Serologic Tests | If a paired agglutination test was done, enter results in this table. If known, enter the agglutination test (SAT, BMAT, Tube AT). Indicate which titers were run- total antibody (complete) and/or IgG (reduced). Enter in the acute and convalescent titers. Indicate if one, both, or paired titers are positive. Enter the testing laboratory’s positive cut-off value for the test. If a single titer was done, enter as an acute titer.  For ELISA, indicate if IgG, IgM, or both titers were run. Enter in the acute and convalescent titers and if one, both, or paired titers are positive. Enter the testing laboratory’s positive cut-off value for the test. | | |
| Date Collected | Enter the dates the acute and convalescent samples were collected. | | |
| Other Serologic Tests | Enter the value or titer in the row of the test completed, and whether the test was considered positive. If the test used is not listed, enter name and results in “Other”. Indicate the laboratory’s positive cut-off value for the test. | | |
| Other Tests | Select whether PCR and/or culture was attempted. Indicate the source of specimen used for the specified test. Enter the date of specimen collection, if the test was positive, and the species identified (e.g.: *abortus, canis, melitensis, suis,* other). | | |
| Specimen Cultured | Indicate if the specimen for culture was collected prior to administration of antimicrobial therapy. | | |
| Isolate Reported  to CDC | Indicate if a culture-positive result of a select agent was reported to CDC, as required by regulation. Reporting requirements and forms are available at <http://www.selectagents.gov/>. | | |
| Laboratory Exposure | Select if laboratory workers were possibly exposed during specimen processing. The CDC exposure guidelines are available at [www.cdc.gov/mmwr/preview/mmwrhtml/mm5702a3.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5702a3.htm). If a laboratory exposure did occur, review these assessment, monitoring, and prophylaxis recommendations. For assistance, contact CDC at the phone number listed on page one. | | |
| Exposure Reported  to CDC | If a laboratory exposure occurred, indicate if the “release” of a select agent was reported to CDC, as required by regulation. Reporting requirements and forms are available at <http://www.selectagents.gov/>. | | |
| Specimens to CDC | Indicate if the specimen was sent to CDC for testing. | | |
| Specimen available | Indicate if the specimen is still available, if needed for future testing. | | |

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| **-Brucellosis Case Report Form-** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Case Name** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Phone** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Medical Chart No.** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Address** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | **State, ZIP** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **Hospital Name** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| HHSLogo2[1] | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | |  | | | | | | | | | | | |  | | | | | |
| images[1]*Remove case identifier information prior to transmission to CDC.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | **Department of Health and Human Services**  **Centers for Disease Control and Prevention**  **Atlanta, GA 30033** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Brucellosis Case Report Form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Form Approved  OMB No. 0920-0004  Exp. Date 6/30/2013 | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| **- CASE & PHYSICIAN INFORMATION -** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **State Case ID** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **Physician** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Phone Number** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Investigator** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | **NETSS ID No** (if notified): | | | | | | | | | | | | | | | | | | | | | | | | | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_--\_\_ \_\_ \_\_--- \_\_ \_\_  CASE ID SITE STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date Reported** | | | | | | | | | | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| **- DEMOGRAPHICS -** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **State of Residence** | | | | | | | | | | | | | | | | \_\_\_\_\_ | | | | | | | | | **County of Residence** | | | | | | | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | **Age** | | \_\_\_\_ 🞎 mo 🞎 yrs | | | | | | | | | | | | | | | | | | | **Sex** | | | | 🞎 Male 🞎 Female 🞎 Unknown | | | | | | | | | | | | | | | | | | |
| **Pregnant** | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | **Country of Birth** | | | | | | | | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | **Ethnicity** | | | | | | | | 🞎 Hispanic 🞎 Non-Hispanic 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Race** 🞎 American Indian/ Alaskan Native  🞎 Asian/Pacific Islander 🞎 Black 🞎 White  🞎 Unknown 🞎Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Occupation**  🞎 Animal research 🞎 Medical research 🞎 Dairy 🞎 Laboratory 🞎 Wildlife  🞎 Rancher 🞎 Slaughterhouse 🞎 Tannery/rendering 🞎 Veterinarian/Vet Tech  🞎 Lives with person of above occupation 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **- CLINICAL INFORMATION AND TREATMENT -** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Disease Presentation** | | | | | | | | | | | | | | | | | | | | 🞎 Acute (0-8 weeks) 🞎 Subacute (8 weeks - <1 yr) 🞎 Chronic (1 yr+) 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Symptoms, Signs, and Associated Diagnoses** (indicate **date of onset** or **diagnosis**): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | No | Unk | | | | | Symptom | | | | | | | | | | | | | Date Onset | | | | | | | | | | | | | | | | Yes | | | | | No | Unk | | | | | | | Symptom/Sign | | | | | | | | | | | | | Date Diagnosis | | | | | | | | | | Yes | | | | | No | | Unk | | | | | | | Signs | | | | | | | | | | | | | | | Date of Diagnosis | | | | | | | |
| 🞎 | | | 🞎 | 🞎 | | | | | Fever | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | | | | 🞎 | | | | | 🞎 | 🞎 | | | | | | | Anorexia | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | 🞎 | | | | | 🞎 | | 🞎 | | | | | | | Hepatomegaly | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | |
|  | | |  |  | Max temp:\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | (circle) °F or °C | | | | | | | | | | | | | | | | 🞎 | | | | | 🞎 | 🞎 | | | | | | | Myalgia | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | 🞎 | | | | | 🞎 | | 🞎 | | | | | | | Splenomegaly | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | |
| 🞎 | | | 🞎 | 🞎 | | | | | Night sweats | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | | | | 🞎 | | | | | 🞎 | 🞎 | | | | | | | Weight loss | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | 🞎 | | | | | 🞎 | | 🞎 | | | | | | | Arthritis | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | |
| 🞎 | | | 🞎 | 🞎 | | | | | Arthralgia | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | | | | 🞎 | | | | | 🞎 | 🞎 | | | | | | | Endocarditis | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | 🞎 | | | | | 🞎 | | 🞎 | | | | | | | Meningitis | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | |
| 🞎 | | | 🞎 | 🞎 | | | | | Headache | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | | | | 🞎 | | | | | 🞎 | 🞎 | | | | | | | Orchitis | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | 🞎 | | | | | 🞎 | | 🞎 | | | | | | | Spondylitis | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | |
| 🞎 | | | 🞎 | 🞎 | | | | | Fatigue | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | | | | 🞎 | | | | | 🞎 | 🞎 | | | | | | | Epididymitis | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | 🞎 | | | | | 🞎 | | 🞎 | | | | | | | Other:\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | |
| **Was the case hospitalized because of this illness?** | | | | | | | | | | | | | | | | | | | | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | If yes, admission date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | |
| If applicable, discharge date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | |
| **Is the case deceased?** | | | | | | | | | | | | | | | | | | | | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | If yes, date of death: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | |
| **Treatment and Duration** (check all that apply): 🞎 Currently under treatment 🞎 Completed treatment 🞎 Not treated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 🞎 Doxycycline | | | | | | | | | | | |  | | | | | | mg/day | | | | | | | | |  | | | days | | | | | | | | | | | | | | | | 🞎 Other: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | mg/day | | | | |  | | | | days | | | | |
| 🞎 Rifampin | | | | | | | | | | | |  | | | | | | mg/day | | | | | | | | |  | | | days | | | | | | | | | | | | | | | | 🞎 Other: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | mg/day | | | | |  | | | | days | | | | |
| 🞎 Streptomycin | | | | | | | | | | | |  | | | | | | mg/day | | | | | | | | |  | | | days | | | | | | | | | | | | | | | | 🞎 Other: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | mg/day | | | | |  | | | | days | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | |  | | |
| **- RISK FACTORS -** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **In the 6 months prior to illness onset, did the case:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Travel outside state of residence?**  🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **If Yes, where?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Dates of travel** \_\_\_/\_\_\_/\_\_\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **If Yes, where?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Dates of travel** \_\_\_/\_\_\_/\_\_\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Have contact with animals?** 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Who owns the animal(s)?** | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Type of contact | | | | | | | | | | | | | | | | | | | | | | | Cattle | | | | | | Pig | | | | | Goat | | | | | | Sheep | | | | | | | | | Dog | | | | | Deer | | | | | Bison | | | | | | Elk | | | Other | | | | | | |  | | Case | | | | | | | | | | Private | | | | | | | Wild | | | | | | Commercial | | | | | | Unknown | | | | | | |
|  | Birthing/animal products | | | | | | | | | | | | | | | | | | | | | | 🞎 | | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | | | | | | | 🞎 | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | 🞎 \_\_\_\_\_\_\_\_ | | | | | | |  | | 🞎 | | | | | | | | | | 🞎 | | | | | | | 🞎 | | | | | | 🞎 | | | | | | 🞎 | | | | | | |
| Skinning/slaughter | | | | | | | | | | | | | | | | | | | | | | 🞎 | | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | | | | | | | 🞎 | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | 🞎 \_\_\_\_\_\_\_\_ | | | | | | |  | | 🞎 | | | | | | | | | | 🞎 | | | | | | | 🞎 | | | | | | 🞎 | | | | | | 🞎 | | | | | | |
| Hunting | | | | | | | | | | | | | | | | | | | | | | 🞎 | | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | | | | | | | 🞎 | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | 🞎 \_\_\_\_\_\_\_\_ | | | | | | |  | | 🞎 | | | | | | | | | | 🞎 | | | | | | | 🞎 | | | | | | 🞎 | | | | | | 🞎 | | | | | | |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | 🞎 | | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | | | | | | | 🞎 | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | 🞎 \_\_\_\_\_\_\_\_ | | | | | | |  | | 🞎 | | | | | | | | | | 🞎 | | | | | | | 🞎 | | | | | | 🞎 | | | | | | 🞎 | | | | | | |
| **Consume unpasteurized dairy or undercooked meat?** 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **In what country was the product acquired?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of food product | | | | | | | | | | | | | | | | | | | | | Cattle | | | | | | | Pig | | | | | Goat | | | | | | | Sheep | | | | | | | | | Dog | | | | | Deer | | | | | Bison | | | | | | Elk | | | Other | | | | | | |  | | U.S. | | | | | | | Other | | | | | | | | | | | | | | | | | Other | | | | | | | | | | | |
|  | Milk | | | | | | | | | | | | | | | | | | | | 🞎 | | | | | | | 🞎 | | | | | 🞎 | | | | | | | 🞎 | | | | | | | | | 🞎 | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | 🞎 \_\_\_\_\_\_\_\_ | | | | | | | 🞎 | | | | | | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Fresh/soft cheese | | | | | | | | | | | | | | | | | | | | 🞎 | | | | | | | 🞎 | | | | | 🞎 | | | | | | | 🞎 | | | | | | | | | 🞎 | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | 🞎 \_\_\_\_\_\_\_\_ | | | | | | | 🞎 | | | | | | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Undercooked meat | | | | | | | | | | | | | | | | | | | | 🞎 | | | | | | | 🞎 | | | | | 🞎 | | | | | | | 🞎 | | | | | | | | | 🞎 | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | 🞎 \_\_\_\_\_\_\_\_ | | | | | | | 🞎 | | | | | | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | 🞎 | | | | | | | 🞎 | | | | | 🞎 | | | | | | | 🞎 | | | | | | | | | 🞎 | | | | | 🞎 | | | | | 🞎 | | | | | | 🞎 | | | 🞎 \_\_\_\_\_\_\_\_ | | | | | | | 🞎 | | | | | | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **Have a link to a confirmed case?** 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Who?** | | | | | | | 🞎 Household 🞎 Neighbor 🞎 Coworker  🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Know of similar illness in contact?** 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Have an exposure**  **to a *Brucella?*** | | | | | | | | | | | | | | | | | 🞎 Clinical specimen 🞎 Isolate 🞎 Vaccine 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Where did the exposure occur?** | | | | | | | | | | | | | | 🞎 Clinical setting 🞎 Laboratory 🞎 Farm/Ranch  🞎 Surgery 🞎 Unknown 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Exposure Risk Status:** | | | | | | | | | | | | | | | | | | | 🞎 High 🞎 Low 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **If exposed to vaccine, Indicate which:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞎 S19 🞎 RB51 🞎 Rev1 🞎 Other | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Receive post-exposure prophylaxis (PEP)?** | | | | | | | | | | | | | | | | | | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | | | | | | | | **If no, why not?** | | | | | | | | | | | | | | | | | | | 🞎 Unaware of exposure 🞎 Unavailable 🞎 Allergic 🞎 Pregnant 🞎 Unknown 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **If yes, did case complete course?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown 🞎 Partial *explain*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Public reporting burden of this collection of information is estimated to average 20 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 30333; ATTN: PRA (0920-0004). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **-CASE DEFINITION (2010)-** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Confirmed**: A clinically compatible illness with definitive laboratory evidence (i.e.: culture and identification of *Brucella* spp. from clinical specimens OR serological evidence of a fourfold rise in *Brucella* antibody titer in paired acute and convalescent serum specimens greater than or equal to 2 weeks apart).  **Probable**: A clinically compatible illness epidemiologically linked to a documented *Brucella* case OR has presumptive laboratory evidence (i.e.: *Brucella* total antibody titer of greater than or equal to 160 by standard tube agglutination test (SAT) or Brucella microagglutination test (BMAT) in one or more serum specimens obtained after onset of symptoms OR detection of Brucella DNA in a clinical specimen by PCR assay). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **- LABORATORY DATA -** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NOTE**: Complete a new Laboratory Data section for each laboratory receiving and processing case samples. Print extra copies if necessary.  Leave the test field blank for each test not performed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Case Status**  🞎 Culture confirmed 🞎 Serologically confirmed 🞎 Probable | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Laboratory Name: | | | |  | | | | | | | | City: | | |  | | | | | | | | | | State: |  | | | | | Zip: | | | |  | |  | | |
| Received From: | | |  | | | | | | | City: | | |  | | | | | | | | State: | |  | | | Date Received: | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | |
| Below, indicate Yes or No **only** if the test or procedure was performed. Lack of selection indicates that the test was not performed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Paired Serologic Tests** | | | | **Titers** | | | | **Acute Titer** | | | | | | | | **Convalescent Titer** | | | | | | | **Positive?** | | | | | | | | | | | | **Positive Cut-off:** | | |  |
| Agglutination Test:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Total antibody  🞎 IgG | | | | \_\_**:**\_\_\_\_\_  \_\_**:**\_\_\_\_\_ | | | | | | | | \_\_**:**\_\_\_\_\_  \_\_**:**\_\_\_\_\_ | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown  🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | |  | | |
|  | ELISA: \_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 IgG  🞎 IgM | | | | \_\_**:**\_\_\_\_\_  \_\_**:**\_\_\_\_\_ | | | | | | | | \_\_**:**\_\_\_\_\_  \_\_**:**\_\_\_\_\_ | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown  🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | |  | | |  |
|  | **Date Sample Collected:** | | | | **Acute:** \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | **Convalescent:** \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Other Serologic Tests** | | | | | **Titer or Value** | | | | | **Positive?** | | | | | | | | | | | **Positive Cut-off** | | | | | | |  | | | | | | | | | | |
|  | Rose Bengal | | | | | \_\_**:**\_\_\_\_\_ | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | |
|  | Coombs IgG | | | | | \_\_**:**\_\_\_\_\_ | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | |  | | | | | | |  | |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | \_\_**:**\_\_\_\_\_ | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | ( \_ \_ \_ \_ ) | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | |  | | | | | | |  |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | |  |  | | | | | |  | | | | | | |
|  | **Other Tests** | **Source of Specimen** | | | | | | | | | | | | | | **Date Collected** | | | | | | **Positive?** | | | | | | | | | | | | **Species** | | | | |  |
|  | PCR | 🞎 Blood 🞎 Abscess/wound 🞎 Bone Marrow  🞎 CSF 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | |  | | | | |  |
|  | Culture | 🞎 Blood 🞎 Abscess/wound 🞎 Bone Marrow  🞎 CSF 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | |  | | | | |  |
|  | Was the specimen for culture collected prior to antimicrobial therapy? | | | | | | | | | | | | | | | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | |  |
|  | If culture positive, was the identification of a select agent reported to CDC? | | | | | | | | | | | | | | | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | | | | | |  |
|  | Did a possible laboratory exposure occur? | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | If yes, was it reported to CDC? | | | | | | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | |  |
|  | Were specimens sent to CDC for testing? | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | | | Is the specimen still available? | | | | | | | | | | | | 🞎 Yes 🞎 No 🞎 Unknown | | | | | | |  |
|  |  | | | | | |  | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | |