



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 -

Patient's name: _____ Date submitted: ____/____/____ (mm/dd/yyyy)
 Address: _____ 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: <input type="text"/> <input type="text"/> <small>(24-25)</small>	2. County of residence: <input type="text"/> <small>(26-50)</small>	3. Zip code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>(51-59)</small>	4. Date of birth: ____/____/____ <small>(mm/dd/yyyy)</small> <small>(60-61) (62-63) (64-67)</small>	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
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8. Occupation at date of onset of illness (Check all that apply)
 wool or felt plant (71) animal research (76) live in household with person occupationally related to above? (80)
 tannery or rendering plant (72) slaughterhouse worker (77) laboratory worker (78) other (please specify) (81)
 dairy (73) veterinarian (74) medical research (75) rancher (79)

9. Any contact with animals within 2 months prior to onset? (check all that apply)
 Cattle (82) Goats (84) Cats (86)
 Sheep (83) Pigeons (85) Rabbits (87)
 Other (please specify) (88)

10. Any exposure to birthing animals? (89)
 Yes No Unk
 If yes, which animal _____

11. Exposure to unpasteurized milk? (90)
 Yes No 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)
 Yes No Unk

- 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)
 fever (>100.5) (102) malaise (105) headache (108) pneumonia (111) Other (please specify) (114)
 myalgia (103) rash (106) splenomegaly (109) hepatitis (112)
 retrobulbar pain (104) cough (107) hepatomegaly (110) endocarditis (113)

16. Any pre-existing medical conditions? (check all that apply)
 immunocompromised (115) valvular heart disease or vascular graft (117)
 pregnancy (116) Other (118)

17. Was patient hospitalized because of this illness? (119)
 Yes No Unk

18. Did patient die from complications of this illness? (120) (If yes, date) (mm/dd/yyyy)
 Yes No Unk ____/____/____
(121-22) (123-24) (125-28)

- 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	
	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>
	Titer or OD* Positive?	Titer or OD* Positive?	Titer or OD* Positive?	Titer or OD* Positive?
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)
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)
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)
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)

*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? Yes No (177)

22. Other Diagnostic Tests ?*		Positive?
PCR	<input type="checkbox"/> Yes <input type="checkbox"/> No (178)	
Immunostain	<input type="checkbox"/> Yes <input type="checkbox"/> No (179)	
Culture	<input type="checkbox"/> Yes <input type="checkbox"/> No (180)	

* Check only if specific assay was performed.

Sample(s) tested:

- FINAL DIAGNOSIS -

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

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).



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333

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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: <input type="text"/> <input type="text"/> (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) 6 <input type="checkbox"/> animal research (76) 10 <input type="checkbox"/> live in household with person occupationally related to above? (80) 2 <input type="checkbox"/> tannery or rendering plant (72) 7 <input type="checkbox"/> slaughterhouse worker (77) 3 <input type="checkbox"/> dairy (73) 8 <input type="checkbox"/> laboratory worker (78) 88 <input type="checkbox"/> other (please specify) (81) 4 <input type="checkbox"/> veterinarian (74) 9 <input type="checkbox"/> rancher (79) 5 <input type="checkbox"/> medical research (75)	9. Any contact with animals within 2 months prior to onset? (check all that apply) 1 <input type="checkbox"/> Cattle (82) 3 <input type="checkbox"/> Goats (84) 5 <input type="checkbox"/> Cats (86) 2 <input type="checkbox"/> Sheep (83) 4 <input type="checkbox"/> Pigeons (85) 6 <input type="checkbox"/> Rabbits (87) 8 <input type="checkbox"/> Other (please specify) (88)
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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 <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
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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) 4 <input type="checkbox"/> malaise (105) 7 <input type="checkbox"/> headache (108) 10 <input type="checkbox"/> pneumonia (111) 88 <input type="checkbox"/> Other (please specify) (114) 2 <input type="checkbox"/> myalgia (103) 5 <input type="checkbox"/> rash (106) 8 <input type="checkbox"/> splenomegaly (109) 11 <input type="checkbox"/> hepatitis (112) 3 <input type="checkbox"/> retrobulbar pain (104) 6 <input type="checkbox"/> cough (107) 9 <input type="checkbox"/> hepatomegaly (110) 12 <input type="checkbox"/> endocarditis (113)
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16. Any pre-existing medical conditions? (check all that apply) 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)	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 (121-22) (123-24) (125-28)
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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	Titer or OD* Positive? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (137)	Titer or OD* Positive? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (149)	Titer or OD* Positive? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (161)	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)	* Check only if specific assay was performed. 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 Yes 2 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)



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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)			9. Any contact with animals within 2 months prior to onset? (check all that apply)		
1 <input type="checkbox"/> wool or felt plant (71)	6 <input type="checkbox"/> animal research (76)	10 <input type="checkbox"/> live in household with person occupationally related to above? (80)	1 <input type="checkbox"/> Cattle (82)	3 <input type="checkbox"/> Goats (84)	5 <input type="checkbox"/> Cats (86)
2 <input type="checkbox"/> tannery or rendering plant (72)	7 <input type="checkbox"/> slaughterhouse worker (77)	8 <input type="checkbox"/> other (please specify) (81)	2 <input type="checkbox"/> Sheep (83)	4 <input type="checkbox"/> Pigeons (85)	6 <input type="checkbox"/> Rabbits (87)
3 <input type="checkbox"/> dairy (73)	8 <input type="checkbox"/> laboratory worker (78)		8 <input type="checkbox"/> Other (please specify) (88)		
4 <input type="checkbox"/> veterinarian (74)	9 <input type="checkbox"/> rancher (79)				
5 <input type="checkbox"/> medical research (75)					

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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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)
	1 <input type="checkbox"/> fever (>100.5) (102) 4 <input type="checkbox"/> malaise (105) 7 <input type="checkbox"/> headache (108) 10 <input type="checkbox"/> pneumonia (111) 8 <input type="checkbox"/> Other (please specify) (114)
	2 <input type="checkbox"/> myalgia (103) 5 <input type="checkbox"/> rash (106) 8 <input type="checkbox"/> splenomegaly (109) 11 <input type="checkbox"/> hepatitis (112)
	3 <input type="checkbox"/> retrobulbar pain (104) 6 <input type="checkbox"/> cough (107) 9 <input type="checkbox"/> hepatomegaly (110) 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)	18. Did patient die from complications of this illness? (120) (If yes, date) (mm/dd/yyyy)
1 <input type="checkbox"/> immunocompromised (115) 3 <input type="checkbox"/> valvular heart disease or vascular graft (117)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
2 <input type="checkbox"/> pregnancy (116) 8 <input type="checkbox"/> Other _____ (118)		____/____/____ (121-22) (123-24) (125-28)

- 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) <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>			Titer or OD* Positive?
IFA - IgG	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (137)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (149)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (161)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (173)	PCR	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (178)	
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)	Immunostain	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (179)	
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)	Culture	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (180)	
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)	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.

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Name: _____ Title: _____ Date: ____/____/____ (mm/dd/yyyy)

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