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:

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

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. 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. 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.

Case Name _____ **Phone** _____ **Medical Chart No.** _____

Address _____ **State, ZIP** _____ **Hospital Name** _____

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
☐	☐	☐	Fever	__/__/____
			Max temp:_____ (circle) °F or °C	
☐	☐	☐	Night sweats	__/__/____
☐	☐	☐	Arthralgia	__/__/____
☐	☐	☐	Headache	__/__/____
☐	☐	☐	Fatigue	__/__/____

Yes	No	Unk	Symptom/Sign	Date Diagnosis
☐	☐	☐	Anorexia	__/__/____
☐	☐	☐	Myalgia	__/__/____
☐	☐	☐	Weight loss	__/__/____
☐	☐	☐	Endocarditis	__/__/____
☐	☐	☐	Orchitis	__/__/____
☐	☐	☐	Epididymitis	__/__/____

Yes	No	Unk	Signs	Date of Diagnosis
☐	☐	☐	Hepatomegaly	__/__/____
☐	☐	☐	Splenomegaly	__/__/____
☐	☐	☐	Arthritis	__/__/____
☐	☐	☐	Meningitis	__/__/____
☐	☐	☐	Spondylitis	__/__/____
☐	☐	☐	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

Type of contact	Cattle	Pig	Goat	Sheep	Dog	Deer	Bison	Elk	Other
Birthing/animal products	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Skinning/slaughter	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Hunting	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Other:_____	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

Who owns the animal(s)?

Case	Private	Wild	Commercial	Unknown
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐

Consume unpasteurized dairy or undercooked meat? ☐ Yes ☐ No ☐ Unknown

Type of food product	Cattle	Pig	Goat	Sheep	Dog	Deer	Bison	Elk	Other
Milk	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Fresh/soft cheese	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Undercooked meat	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

In what country was the product acquired?

U.S.	Other	Other
☐	☐ _____	☐ _____
☐	☐ _____	☐ _____
☐	☐ _____	☐ _____
☐	☐ _____	☐ _____

Have a link to a confirmed case? ☐ Yes ☐ No ☐ Unknown

Know of similar illness in contact? ☐ Yes ☐ No ☐ Unknown

Who? ☐ Household ☐ Neighbor ☐ Coworker ☐ Other:_____

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*:_____

-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).

- 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