

CANINE LEPTOSPIROSIS SURVEILLANCE

CASE QUESTIONNAIRE

Study Case ID:

Place pre-printed label here

Clinic/Shelter ID:

Date: ____ / ____ / ____ (MM, DD, YY)

Clinic / Shelter Name: _____ Facility type: Clinic Shelter Vet / Staff Name: _____

Section 1. General Information

Owner Information

Does the dog have an owner? Yes No (stray) Unknown

If yes, Last Name: _____ First Name: _____

Address of owner or stray pick-up location:

Street Address (or major intersection): _____

City: _____ Municipality: _____ Zip Code: _____

Signalment

Dog's Name: _____ Age: ____ Yr Mo Sex: Male Female Spayed/Neutered? Yes No

Breed: Mix Purebred Breed (if known): _____ Weight: _____ lbs kg

Section 2. Risk Factors and Exposures

Check all that apply (unless otherwise indicated):

Is the dog a: Pet Neighborhood dog Watchdog Hunting dog Herding dog Other: _____

Where does the dog spend his/her time (pick one)?

Mostly indoors Mostly outdoors 50% indoors / 50% outdoors Always outdoors

When outdoors, in what area does the dog spend time (pick one)?

Fenced yard Allowed to roam Both areas

Does the dog drink water from:

Inside house Outside house Puddles Lake/pond River/stream Other: _____

Does the dog eat food: Inside house Outside house Other: _____

Does the dog sleep: Inside house Outside house Other: _____

Does the dog have contact with:

Owned dogs Stray dogs Rodents Livestock: _____ Wildlife: _____ Other: _____

In the last 30 days, has the dog swum in: River/stream Lake/pond Puddle

In the last 30 days, has the dog traveled outside of the city of residence?

Yes, where? _____ No Unknown

In the last 30 days, has the dog had contact with a sick dog diagnosed with leptospirosis? Yes No Unknown

Have rodents or evidence of rodents (feces, eaten food stores, holes) been seen in the house? Yes No Unknown

Have rodents or evidence of rodents been seen in other areas where the dog lives/goes?

Yes, where? _____ No Unknown

Has the dog had a previous diagnosis of leptospirosis? Yes, date: ____ / ____ / ____ (MM, DD, YY) No Unknown

Has the dog been vaccinated against leptospirosis? Yes No Unknown

If yes, , Date of vaccination: ____ / ____ / ____ (MM, DD, YY) Vaccine Name: _____

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Section 3. Clinical and Laboratory Information

Signs and Symptoms

Date: _____
 Wh Date: ____/____/____
 Pro Negative
 Positive

Perform test #2 if the first lepto rapid test was negative and blood was collected ≤7 days after symptom onset.

Lepto Rapid Test 2:

Date: ____/____/____
 Negative
 Positive

Conjunctivitis/red eyes

Icterus/yellow skin or eyes yes NO UNK

Other lab tests done:

- Hematology
 Biochemistry
 Urinalysis

PLEASE ATTACH A COPY OF THE LAB REPORT

Specimens collected:

Date: ____/____/____

- Serum
 Blood
 Urine - cystocentesis
 Urine - free catch
 Kidney tissue

IDEXX Lepto snap:

- Pos Neg N/A

Lab Values:

| | | | | |
|---------------------------------------|-------------------------------|-------------------------------|------------------------------|-----|
| Creatinine: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| BUN: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| ALT: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| AST: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| ALP: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| Bilirubin: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| Albumin: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| CPK: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| K: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| HCT = _____% | | | | Ink |
| Platelet: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| WBC: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | Ink |
| Neutrophil: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | No |
| Lymphocyte: | <input type="checkbox"/> Norm | <input type="checkbox"/> High | <input type="checkbox"/> Low | No |
| Urine specific gravity = _____ | | | | No |

Outcome

Was the dog hospitalized? Yes, # of days: _____ No

Outcome: Discharged Died Unknown

If died, was it due to: Euthanasia Unassisted/natural death

Were antibiotics prescribed? Yes No

If yes, no. of days prescribed: _____ ; Name of antibiotic(s): _____

Send a copy of this form by fax to 404-471-8642 OR by email to study coordinators OR with monthly shipments to CDC. Thank you!

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Form Approved
OMB No. 0920-xxxx
Expires xx/xx/xxxx

Public reporting burden of this collection of information is estimated to average 15 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-xxxx).