CANINE LEPTOSPIROSIS SURVEILLANCE CASE QUESTIONNAIRE

Form Approved OMB No. 0920-1170 Expires 03/31/2019

Place pre-printed label here

Study Case ID:

Clinic/Shelter Patient Record ID:

Date: / (MM, DD, YY)				
Clinic / Shelter Name: Fa	cility type:			
et / 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:				
<u>Signalment</u>				
Dog's Name: Age:	Spayed/Neut	ered? 🗆	Yes 🗌 No	
Breed: 🗆 Mix 🗆 Purebred Breed (if known):	Weight:	[] lbs 🗆 kg	
Section 2. Risk Factors and Exposures				
Check all that apply (unless otherwise indicated):				
 Where does the dog spend his/her time (pick one)? Mostly indoors	ways outdoor:	5		
\Box Inside house \Box Outside house \Box Puddles \Box Lake/pond \Box River/stream	\Box 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: Wildlife: Wildlife: Nithe last 30 days, has the dog swum in: River/stream Lake/pond Pude In the last 30 days, has the dog traveled outside of the city of residence?		Other:		
\Box Yes, where? \Box No \Box Unknown				
In the last 30 days, has the dog had contact with a sick dog diagnosed with leptospirosis?		□ No	Unknown	
Have rodents or evidence of rodents (feces, eaten food stores, holes) been seen in the ho		🗆 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:/ (I			🗆 Unknown	
Has the dog been vaccinated against leptospirosis? \Box Yes \Box No \Box Unknow				
If yes, , Date of vaccination: / / (MM, DD, YY) Vaccine Name:				

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 (0920-1170).

CANINE LEPTOSPIROSIS SURVEILLANCE

Signs and Sumptom Outer of symptom onset:	Section 3. Clinical and Laboratory Information										
Date Symptom disc:	Signs and Symptoms			Laboratory Results							
What clinical signs have occurred since symptom onset? Protive and signs have occurred since symptom onset? Date:/ Dote Date:/ Dote Date:/ Date:/ Date:/ Dote Dote	Date of symptom onset:	/ /	(MM. I	D. YY))		Specimens collected:				
Provide one response for each line. No No No Biod Fever Yes, Temp: C No Unk Lethargy/weakness Yes No Unk Inappetence/anorexia Yes No Unk Diarrhea Yes No Unk Abdominal pain Yes No Unk Conjunctivitis/red eyes Yes No Unk Keterus/yellow skin or eyes Yes No Unk Oliguria/anuria Yes No Unk Oliguria/anuria Yes No Unk Abdorninal pain Yes No Unk Conjunctivitis/red eyes Yes No Unk Muscle/Joint tenderness Yes No Unk Other Lab Tests Done: Zoetis WTRNESS lepto: Positive Cough Yes No Unk Attach acopy of the lab report OR fill in lab values below: Creatinine: Norm Oliguria/anuria Yes No Unk Altered mentation Yes No Unk <td></td> <td></td> <td></td> <td></td> <td colspan="2">Lepto Rapid Test 1: Date</td> <td>Date:</td> <td colspan="2">ate://</td>					Lepto Rapid Test 1: Date		Date:	ate://			
Fever Yes, Temp: C No Unk Positive Urine - rystocentesis Lethargy/weakness Yes No Unk Perform test #2 if the first report test #3 report 10 report #3 report 10 report #3 report 10 reportes 10 reportes 10 report 10 report 10 reportes 10 report 10 repor	•		iptom on	sel:			🗆 Serum				
Lethargy/weakness Yes No Ukh Perform test #2 if the first leto rapid test was negative and blood was collected <7 days after symptom onset.	Fever 🗌 Yes, Temp:	°C	🗆 No	🗆 Unk	-						
Inappetence/anorexia Yes No Ukh Iepto rapid test was negative Kidney tissue Nomiting Yes No Ukh Iepto rapid test was negative Kidney tissue Diarrhea Yes No Ukh Iepto Rapid Test 2: DEX lepto snap:			🗆 No	🗆 Unk	Perform test #2 if	the first					
Vomiting \Yes \No \Unk days after symptom onset. If other lepto tests were done, please record results: Diarrhea \Yes \No \Unk Date:				🗆 Unk							
Diarrhea \Yes \No \Urk Abdominal pain \Yes \No \Urk Abdominal pain \Yes \No \Urk Muscle/joint tenderness \Yes \No \Urk Conjunctivitis/red eyes \Yes \No \Urk Cough \Yes \No \Urk Tachypnea/dyspnea \Yes \No \Urk Polyuria/polydipisia \Yes \No \Urk Polyuria/polydipisia \Yes \No \Urk Attach a copy of the lab report OR fill in lab values below: Creatinine: \Norm Polyuria/polydipisia \Yes \No \Urk Atter a copy of the lab report OR fill in lab values below: Creatinine: \Norm Veritis \Yes \No \Urk Atter a copy of the lab report OR fill in lab values below: Atter a copy of the lab report OR fill in lab values below: Creatinine: \Norm \High \Low Atter a copy of the lab report OR fill in lab values below: Atter a copy of the lab report OR fill in lab values below: Uveritis \No \No \Urk <td></td> <td></td> <td></td> <td></td> <td colspan="2"></td> <td colspan="2">If other lento tests were</td>							If other lento tests were				
Abdominal pain \\Pers \Pers \Pers <td>-</td> <td></td> <td></td> <td></td> <td>Lepto Rapid Test 2</td> <td>2:</td> <td colspan="2"></td>	-				Lepto Rapid Test 2	2:					
Muscle/joint tenderness Yes No Unk Conjunctivitis/red eyes Yes No Unk Icterus/yellow skin or eyes Yes No Unk Cough Yes No Unk Tachypnea/dyspnea Yes No Unk Oliguria/anuria Yes No Unk Polynia/polydipsia Yes No Unk Real failure/leved enzymes Yes No Unk Attered mentation Yes No Unk Other signs/symptoms Yes, No Unk Other signs/symptoms Yes, # of days No Unknown If died, was it due to: Euthanasia Unsknown If died, was it due to:						Date://					
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If yes, # of days prescribed:; Name of antibiotic(s):	If died, was it due to:	🗆 Euthana	asia 🗆	Unassisted	d/natural death						
	Were antibiotics prescribed? \Box Yes \Box No										
Send a conv of this form by fax to 404-471-8642 OP by email to ygn3@cdc gov OP with monthly chinmonts to CDC	If yes, # of days prescribed:; Name of antibiotic(s):										
Send a copy of this form by fax to 404 47 1-0042 OK by email to ygns@cdc.gov OK with monthly snipments to CDC.											

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