

## **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 or <a href="https://www.background.com">bspb@cdc.gov</a>.

Send the completed form with all personal identifiers removed to CDC either by:

Email: <u>bspb@cdc.gov</u>

Fax: (404) 929-1590

DCIPHER: contact <u>bspb@cdc.gov</u> for more information

**NOTE:** All Sections: record date as MM/DD/YYYY

Reporting Information	Description
Date of Notification	Date case was first reported to jurisdiction.
Reporting Jurisdiction	State, territory, or jurisdiction reporting to CDC.
State Case ID	Unique identifier given by the state health department.
NNDSS Case ID	If different from State Case ID, provide the Case Identifier transmitted in NNDSS.
Reporter Name, Phone number, and Email	Contact information for person reporting the case to CDC.
Demographic Information	Description
Sex	Genetic sex of patient.
Pregnant	Pregnancy status at onset of current illness.
Date of Birth	Patient's date of birth, if known.
Age	Age of patient at time of diagnosis.
Residence	State, territory, county and zip code of residence.
Country of Birth	Indicate country of birth, if not U.S. If unknown, please enter "Unknown."
Occupation	List the patient's current occupation.
Race and Ethnicity	Race and ethnicity 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 or ethnicity is unknown, please check "Unknown."
Clinical Information	Description
Illness onset	Date of the beginning of this illness or date of the onset of symptoms of this illness as reported to the public health system.
Clinical Manifestations	Select patient-described symptoms or clinician-identified conditions associated with illness.
Treatment and Outcome	Description
Antibiotics	Indicate if the patient received antibiotics for this illness.
Treatment	Select all antibiotics the patient was prescribed, list the start date for each and the number of days the antibiotic was taken by the patient. If prescribed antibiotic is not listed, list the name of the medication, and start date.
Treatment Completion	Indicate if the patient completed prescribed antibiotic treatment for this illness.
Hospitalization	Indicate whether the patient was admitted to a hospital for this illness. Enter admission and discharge dates, if applicable.
Death	Indicate if the patient died from this illness. If yes, list the date of death.

Risk Factors	Description
Travel	Select whether the patient traveled out of state or country in the 6 months prior to illness onset, and where and when if applicable.
Animal Contact	Indicate if the patient had animal contact in the 6 months prior to illness onset. If yes, select the type of animals, type of contact, type of animal ownership and location of exposure.
Dairy and Meat Products	Indicate if the patient consumed unpasteurized dairy products or undercooked meats in the 6 months prior to illness onset. If yes, select the food product consumed, type of animal the food came from and the country the food was produced.
Epi-Linked	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 <i>Brucella</i> , indicate the location of exposure. Also indicate the assessed risk status of the exposure. Finally, if exposed to a <i>Brucella</i> vaccine, indicate to which vaccine the case was exposed.
Post-Exposure Prophylaxis	If the patient was exposed to <i>Brucella</i> , indicate if the patient received PEP, reasons for not taking PEP and medication taken.
Completed PEP	If exposed, indicate if the patient completed the entire course of PEP as prescribed.
Case Classification	Indicate the patient's case classification based on the brucellosis case definition. Confirmed and Probable brucellosis cases must be reported to CDC following the notification criteria outlined in the CSTE position statement (24-ID-03).

<b>Test &amp; Specimen Information</b> (Please complete a new test section for each laboratory test performed)	Description
Test Type	Indicate the laboratory test performed.
Performing Laboratory	Indicate the laboratory that performed the test.
Specimen Type	Identify the type of specimen collected for testing, and date specimen collected.
Specimen Collection Date	Indicate the date the specimen was collected (mm/dd/yyyy).
Result	Indicate any quantitative, qualitative or other results acquired from the test above. If determined by the test, report what organism was identified in the sample and the date of the result.
Specimen Culture	Indicate if the specimen for culture was collected prior to administration of antibiotic therapy.
Specimens to CDC	Indicate if the specimen was sent to CDC for testing.
Laboratory Exposures	Select if laboratory workers were possibly exposed during specimen processing. The CDC exposure guidelines are available at <u>https://www.cdc.gov/brucellosis/media/pdfs/brucellosis-risk-assessment-chart.pdf?CDC AAref Val=https://www.cdc.gov/ brucellosis/laboratories/risk-level.html</u> . If a laboratory exposure did occur, review these assessment, monitoring, and prophylaxis recommendations. For assistance, please contact the Bacterial Special Pathogens Branch (404-639-1711, <u>bspb@cdc.gov</u> ).



## **BRUCELLOSIS CASE REPORTING FORM**

NOTE: Enter all dates as MM/DD/YYYY

Form Version Sept 2024

Date of Notification: Reporting Jurisdiction: State Case ID:   NDDSS Case ID: Reporter Name: Reporter Name:   Reporter Email: DEMOCRAPHIC INFORMATION   Sex: Male Female   Democraphic Information: DB:   Age: Years   Years Months   Days Country of Birth:   Reporter This Black or African American Native Hawalan or Pacific Estande:   Age: Non-Hispanic   Age: Unknown   Black or African American Native Hawalan or Pacific Estande:   Minie Difference   CILINICAL INFORMATION  Date of illness onset:   Select all clinical manifestations associated with this illness (select all that apply):   Fever Splenomegaly Workins   Other: Splenomegaly Other, specify:   Fever Splenomegaly Workins   Date of illness onset: Chere:   Select all clinical manifestations associated with this illness (select all that apply):   Fever Splenomegaly Workins   Other: Splenomegaly Dischis   Date of illness onset: County of this illness   Select all clinical manifestations associated Enclosentific   Did the patient receive antibiotics for this illness? Yes   No Unknown   Select all medications the patient received for treatment   Doxycycline Start Date:   Doxycycline Start Date:   Did the patient receive antibiotics received?   Yes Modication not started Medicat	REPORTING INFORMATION										
Reporter Email:       DEMOGRAPHIC INFORMATION         Sex:       Male       Fernale       DOB:	Date of Notification:	Reporting Jurisdiction: _	5	State Case ID:							
DEMOGRAPHIC INFORMATION         Sex:       Male       Female       DOB:	NNDSS Case ID:	_ Reporter Name:		Rep	orter Phone Number:						
Sex: Male Female DOB:	Reporter Email:										
Sex: Male Fenale DOB:	DEMOGRAPHIC INFORMATION										
Pregnant:       Yes       No       Unknown       RESIDENCE:       State:											
Country of Birth: Ethnicity: Hispanic Non-Hispanic Unknown     Race: American Indian/Alaskan Native Black or African American Native Hawaiian or Pacific Islander Other:	Sex: Male Female		DOB:	Age:	Years Months	Days					
Race: Asian Native Hawaian or Pacific Islander       Other: 	Pregnant: Yes No Unknown	RESIDENCE: State:	County:		Zip Coo	le:					
Araina     Black or African American Native Hawaiian or Pacific Islander Unknown     Other:       Occupation:	Country of Birth:		Ethnicity:	Hispanic Non-Hisp	anic Unknown						
Asian Native Hawaiian or Pacific Islander   White Unknown     Occupation: Other:    CLINICAL INFORMATION   Date of illness onset: Select all clinical manifestations associated with this illness (select all that apply):   Fever Splenomegaly   Orchitis/epididymitis Osteomyelitis   Arthraigia Meningitis   Hepatomegaly Orchitis/epididymitis   Myalgia Headaches   Splenotics Splenotics   Myalgia Headaches   Splenotics Spondylitis   Endocarditis Anorexia   Endocarditis Anorexia   Endocarditis Anorexia   Encephalitis Encephalitis   Endocarditis Anorexia   Encephalitis Encephalitis   Endocarditis Anorexia   Encephalitis Encephalitis   Encephalitis Encephalitis   Encephalitis Encephalitis   Encephalitis Encephalitis   Encephalitis Encephalitis   Start Date: Days:   Did the patient receive antibiotics for this illness? Yes   No Unknown   Other: Start Date: Days: Other: Other: Start Date: Did the patient complete the course of antibiotics received? Yes Medication not started No Unknown Discharge date: No Discharge date: No Discharge date: No Discharge date: No No No Discharge date: Discharge date: Discharge dat											
White         Unknown           Occupation:         Other:           Cocupation:         Other:           Cocupation:         Other:           Cocupation:         CLINICAL INFORMATION           Date of illness onset:         Select all clinical manifestations associated with this illness (select all that apply):           Fever         Splenomegaly         Orchitis/epid(dymitis)         Osteomyelitis           Arthralgia         Meningitis         Hepatomegaly         Other, specify:           Fatigue         Night sweats         Arthritis           Myalgia         Headaches         Spondylitis           Endocarditis         Anorexia         Encephaltitis           Epididymitis         Weight loss         Discitis           Did the patient receive antibiotics for this illness?         Yes         No         Unknown           Select all medications the patient received for treatment         Days:			0 1101								
CLINICAL INFORMATION         Date of illness onset:											
Date of illness onset:	Occupation:		Other:								
Date of illness onset:		CLIN	NICAL INFORMA	TION							
Select all clinical manifestations associated with this illness (select all that apply):   Fever Splenomegaly   Fever Splenomegaly   Arthralgia Meningitis   Hepatomegaly Otchitis/epididymitis   Myalgia Headaches   Spondylitis Anorexia   Endocarditis Anorexia   Epididymitis Oseomyelitis   Endocarditis Anorexia   Endocarditis Anorexia   Epididymitis Oseomyelitis   Epididymitis Discitis <b>TREATURENT AND OUTCOME Stere this illness?</b> Yes Medication not started Mo Ves Medication not started Mo Ves No <p< td=""><td></td><td></td><td></td><td></td><td></td><td></td></p<>											
Fever Splenomegaly Orchitis/epididymitis Osteomyelitis   Arthralgia Meningitis Hepatomegaly Other, specify:   Fatigue Night sweats Arthritis   Myalgia Headaches Spondylitis   Endocarditis Anorexia Encephalitis   Epididymitis Weight loss Discitis     Discitis   Did the patient receive antibiotics for this illness? Yes   No Unknown        Select all medications the patient received for treatment   Select all medications the patient received for treatment   Select all medications the patient received for treatment   Start Date: Days:   Other: Start Date:   Days: Other:   Streptomycin Start Date:   Did the patient complete to course of antibiotics received?   Yes   Medication not started   Medication not started   Medication not started   Medication not started   No   Unknown      If yes, admission date: If yes, admission date: Discharge date: Discharge date: No			. <i></i>								
Arthralgia Meningitis Hepatomegaly Other, specify:   Fatigue Night sweats Arthritis   Myalgia Headaches Spondylitis   Endocarditis Anorexia Encephalitis   Epididymitis Weight loss Discitis											
Fatigue       Night sweats       Arthritis         Myalgia       Headaches       Spondylitis         Endocarditis       Anorexia       Encephalitis         Epididymitis       Weight loss       Discritis         TREATMENT AND OUTCOME         Did the patient receive antibiotics for this illness?       Yes         Did the patient receive antibiotics for this illness?       Yes       No       Unknown         Start Date:       Days:       Other:       Start Date:       Days:         Bid the patient complete the course of antibiotics received?       Yes       Was the patient hospitalized for this illness?       Yes       If yes, admission date:       No       Unknown       Discharge date:       If yes, No       If yes, No       If yes, No       If yes, No       If yes       No <td< td=""><td>•</td><td></td><td></td><td></td><td></td><td></td></td<>	•										
Myalgia Headaches Spondylitis   Endocarditis Anorexia Encephalitis   Epididymitis Weight loss Discitis <b>Did the patient receive antibiotics for this illness?</b> Yes  No <b>Did the patient receive antibiotics for this illness?</b> Yes <b>No Did the patient receive antibiotics for this illness?</b> Yes <b>No Did the patient at Date: Days: Did the patient complete the course of antibiotics received? Yes Medication partially completed Did the patient die from this illness? Yes No Did the patient die from this illness? Yes No No Did the patient die from this illness? Yes No No Did the patient die from this illness? Yes No No Did the patient die from this illness? Yes No No Did the patient die from this illness? Yes No No</b>	0	U U									
Epididymitis Weight loss Discitis   TREATMENT AND OUTCOME   Did the patient receive ant ib is illness? Yes No Unknown   Start Date: Days:   Other: Start Date: Days: Other: Start Date: Days:   Doxycycline Start Date: Days: Other: Start Date: Days:   Bif ampin Start Date: Days: Other: Start Date: Days:   Streptomycin Start Date: Days: Other: Start Date: Days:   Did the patient complete to course of antibiotics received? Was the patient hospitalized for this illness? If yes, admission date:   Yes No Unknown If yes, admission date: Discharge date:   Did the patient die from this illness? Yes No Discharge date:   Yes No No No   No No No No   Did the patient die from this illness? Yes No   Yes No No   No No No   Did the patient die from this illness? Yes   Yes No   Yes No   No			Spondylitis								
TREATMENT AND OUTCOME         Did the patient receive antibiotics for this illness?       Yes       No       Unknown         Select all medications the patient received for treatment	Endocarditis And	prexia	Encephalitis								
Did the patient receive antibiotics for this illness? Yes No Unknown   Select all medications the patient received for treatment   Doxycycline Start Date: Days: Other: Start Date: Days:   Rifampin Start Date: Days: Other: Start Date: Days:   Streptomycin Start Date: Days: Unknown Start Date: Days:   Did the patient complete the course of antibiotics received? Was the patient hospitalized for this illness? Yes   Medication not started No Unknown Discharge date:   Ves No Unknown Discharge date:	Epididymitis We	ight loss	Discitis								
Select all medications the patient received for treatment         Doxycycline       Start Date:       Days:       Other:       Start Date:       Days:         Rifampin       Start Date:       Days:       Other:       Start Date:       Days:         Streptomycin       Start Date:       Days:       Unknown       Start Date:       Days:         Did the patient complete the course of antibiotics received?       Was the patient hospitalized for this illness?       If yes, admission date:		TREAT	MENT AND OU	ТСОМЕ							
Doxycycline Start Date: Days: Cother: Start Date: Days:   Rifampin Start Date: Days: Other: Start Date: Days:   Streptomycin Start Date: Days: Unknown Unknown      Did the patient complete the course of antibiotics received? Was the patient hospitalized for this illness? Yes   Yes Yes Yes If yes, admission date: If yes, admission date:   No Unknown Unknown Discharge date: If yes, admission date:	Did the patient receive antibiotics for t	this illness? Yes	No U	nknown							
Rifampin Start Date: Days: Other: Start Date: Days: Days:   Streptomycin Start Date: Days: Unknown Unknown     Did the patient complete the course of antibiotics received? Was the patient hospitalized for this illness? Yes   Yes Yes If yes, admission date: No   Medication partially completed Unknown Discharge date: Discharge date:   Did the patient die from this illness?   Yes Yes No   No No No	Select all medications the patient rece	eived for treatment									
Streptomycin Start Date: Days: Unknown     Did the patient complete the course of antibiotics received?   Yes Yes   Medication not started Ves   Medication partially completed Unknown   Did the patient die from this illness?   Yes Yes   No No   Unknown Discharge date:   The patient die from this illness?   Yes Yes   No No	Doxycycline Start Date	e: Days:	Other:		Start Date:	_ Days:					
Did the patient complete the course of antibiotics received?       Was the patient hospitalized for this illness?         Yes       Yes         Medication not started       No         Medication partially completed       Unknown         Did the patient die from this illness?       Yes         Yes       Yes         No       No         Did the patient die from this illness?       Yes         Yes       Yes         No       Yes         No       Yes         Yes       Yes         No       Yes         Yes       Yes         No       Yes         No       Yes         No       Yes         No       Yes         No       Yes         No       Yes         Yes       Yes         No       Yes         Yes       Yes	Rifampin Start Date	e: Days:	Other:		Start Date:	Days:					
Yes     Yes     If yes, admission date:       Medication not started     No     Discharge date:       Medication partially completed     Unknown     Discharge date:       Did the patient die from this illness?     Yes     No       Yes     No     Ves	Streptomycin Start Date	e: Days:	Unknown								
Medication not started     No       Medication partially completed     Unknown       Did the patient die from this illness?       Yes       No	Did the patient complete the course o	f antibiotics received?	Was the patient h	ospitalized for this illness?							
Medication not started     No       Medication partially completed     Unknown       Did the patient die from this illness?       Yes       No	Yes		Yes		If yes, admission date						
Unknown Did the patient die from this illness? Yes No				-							
Yes No			UNKNOWN		Discharge date:						
Yes No	Did the patient die from this illness?										
No											
Unknown If yes, date of death:	No										
	Unknown	If yes, date of death: _									

					RISK	FACTO	DRS			
Did the patient travel in the 6	months p	orior to il	Iness on	set?	Y	⁄es	No	Ur	nknown	
If Yes,										
U.S. State:			or Count	ry:					Dates of Travel: to	
U.S. State:			or Count	ry:					Dates of Travel: to	
U.S. State:			or Count	ry:					Dates of Travel: to	
In the 6 months prior to illness	s onset. c	did the p	atient ha	ve conta	ct with a	nv anima	als or th	eir bodv f	luids? Yes No Unk	nown
Indicate type of animals and		-				-		-		
						-			Other Animal, Specify:	
Contact Type			Cattle	Deer	Dog	Goat	Pig	Sheep		Unknown Animal
Birthing Products										
Skinning/Slaughter										
Hunting										
Other, Specify:				1						
Animal Ownership										
									Other Animal, Specify:	
Ownership			Cattle	Deer	Dog	Goat	Pig	Sheep		Unknown Animal
Domestic/Commercial										
Wild										
Unknown										
Location of Exposure						•				
_									Other Animal, Specify:	
Location			Cattle	Deer	Dog	Goat	Pig	Sheep		Unknown Animal
Domestic (U.S.)										
International										
Unknown										
In the 6 months prior to illness	s onset, c	did the p	atient co	nsume u	npasteur	ized dai	ry prod	ucts or un	dercooked meat?	I
Yes No Ur	nknown									
Indicate type of unpasteurize	ed dairy o	or under	cooked I							
				Oth	er Anima	al, Speci	iy:	Unknov		
Food product consumed	Cattle	Goat	Sheep					Anima	al product produced?	
Milk										
Fresh/soft cheese										
Undercooked meat										
Unknown										
Other:										
Is the case epi-linked to a lab	oratory-c	onfirme	d case?		Yes	No		Unknow	n	
How is the patient related to t		case?								
Coworker Neig Household Othe	hbor er	I	Unknown	S	pecify ot	her:				

Does the pati	ent know of a c	ontact with a similar illne	ess?	Yes	No	Unknov	wn		
How is the pa	tient related to	the contact with similar	illness?						
Coworke Househo		ghbor Unknov er	vn	Specify ot	her:				
Did the patier	nt have a known	exposure to Brucella?			If exposed	I to <i>Bruce</i>	lla animal vaccine	, indicate which one.	
Body Flui Clinical s	ds or Tissue becimen	Isolate No Vaccine Ur	o 1known		S19 RB51		REV1 Other vaccine type	Unknown	
Where did the	e known exposu	re occur?							
Clinical se Farm/Rar	0	Laboratory Ur Surgery	nknown	Other: _					
Was the exposure classified as high or low risk?					Low	Unknov	wn		
	nt receive post- name of medic	exposure prophylaxis? eations:		Yes	No	Unknov	vn		
If the nationt	did not receive								
	of exposure		ıknown	Other: _					
Case Status:	Confirmed	Probable	Suspe	ect	Not a Case	ι	Jnknown		
Please list an	y additional exp	osure information not ca	aptured abov	ve:					
	TEST AND	SPECIMEN INFOR	MATION	- Plazsa c	omplete a n		tion for each t	est performed	
1st Test & S		SI ECIMENTIAL ON	MATION	r rease e	ompiete a n	1010 300		csi performed	
	-								
Test Type 1:	lotal Antii IgG (agglu	oody (agglutination) Itination)	IgM ELISA PCR	A or EIA	Other: Unknown				
	IgG ELISA		Culture						
Performing Lab:	CDC Commerc	ial Laboratory	State Pub Other	lic Health La	boratory	-	nknown ther LRN		
Specimen	Whole Blo	ood Serum	n C	Other	Specify oth	her:			
Туре:	Cerebros	binal Fluid Isolate	e l	Jnknown	Date of col	llection: _			
Qualitative Result:	Positive	Negative	Bord	erline	Indetermina	ate			
Quantitative	Acute titers	Convalescent tite	r	Other:				Unknown	
Results	:	::		:					
							C	ut off value:	
	·	:	_	•					
Organism Name:	B. abortu B. meliter			ther: nknown					
Lab Result De	ate:								
		collected prior to antim	icrobial ther	apv?		Yes	No U	Inknown	
vvas specime	n(s) sent to CD0	<i>;</i> :				Yes		Inknown	
Did a possible	e laboratory exp	osure occur in the labor	atory perfor	ming the tes	st?	Yes	No U	Inknown	

2nd Test & S	specimen						
Test Type 2:	Total Antibody IgG (agglutinati IgG ELISA or E	ion)	lgM ELISA or EIA PCR Culture	Other: Unknown			-
Performing Lab:	CDC Commercial La	boratory	State Public Health La Other	boratory	Unknown Other LRN		
Specimen Type:	Whole Blood Cerebrospinal F	Serum Fluid Isolate		Specify other: _			-
Qualitative Result:	Positive	Negative	Borderline	Indeterminate			
Quantitative Results		Convalescent titer::	;				
Organism Name:	B. abortus B. melitensis	B. suis Brucella sp	Other:				
•	men for culture colle n(s) sent to CDC?	ected prior to antimi	crobial therapy?	Yes		Unknown Unknown	
Was specimer	n(s) sent to CDC?		crobial therapy?	Yes	No		
Was specimer Did a possible 3rd Test & S	n(s) sent to CDC?	e occur in the labora		Yes st? Yes	No No	Unknown	
Was specimer Did a possible 3rd Test & S	n(s) sent to CDC? a laboratory exposur pecimen	e occur in the labora (agglutination)	tory performing the te	Yes st? Yes	No No	Unknown Unknown	-
Was specimer Did a possible	n(s) sent to CDC? a laboratory exposure pecimen Total Antibody IgG (agglutinati	e occur in the labora (agglutination) ion) IA	IgM ELISA or EIA	Yes St? Yes Other: Unknown	No No	Unknown Unknown	-
Was specimer Did a possible 3rd Test & S Test Type 3: Performing	n(s) sent to CDC? e laboratory exposure pecimen Total Antibody IgG (agglutinati IgG ELISA or E CDC	e occur in the labora (agglutination) ion) IA boratory Serum	IgM ELISA or EIA PCR Culture State Public Health La Other	Yes St? Yes Other: Unknown boratory	No No Unknown Other LRN	Unknown	
Was specimer Did a possible <b>3rd Test &amp; S</b> Test Type 3: Performing Lab: Specimen	n(s) sent to CDC? e laboratory exposure pecimen Total Antibody IgG (agglutinati IgG ELISA or E CDC Commercial La Whole Blood	e occur in the labora (agglutination) ion) IA boratory Serum	IgM ELISA or EIA PCR Culture State Public Health La Other	Yes St? Yes Other: Unknown boratory Specify other:	No No Unknown Other LRN	Unknown	-
Was specimer Did a possible 3rd Test & S Test Type 3: Performing Lab: Specimen Type: Qualitative Result:	n(s) sent to CDC? e laboratory exposure pecimen Total Antibody I IgG (agglutinati IgG ELISA or E CDC Commercial La Whole Blood Cerebrospinal F	e occur in the labora (agglutination) ion) IA Iboratory Fluid Isolate	IgM ELISA or EIA PCR Culture State Public Health La Other Unknown Borderline	Yes St? Yes Other: Unknown boratory Specify other: Date of collection Indeterminate	No No Unknown Other LRN	Unknown Unknown	
Was specimer Did a possible <b>3rd Test &amp; S</b> Test Type 3: Performing Lab: Specimen Type: Qualitative Result: Quantitative	n(s) sent to CDC? e laboratory exposure pecimen Total Antibody ( IgG (agglutinati IgG ELISA or E) CDC Commercial La Whole Blood Cerebrospinal F Positive Acute titers	e occur in the labora (agglutination) ion) IA boratory Fluid Serum Isolate Negative Convalescent titer	IgM ELISA or EIA PCR Culture State Public Health La Other Other Borderline Cother:	Yes St? Yes Other: Unknown boratory Specify other: Date of collection Indeterminate	No No Unknown Other LRN	Unknown Unknown	
Was specimer Did a possible <b>3rd Test &amp; S</b> Test Type 3: Performing Lab: Specimen Type: Qualitative Result: Quantitative Results Organism Name:	n(s) sent to CDC? e laboratory exposure pecimen Total Antibody eligG (agglutinati IgG ELISA or EligG ELISA or EligG ELISA or EligG ELISA or EligG CDC Commercial La Whole Blood Cerebrospinal Figure Positive Acute titers : B. abortus B. melitensis	e occur in the labora (agglutination) ion) IA boratory Fluid Serum Fluid Isolate Negative Convalescent titer	IgM ELISA or EIA PCR Culture State Public Health La Other Unknown Borderline Other:	Yes St? Yes Other: Unknown boratory Specify other: Date of collection Indeterminate	No No Unknown Other LRN	Unknown Unknown	
Was specimer Did a possible <b>3rd Test &amp; S</b> Test Type 3: Performing Lab: Specimen Type: Qualitative Result: Quantitative Results Organism Name: Lab Result Da Was the speci	n(s) sent to CDC? e laboratory exposure pecimen Total Antibody eligG (agglutinati IgG ELISA or EligG ELISA or EligG ELISA or EligG ELISA or EligG CDC Commercial La Whole Blood Cerebrospinal Figure Positive Acute titers : B. abortus B. melitensis	e occur in the labora (agglutination) ion) IA boratory Fluid Isolate Negative Convalescent titer B. suis Brucella s	IgM ELISA or EIA PCR Culture State Public Health La Other Unknown Borderline Other:	Yes St? Yes Other: Unknown boratory Specify other: Date of collectio Indeterminate	No No Unknown Other LRN on:	Unknown Unknown	

4th Test & S	pecimen							
Test Type 4:	Total Antibody (agglutination) IgG (agglutination) IgG ELISA or EIA		IgM ELISA or EIA PCR Culture	Other: Unknown				
Performing Lab:	CDC Commercial Lab	poratory	State Public Health Laboratory Other		Unknow Other Lf			
Specimen Type:	Whole Blood Cerebrospinal F	Serum luid Isolate	Other Unknown	Specify other:				
Qualitative Result:	Positive	Negative	Borderline	Indeterminate				
Quantitative Results	Acute titers	Convalescent titer					Unknown	
	:	:	:				Cut off value:	
Organism Name:	B. abortus B. melitensis	B. suis Brucella spp	Other: . Unknown					
	ate: imen for culture colle	cted prior to antimic	robial therapy?	Y	′es	No	Unknown	
Was specime	n(s) sent to CDC?			Ŷ	′es	No	Unknown	
Did a possible	e laboratory exposure	occur in the laborat	ory performing the tes	t? Y	⁄es	No	Unknown	