Tickborne Rickettsial Disease Case Report

CDC#

Use for Spotted Fever Rickettsiosis (SFR) including Rocky Mountain spotted fever (RMSF), *Anaplasmosis*, and *Ehrlichiosis* case reporting. Visit https://ndc.services.cdc.gov/event-codes-other-surveillance-resources/ for complete case definitions or visit the disease website(s) for a fillable/downloadable PDF version of this case report form.

Patient Name: _____ **Date submitted (mm/dd/yyyy):** _____

Address: _____ **Healthcare provider's name:** _____

City: _____ **Local Patient ID.: (if reported)** _____ (Local ID) _____ (Site) _____ (State)

1. State of residence (postal abbrev.): _____

2. County of residence: _____

3. Sex:
1 ○ Male 2 ○ Female 9 ○ Undetermined

4. Patient age (years) at time of case investigation: _____

5. Race (check all that apply):
1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
4 ☐ Asian
5 ☐ Native Hawaiian or Other Pacific Islander
6 ☐ Other race
7 ☐ Unknown
8 ☐ Refused

6. Hispanic or Latino ethnicity:
1 ○ Yes
2 ○ No
9 ○ Unknown

7. In the two weeks before symptom onset or diagnosis (use earlier date), did the patient travel out of their county, state, or country of residence?
1 ○ Yes 2 ○ No 9 ○ Unknown

Destination (county, state, or country): _____ **When did they arrive? (mm/dd/yyyy)** _____ **When did they depart? (mm/dd/yyyy)** _____

8. In the two weeks before symptom onset or diagnosis (use earlier date), did the patient notice any tick bites?
1 ○ Yes 2 ○ No 9 ○ Unknown

If yes, date (mm/dd/yyyy): _____

If the patient removed a tick from their body, what was the geographic location at the time (county, state, or country)? _____

9. Clinical evidence of tickborne rickettsial disease:

Fever	1 ○ Yes	2 ○ No	9 ○ Unknown	Anemia	1 ○ Yes	2 ○ No	9 ○ Unknown
Chills/sweats	1 ○ Yes	2 ○ No	9 ○ Unknown	Thrombocytopenia	1 ○ Yes	2 ○ No	9 ○ Unknown
Rash	1 ○ Yes	2 ○ No	9 ○ Unknown	Hepatic transaminase elevation	1 ○ Yes	2 ○ No	9 ○ Unknown
Eschar	1 ○ Yes	2 ○ No	9 ○ Unknown	Leukopenia	1 ○ Yes	2 ○ No	9 ○ Unknown
Headache	1 ○ Yes	2 ○ No	9 ○ Unknown	Elevated C-reactive proteins	1 ○ Yes	2 ○ No	9 ○ Unknown
Myalgia	1 ○ Yes	2 ○ No	9 ○ Unknown	Other, specify:	1 ○ Yes	2 ○ No	9 ○ Unknown
Fatigue/malaise	1 ○ Yes	2 ○ No	9 ○ Unknown				
Nausea/vomiting	1 ○ Yes	2 ○ No	9 ○ Unknown				

10. Date of illness onset(mm/dd/yyyy): _____

11. Did the patient experience any severe complications in the clinical course of this illness?
1 ○ Yes 2 ○ No 9 ○ Unknown

If the patient experienced severe complications due to this illness, specify the complication(s):
1 ☐ Acute respiratory distress syndrome (ARDS)
2 ☐ Disseminated intravascular coagulation (DIC)
3 ☐ Meningitis/encephalitis
4 ☐ Organ failure
5 ☐ Other, specify: _____

12. At the time of diagnosis, was the patient immunocompromised due to medical condition(s) or treatment(s) (such as one of the following: chemotherapy for current illness, HIV, anti-rejection drugs post-transplant, corticosteroids >14 days [such as prednisone, methylprednisolone, or dexamethasone], rheumatoid arthritis [with use of immunomodulator])**?**
1 ○ Yes 2 ○ No 9 ○ Unknown

Specify condition(s) or treatment(s): _____

13. Was the patient hospitalized because of this illness?
1 ○ Yes 2 ○ No 9 ○ Unknown

Admission date (mm/dd/yyyy): _____ **Discharge date (mm/dd/yyyy):** _____

14. Did the patient die from this illness or complications of this illness?
1 ○ Yes 2 ○ No 9 ○ Unknown

If yes, date (mm/dd/yyyy): _____

15. Were antibiotics prescribed for this infection?
1 ○ Yes 2 ○ No 9 ○ Unknown

Specify antibiotic (if multiple antibiotics were prescribed, please specify in comments): _____ **Date treatment was prescribed (mm/dd/yyyy):** _____ **Prescribed duration (days):** _____

16. In the year before symptom onset or diagnosis (use earlier date), did the patient receive a blood transfusion?
1 ○ Yes 2 ○ No 9 ○ Unknown

If no or unknown, skip to Q. 17 below. Otherwise, continue with 16a, 16b, and 16c.

16a. Date of blood transfusion (mm/dd/yyyy) (If multiple antibiotics were prescribed, please specify in comments): _____

16b. Was the patient's infection transfusion-associated?
1 ○ Yes 2 ○ No 9 ○ Unknown

16c. If a blood product was implicated in the infection, specify which type(s):
1 ☐ Plasma product 2 ☐ Platelet product 3 ☐ Red blood cells
4 ☐ Unknown 5 ☐ Other, specify: _____

17. In the year before symptom onset or diagnosis (use earlier date), did the patient receive an organ transplant?

1 ○ Yes 2 ○ No 9 ○ Unknown

If no or unknown, skip to Q. 18 below. Otherwise, continue with 17a, 17b, and 17c.

17a. Date of transplant (mm/dd/yyyy): _____

17b. Was the patient's infection transplant-associated?

1 ○ Yes 2 ○ No 9 ○ Unknown

17c. If the patient received an organ transplant, specify which organ(s):

_____

18. Did the patient donate blood in the 30 days prior to symptom onset?

1 ○ Yes 2 ○ No 9 ○ Unknown

If no or unknown, skip to Q. 19 below. Otherwise, continue with 18a, 18b, 18c, and 18d.

18a. Date of blood donation (mm/dd/yyyy): _____

18b. Was the patient a blood donor identified during an investigation into a transfusion-associated infection?

1 ○ Yes 2 ○ No 9 ○ Unknown

18c. If a blood product was implicated in the infection, specify which type(s):

1 ☐ Plasma product 2 ☐ Platelet product 3 ☐ Red blood cells

4 ☐ Unknown 5 ☐ Other, specify: _____

18d. Was the blood bank/hospital/ transplant service notified?

1 ○ Yes 2 ○ No 9 ○ Unknown

19. Performing laboratory name (organization that performed diagnostic testing): _____

State (postal abbrev.): _____

20. Serology 1 collection date (mm/dd/yyyy): _____

Serologic Tests	Titer	Results
IFA - IgG		○ Positive ○ Negative ○ Not performed
IFA - IgM		○ Positive ○ Negative ○ Not performed
Other, specify: _____		○ Positive ○ Negative ○ Not performed

If additional serology testing performed, please specify in comments.

Serology 2 collection date* (mm/dd/yyyy): _____

Serologic Tests	Titer	Results
IFA - IgG		○ Positive ○ Negative ○ Not performed
IFA - IgM		○ Positive ○ Negative ○ Not performed
Other, specify: _____		○ Positive ○ Negative ○ Not performed

*Was there a fourfold change in antibody titer between the two IgG serum specimens?

○ Yes ○ No

21. Other Diagnostic Tests:

Tests	Date Collected (mm/dd/yyyy)	Specimen Type	Results
PCR			○ Positive ○ Negative ○ Not performed
Other molecular detection*			○ Positive ○ Negative ○ Not performed
Morulae visualization			○ Positive ○ Negative ○ Not performed
Immunostain			○ Positive ○ Negative ○ Not performed
Culture (confirmed by PCR)			○ Positive ○ Negative ○ Not performed

*Other molecular detection can include nucleic acid amplification tests or genetic sequencing. Please enter specific type of test in comments.

22. If PCR, immunostain, or sequencing performed, specify genus or species identified:

1 ○ *Anaplasma phagocytophilum*
2 ○ *Ehrlichia chaffeensis*
3 ○ *Ehrlichia ewingii*
4 ○ *Ehrlichia muris eauclairensis*
5 ○ *Ehrlichia* species (pan-*Ehrlichia)*
6 ○ Genera *Ehrlichia/Anaplasma*
7 ○ *Rickettsia africae*
8 ○ *Rickettsia parkeri*
9 ○ *Rickettsia rickettsii*
10 ○ *R. rickettsii* subsp. *californica*
11 ○ *Rickettsia* species (pan-*Rickettsia)*
12 ○ Spotted fever group *Rickettsiae*
13 ○ Other, specify: _____

23. Condition or event that constitutes the reason the notification is being sent:

1 ○ SFR (including RMSF)
2 ○ Ehrlichiosis - *E. chaffeensis*
3 ○ Anaplasmosis - *A. phagocytophilum*
4 ○ Ehrlichiosis - *E.ewingii*
7 ○ Ehrlichiosis - *E. muris eauclairensis*
8 ○ Other *Ehrlichia* spp. or unspeciated

24. Case Outcome (only confirmed and probable cases to be reported to CDC)**:**

1 ○ Confirmed 3 ○ Suspect 9 ○ Unknown
2 ○ Probable 4 ○ Not a Case

State Health Department Official who reviewed this report:

Name: _____ **Phone number:** _____

Title: _____ **Email address:** _____

Date: _____

Comments:

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