Brucellosis

Agency:

Investigator:

Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of death / /
Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Type biovar ☐ Other

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Type biovar ☐ Other

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Test type:

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Type biovar ☐ Other

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

Occupation type: Job title:

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name:

Date worked from: / / Address:

Date worked to: / / Zip code:

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: State: County:

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: Job title:

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name:

Date worked from: / / Address:

Date worked to: / / Zip code:

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: State: County:

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry):

Admission date: / / Discharge date: / / Days hospitalized:

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

Hospital: Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry):

Admission date: / / Discharge date: / / Days hospitalized:

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Episode Type:
☐ First attack
☐ Recurrence
☐ Chronic

Episode Severity:
☐ Mild
☐ Moderate
☐ Severe

Symptoms:
☐ Anorexia
☐ Chills
☐ Headache
☐ Muscle Pain
☐ Muscle Weakness
☐ Weight Loss

Date Returned to Normal Activities: / /

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic: Antibiotic: Antibiotic:

Date started: / / Date / / Date started: / /

	started:	
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
Number of days: Number of times a day:	Number of days: Number of times a day:	Number of days: Number of times a day:
Route:	Route:	Route:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.

EXPOSURE PERIOD — The incubation period for **brucellosis** is usually 5-60 days and occasionally several months.

Onset

COMMUNICABLE PERIOD — There is no evidence of person to person transmission of **brucellosis**.

RISK FACTORS/TRAVEL

In the 60 days before the onset of symptoms did the case:

Travel within Iowa? ☐ Yes ☐ No ☐ Unk — City in Iowa: _____ Departure date: / / Return date: / /

Travel within U.S.? ☐ Yes ☐ No ☐ Unk — State: _____ City: _____ Departure date: / / Return date: / /

Travel outside U.S.? ☐ Yes ☐ No ☐ Unk — Country: _____ Departure date: / / Return date: / /

Give birth: ☐ Yes ☐ No ☐ Unknown

Have animal contact: ☐ Yes ☐ No ☐ Unknown

Animal type: ☐ Bison ☐ Deer ☐ Elks ☐ Goats ☐ Horses ☐ Pigs ☐ Rabbits ☐ Rats ☐ Sheep ☐ Caribou ☐ Other:

Were any of these animals birthing: ☐ Yes ☐ No ☐ Unknown

Exposed to potential Infection sources: ☐ Yes ☐ No ☐ Unknown

Check all possible sources:
☐ Abattoirs (Slaughter house)
☐ Aborted animal fetuses or placentas
☐ Laboratory
☐ Livestock Handling
☐ Livestock Vaccine
☐ Packing Plant
☐ Unpasteurized dairy product

CONTACTS

Others with the same exposures? ☐ Yes ☐ No ☐ Unknown

Others with the same exposures

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case	List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian ☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case	List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian ☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

NOTES: