BRUCELLOSIS INVESTIGATION FORM

PERSON PROVIDING INFORMATION

Name of Person Being Interviewed: _____ Relationship to Patient: _____ Preferred Language: _____

If patient is less than 18 years old, provide parent/proxy's name: _____

Has the patient or patient's proxy been notified by the reporter of this diagnosis or lab result? ☐No ☐Unknown ☐Yes

BASIC DEMOGRAPHIC DATA

Last Name:_____First Name:_____Middle Name:_____ DOB:_

_____/_____/_____ Age:_____years months Current Sex: Female Male Unknown

Is the patient deceased? No Unknown Yes Date of Death:_____/_____/_____

Street Address 1:_____Street Address 2:_____

City:_____State:_____Zip Code:_____County:_____

Home Phone: (_____) -_____-_____Cell Phone: (_____) -_____-_____Work Phone: (_____) -_____-_____Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

INVESTIGATION SUMMARY

Investigation Start Date:_____/_____/_____Investigation Status: Open Closed Investigator:_____

REPORTING SOURCE

Date of Report:_____/_____/_____Reporting Source:_____

CLINICAL

Physician's Name:_____Phone Number: (_____) -_____-_____Ext. _____

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name:_____

Admission Date: / /_____Discharge Date: / /_____ Duration of Stay_____day(s)

Diagnosis Date:_____/_____/_____ Illness Onset Date: /_____/_____ Illness End Date: /_____/_____

Age at Onset:_____ days hours minutes months unknown weeks years

Did the patient die from this illness? No Unknown Yes Date of Death: / /_____

EPIDEMIOLOGIC

Is this patient associated with a day care facility? No Unknown Yes Is this patient a food handler? No Unknown Yes

Is this case part of an outbreak? No Unknown Yes If yes, outbreak name:_____

Case Status: Confirmed Not a Case Probable MMWR Week:_____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

JEFFERSON COUNTY SUPERVISOR REVIEW

Date Due:_____/_____/_____	Investigation ready for supervisor review:	Reviewed (Complete)	Reviewed (Incomplete)
Date investigation ready for supervisor review:_____/_____/_____		Reviewed (Not a case)	Yes
Review comments (completed by supervisor):_____			

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt:_____/_____/_____ 2nd Attempt:_____/_____/_____ 3rd Attempt:_____/_____/_____

Patient Contact Date(s):

1st Attempt:_____/_____/_____Time:_____AM ☐ PM 2nd Attempt:_____/_____/_____Time:_____AM ☐ PM

3rd Attempt:_____/_____/_____Time:_____AM ☐ PM

Regular Letter Mailed:_____/_____/_____ Certified Letter Mailed:_____/_____/_____

Was clinical information obtained from the physician or patient? ☐ Yes ☐ No

SIGNS AND SYMPTOMS

Onset type: ☐ Acute ☐ Insidious ☐ Not Stated

Fever:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Chills:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Weight Loss:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Sweating:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Body Ache:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Weakness:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Headache:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Malaise:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Anorexia:	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____
Abscess (Bone, Joint, Muscle):	☐ No ☐ Unknown ☐ Yes	Duration / Severity: _____

Other Symptoms: _____

OTHER CLINICAL

Was *Brucella* species isolated from a clinical specimen? ☐ No ☐ Unknown ☐ Yes

What species was identified? _____

ANIMAL CONTACT

Did patient come in contact with an animal? ☐ No ☐ Unknown ☐ Yes Applicable incubation period for this illness is : **7 – 21 days**

If yes, select type of animal:

☐ Cat	☐ Cattle	☐ Chicken	☐ Dog	☐ Goats	☐ Lizard
☐ Rodent	☐ Sheep	☐ Turkey	☐ Turtle	☐ Domestic pig	☐ Wild boar/feral pig
☐ Unknown	☐ Other, specify: _____				

Did the patient acquire a pet prior to onset of illness? ☐ No ☐ Unknown ☐ Yes

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐ CSF leak	☐ Hodgkin's disease	☐ IVDU
☐ Alcohol abuse	☐ Asthma	☐ Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐ Burns	☐ Cerebral vascular accident (CVA) stroke	☐ Chronic GI illness/diarrhea
☐ Cirrhosis/liver failure	☐ Cochlear implant	☐ Current smoker
☐ Deaf/profound hearing loss	☐ Diabetes mellitus (insulin): ☐No ☐Unk ☐Yes	☐ Emphysema/COPD
☐ Gastric surgery (type):_____	☐ Heart failure	☐ Hematologic disease (type): _____
☐ Immunodeficiency (type):_____	☐ Immunoglobulin deficiency	☐ Immunosuppressive therapy (steroids, chemotherapy)
☐ Leukemia	☐ Multiple myeloma	☐ Nephrotic Syndrome
☐ None	☐ Organ transplant (organ):_____	☐ Other liver disease (type): _____
☐ Other malignancy (type):_____	☐ Other prior illness (type):_____	☐ Other renal disease (type): _____
☐ Peptic ulcer	☐ Renal failure/dialysis	☐ Sickle cell anemia
☐ Splenectomy/asplenia	☐ Systemic lupus erythematosus (SLE)	☐ Unknown

EXPOSURES

Type of Exposure: ☐Occupational (list occupation) _____ ☐Other (list other)_____

Date of most recent exposure (Day 0):_____

Monitoring End Date (Day 180):_____

Date patient started post-exposure prophylaxis: _____