

LEPTOSPIROSIS 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 INVESTIGATION

Contact Investigation Priority:
High Low Medium No Contact
Infectious Period From: ___/___/____ Infectious Period To: ___/___/____ :
Contact Investigation Status: Open Closed
Contact Investigation Comments: _____

SIGNS AND SYMPTOMS

Illness onset date: ___/___/____ Illness end date: ___/___/____
Illness Duration: _____ Minute Hour Day Month Unknown Age at Onset: _____ Minutes Hours Days Month Unknown
Fever: No Unknown Yes Highest Temp: _____°F Renal insufficiency: No Unknown Yes
Gastrointestinal symptoms: No Unknown Yes Acute renal failure: No Unknown Yes
Myalgia: No Unknown Yes Weight Loss: No Unknown Yes
Jaundice: No Unknown Yes Aseptic meningitis: No Unknown Yes
Rash: No Unknown Yes Pulmonary complications: No Unknown Yes
Cardiac arrhythmias : No Unknown Yes Generalized hemorrhages: No Unknown Yes
Other Symptoms: _____

LABORATORY TEST INFORMATION

Was laboratory testing done? No Unknown Yes Specimen collection date (initial): ___/___/____
Test Method: Culture Darkfield Microscopy ELISA IHC Lateral flow test MAT PCR Unknown Other _____
Type of ELISA test performed: IgG IgM IgG \$ IgM Immunodot_IgM N/A
Lab test result: Indeterminate Negative Not Done Positive Unknown
Leptospira serovar.serogroup: _____
Specimen collection date (convalescent if applicable): ___/___/____
Convalescent titer result (>2 weeks later): _____
Acute (initial) titer result: _____
Was a single titer >= 800? Yes No Unknown
Was there a fourfold rise in titer? Yes No Unknown

TREATMENT INFORMATION

Was treatment initiated for this illness? No Unknown Yes Treatment start date: ___/___/____
Specify treatment(s) received: _____

EXPOSURES

Involvement in an event (adventure, race, triathalon) with known lab-confirmed case? No Unknown Yes
Has the patient been in an area with flooding? No Unknown Yes
Has the patient been in an area with heavy rainfall? No Unknown Yes

Does the patient have similar environmental exposures as a contact diagnosed with leptospirosis? No Unknown Yes

Has the individual ever been previously diagnosed with leptospirosis? No Unknown Yes

If yes to any of the above questions, provide explanations:

Is there any evidence of rodents where the patient lives? No Unknown Yes

If yes, was the dwelling with rodents in a rural area? No Unknown Yes

DRINKING WATER EXPOSURE

What is the source of tap water at home? Do not use tap water Municipal, city, or county Other _____ Private well Unknown

If "Private Well", how was home well water treated?

Both filtered and disinfected Disinfected Filtered Neither filtered nor disinfected Unknown

What is the source of tap water at school/work? Do not use tap water Municipal, city, or county Other _____ Private well Unknown

If "Private Well", how was school/work well water treated?

Both filtered and disinfected Disinfected Filtered Neither filtered nor disinfected Unknown

Did the patient drink untreated water in the **12 days** prior to onset of illness (e.g., from a river while camping)? No Unknown Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **12 days** prior to illness? No Unknown Yes

What was the recreational water exposure type? (select all that apply)

Hot Spring Hot Tub-Whirlpool-Jacuzzi-Spa Interactive Fountain Lake-Pond-River-Stream
Ocean Other _____ Recreational Water Park Swimming Pool

If "Swimming Pool", please specify swimming pool type:

Camp Pool Hospital/Therapy Pool Hotel/Motel/Resort Vacation Pool
Kiddie/Wading Pool Municipal/Community Pool Neighborhood/subdivision/Apartment/Condo Pool
Other, specify _____ Private Club/Membership Pool Private Home Pool, not a kiddie/wading pool
School/College/University Pool Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come in contact with an animal? No Unknown Yes

Applicable incubation period for this illness is : **1 – 12 days**

If yes, select type of animal: Cat Cattle Chicken Dog Goats Lizard
Rodent Sheep Turkey Turtle Unknown
Other, specify: _____

Name or location of animal contact: _____

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