



Q Fever Case Report



Centers for Disease Control and Prevention Fax: (404) 639-2778

CDC# (1-4)

- PATIENT/PHYSICIAN INFORMATION -

Patient's name: _____ **Date submitted:** ____/____/____ (mm/dd/yyyy)
Address: _____ **Physician's name:** _____ **Phone no.:** _____
 (number, street) _____
City: _____
 State Zip Case ID (13-18) Site (19-21) State (22-23)

- DEMOGRAPHICS -

1. State of residence: <input type="text"/> <input type="text"/> (24-25)	2. County of residence: _____ (26-50)	3. Date of birth: (mm/dd/yyyy) ____/____/____ (51-52) (53-54) (55-58)	4. Sex: (59) 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Not specified	5. Ethnicity: (60) 1 <input type="checkbox"/> Hispanic/Latino 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> Not Hispanic/Latino	6. Race: (61) 1 <input type="checkbox"/> American Indian/Alaskan Native 2 <input type="checkbox"/> Asian 3 <input type="checkbox"/> Black or African American 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> White 9 <input type="checkbox"/> Unk
7. Occupation at date of onset of illness (Check all that apply) 1 <input type="checkbox"/> wool or felt plant (62) 6 <input type="checkbox"/> animal research (67) 10 <input type="checkbox"/> live in household with person occupationally related to above? (71) 2 <input type="checkbox"/> tannery or rendering plant (63) 7 <input type="checkbox"/> slaughterhouse worker (68) 3 <input type="checkbox"/> dairy (64) 8 <input type="checkbox"/> laboratory worker (69) 8 8 <input type="checkbox"/> other (please specify) (72) 4 <input type="checkbox"/> veterinarian (65) 9 <input type="checkbox"/> rancher (70) 5 <input type="checkbox"/> medical research (66)				8. Any contact with animals within 2 months prior to onset? (check all that apply) 1 <input type="checkbox"/> Cattle (73) 3 <input type="checkbox"/> Goats (75) 5 <input type="checkbox"/> Cats (77) 2 <input type="checkbox"/> Sheep (74) 4 <input type="checkbox"/> Pigeons (76) 6 <input type="checkbox"/> Rabbits (78) 8 <input type="checkbox"/> Other (please specify) (79)	

9. Any exposure to birthing animals? (80) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If yes, which animal _____	10. Exposure to unpasteurized milk? (81) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If yes, which animal _____	11. Any travel in last year? (82-83) If yes, State <input type="text"/> <input type="text"/> County _____ Foreign Country _____	12. Other family member with similar illness in last year? (84) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
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- CLINICAL FINDINGS -

13. Date of Onset of Symptoms: ____/____/____ (85-86) (87-88) (89-92) (mm/dd/yyyy)	14. Clinical Signs and syndromes (check all that apply) 1 <input type="checkbox"/> fever (>100.5) (93) 4 <input type="checkbox"/> malaise (96) 7 <input type="checkbox"/> headache (99) 10 <input type="checkbox"/> pneumonia (102) 8 8 <input type="checkbox"/> Other (please specify) (105) 2 <input type="checkbox"/> myalgia (94) 5 <input type="checkbox"/> rash (97) 8 <input type="checkbox"/> splenomegaly (100) 11 <input type="checkbox"/> hepatitis (103) 3 <input type="checkbox"/> retrobulbar pain (95) 6 <input type="checkbox"/> cough (98) 9 <input type="checkbox"/> hepatomegaly (101) 12 <input type="checkbox"/> endocarditis (104)
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15. Any pre-existing medical conditions? (check all that apply) 1 <input type="checkbox"/> immunocompromised (106) 3 <input type="checkbox"/> valvular heart disease or vascular graft (108) 2 <input type="checkbox"/> pregnancy (107) 8 <input type="checkbox"/> Other _____ (109)	16. Was patient hospitalized because of this illness? (110) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	17. Did patient die from complications of this illness? (111) (If yes, date) (mm/dd/yyyy) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk (112-13) (114-15) (116-19)
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- LABORATORY DATA -

18. Name of laboratory: _____ **City:** _____ **State:** _____ **Zip:** _____

19. Serology (Check only if specific assay was performed)	Phase I Antigen		Phase II Antigen	
	Serology 1 (mm/dd/yyyy)	Serology 2 (mm/dd/yyyy)	Serology 1 (mm/dd/yyyy)	Serology 2 (mm/dd/yyyy)
	(120-21) (122-23) (124-27) Titer Positive?	(132-33) (134-35) (136-39) Titer Positive?	(144-45) (146-47) (148-51) Titer Positive?	(156-57) (158-59) (160-63) Titer Positive?
IFA - IgG	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (128)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (140)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (152)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (164)
IFA - IgM	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (129)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (141)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (153)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (165)
Complement Fixation	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (130)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (142)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (154)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (166)
Other test: _____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (131)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (143)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (155)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (167)

20. Was there a fourfold change in antibody titer between the two serum specimens? 1 Yes 2 No (168)

21. Other Diagnostic Tests ?*		Positive?
PCR	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (169)	
Immunostain	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (170)	
Culture	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (171)	
Sample(s) tested:		

- FINAL DIAGNOSIS -

22. Classify case based on the CDC case definition (see criteria below):
 1 **CONFIRMED** 2 **PROBABLE** (172)

Confirmed Q fever: A clinically compatible case that is laboratory confirmed with 1) a fourfold change in antibody titer to *Coxiella burnetii* antigen by IFA or CF antibody test, or 2) a positive PCR assay, or 3) culture of *C. burnetii* from a clinical specimen, or 4) positive immunostaining of *C. burnetii* in tissue.

Probable Q Fever: A clinically compatible case with single supportive IgG or IgM titer as defined by testing lab.

State Health Department Official who reviewed this report:
 Name: _____
 Title: _____ Date: ____/____/____ (mm/dd/yyyy)