

California Department of Public Health  
 Center for Infectious Diseases  
 Division of Communicable Disease Control  
 Infectious Diseases Branch  
 Surveillance and Statistics Section  
 MS 7306, P.O. Box 997377  
 Sacramento, CA 95899-7377

Local ID Number \_\_\_\_\_

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

## BRUCELLOSIS CASE REPORT

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence			Apartment/Unit Number		
City/Town		State	Zip Code		
Census Tract	County of Residence		Country of Residence		
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone/Pager		Work/School Telephone	
E-mail Address		Other Electronic Contact Information			
Work/School Location		Work/School Contact			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 8)		Other Describe/Specify			
Occupation (see list on page 8)		Other Describe/Specify			
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

- Ethnicity (check one)**  
Hispanic/Latino  
Non-Hispanic/Non-Latino  
Unk
- Race\* (check all that apply, race descriptions on page 8)**  
African-American/Black  
American Indian or Alaska Native  
Asian (check all that apply)  
Asian Indian Japanese  
Cambodian Korean  
Chinese Laotian  
Filipino Thai  
Hmong Vietnamese  
Other: \_\_\_\_\_
- Pacific Islander (check all that apply)  
Native Hawaiian Samoan  
Guamanian  
Other: \_\_\_\_\_
- White  
Other: \_\_\_\_\_  
Unk

\*Comment: self-identity or self-reporting  
 The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

First three letters of patient's last name:

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**SIGNS AND SYMPTOMS**

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset Date (mm/dd/yyyy)			Date First Sought Medical Care (mm/dd/yyyy)
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Fever				Highest temperature (specify °F/°C)
Chills				
Headache				
Severe malaise				
Arthritis or arthralgia				Joint(s)
Weight loss				
Diarrhea				
Sweats				
Anemia				
Abdominal pain				
Abscess				Location(s)
Splenomegaly				
Leukopenia				
Hepatomegaly				
Loss of appetite				

Other signs / symptoms (specify)

**PAST MEDICAL HISTORY**

Prior Brucella diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify diagnosis date (mm/dd/yyyy)
Immunocompromised? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify condition

Other (specify)

**HOSPITALIZATION**

Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, how many total hospital nights?
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If there were any ER or hospital stays related to this illness, specify details below.

First three letters of patient's last name:

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**HOSPITALIZATION - DETAILS**

<i>Hospital Name 1</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>
<i>Hospital Name 2</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>

**TREATMENT / MANAGEMENT**

<i>Received treatment?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, specify the treatments below.</i>
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**TREATMENT / MANAGEMENT DETAILS**

<i>Treatment Type 1</i> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	<i>Treatment Name</i>	<i>Date Started (mm/dd/yyyy)</i>	<i>Date Ended (mm/dd/yyyy)</i>
<i>Treatment Type 2</i> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	<i>Treatment Name</i>	<i>Date Started (mm/dd/yyyy)</i>	<i>Date Ended (mm/dd/yyyy)</i>

**OUTCOME**

<i>Outcome?</i> <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	<i>If Survived,</i> <i>Survived as of _____ (mm/dd/yyyy)</i>	<i>Date of Death (mm/dd/yyyy)</i>
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**LABORATORY INFORMATION**

**LABORATORY RESULTS SUMMARY**

<i>Specimen Type</i> <input type="checkbox"/> Blood	<i>Type of Test</i>	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<i>Collection Date (mm/dd/yyyy)</i>
	<i>Brucella Species</i> <input type="checkbox"/> Brucella abortus <input type="checkbox"/> Brucella melitensis <input type="checkbox"/> Brucella species other: _____ <input type="checkbox"/> Brucella canis <input type="checkbox"/> Brucella suis <input type="checkbox"/> Brucella species unknown		
	<i>Laboratory Name</i>		<i>Telephone Number</i>
<i>Specimen Type</i> <input type="checkbox"/> Clinical specimen (specify): _____	<i>Type of Test</i> <input type="checkbox"/> Culture <input type="checkbox"/> IFA <input type="checkbox"/> PCR <input type="checkbox"/> Other: _____	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	<i>Collection Date (mm/dd/yyyy)</i>
	<i>Brucella Species</i> <input type="checkbox"/> Brucella abortus <input type="checkbox"/> Brucella melitensis <input type="checkbox"/> Brucella species other: _____ <input type="checkbox"/> Brucella canis <input type="checkbox"/> Brucella suis <input type="checkbox"/> Brucella species unknown		
	<i>Laboratory Name</i>		<i>Telephone Number</i>
<i>Specimen Type</i> <input type="checkbox"/> Serum (acute)	<i>Type of Test (Brucella IgM)</i> <input type="checkbox"/> ELISA <input type="checkbox"/> IFA <input type="checkbox"/> Agglutination <input type="checkbox"/> CF <input type="checkbox"/> Other: _____	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	<i>Collection Date (mm/dd/yyyy)</i>
	<i>Results</i> <input type="checkbox"/> Titer <input type="checkbox"/> O.D	<i>Laboratory Name</i>	<i>Telephone Number</i>
<i>Specimen Type</i> <input type="checkbox"/> Serum (acute)	<i>Type of Test (Brucella IgG)</i> <input type="checkbox"/> ELISA <input type="checkbox"/> IFA <input type="checkbox"/> Agglutination <input type="checkbox"/> CF <input type="checkbox"/> Other: _____	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	<i>Collection Date (mm/dd/yyyy)</i>
	<i>Results</i> <input type="checkbox"/> Titer <input type="checkbox"/> O.D	<i>Laboratory Name</i>	<i>Telephone Number</i>

First three letters of patient's last name:

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**LABORATORY RESULTS SUMMARY (continued)**

Specimen Type <input type="checkbox"/> Serum (acute)	Type of Test ( <i>Brucella</i> IgM) <input type="checkbox"/> ELISA <input type="checkbox"/> IFA <input type="checkbox"/> Agglutination <input type="checkbox"/> CF <input type="checkbox"/> Other: _____	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	Collection Date (mm/dd/yyyy)
	Results <input type="checkbox"/> Titer <input type="checkbox"/> O.D.	Laboratory Name	Telephone Number
Specimen Type <input type="checkbox"/> Serum (convalescent)	Type of Test ( <i>Brucella</i> IgG) <input type="checkbox"/> ELISA <input type="checkbox"/> IFA <input type="checkbox"/> Agglutination <input type="checkbox"/> CF <input type="checkbox"/> Other: _____	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	Collection Date (mm/dd/yyyy)
	Results <input type="checkbox"/> Titer <input type="checkbox"/> O.D.	Laboratory Name	Telephone Number

**EPIDEMIOLOGIC INFORMATION**

**INCUBATION PERIOD IS THE 6 MONTHS PRIOR TO ILLNESS ONSET**

**EXPOSURES / RISK FACTORS - MILK, OTHER DAIRY PRODUCTS, AND MEAT**

**DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?**

Food Item	Yes	No	Unk	If Yes, Specify as Noted
Milk				Milk Source <input type="checkbox"/> Cow <input type="checkbox"/> Goat <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
				Process Type <input type="checkbox"/> Pasteurized <input type="checkbox"/> Unpasteurized (raw) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
				Source <input type="checkbox"/> Dairy/ranch/farm <input type="checkbox"/> Retail store <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
				Source Name <input style="width: 100%; border: none;" type="text"/> Source Address <input style="width: 100%; border: none;" type="text"/>
Other dairy products				Dairy Product Type <input type="checkbox"/> Soft cheese <input type="checkbox"/> Queso fresco <input type="checkbox"/> Crema <input type="checkbox"/> Other: _____
				Dairy Product Source <input type="checkbox"/> Cow <input type="checkbox"/> Goat <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
				Process Type <input type="checkbox"/> Pasteurized <input type="checkbox"/> Unpasteurized (raw) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
				Source <input type="checkbox"/> Dairy/ranch/farm <input type="checkbox"/> Retail store <input type="checkbox"/> Street vendor <input type="checkbox"/> Swap meet <input type="checkbox"/> Other: _____
				Source Location <input type="checkbox"/> California <input type="checkbox"/> U.S. State <input type="checkbox"/> Outside U.S. <input style="width: 100%; border: none;" type="text"/>
				Consumed in U.S. and produced outside of U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Meat				Animal Species <input style="width: 100%; border: none;" type="text"/> Meat Product <input style="width: 100%; border: none;" type="text"/>
Other food / drink exposure (specify) <input style="width: 100%; border: none;" type="text"/>				

First three letters of patient's last name:

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**EXPOSURES / RISK FACTORS - OCCUPATIONAL / OTHER CONTACT**

**WAS THE PATIENT EMPLOYED IN (OR SPEND SIGNIFICANT TIME IN) ANY OF THE FOLLOWING ACTIVITIES DURING THE INCUBATION PERIOD?**

Activity	Yes	No	Unk	If Yes, Specify as Noted
Animal farm or dairy				<i>Livestock Species</i> <input type="checkbox"/> Cow <input type="checkbox"/> Goat <input type="checkbox"/> Pig <input type="checkbox"/> Other: _____
Microbiology laboratory				<i>Meat Product</i> _____ <i>Laboratory Name</i> _____

**DID THE PATIENT HAVE CONTACT WITH ANY OF THE FOLLOWING DURING THE INCUBATION PERIOD?**

Type of Contact	Yes	No	Unk	If Yes, Specify as Noted
Known brucellosis infected herd				<i>Livestock Species</i> <input type="checkbox"/> Cow <input type="checkbox"/> Goat <input type="checkbox"/> Pig <input type="checkbox"/> Other: _____
Aborting animal or birthing products				<i>Livestock Species</i> <input type="checkbox"/> Cow <input type="checkbox"/> Goat <input type="checkbox"/> Pig <input type="checkbox"/> Other: _____
<i>Brucella</i> vaccine or recently vaccinated animal				<i>Vaccine Name</i> _____ <i>Animal Species</i> _____ <i>Exposure Date (mm/dd/yyyy)</i> _____
Household member works at animal farm or dairy				<i>Livestock Species</i> <input type="checkbox"/> Cow <input type="checkbox"/> Goat <input type="checkbox"/> Pig <input type="checkbox"/> Other: _____
Animal contact				<i>Animal Species</i> _____ <i>Nature of Contact</i> _____

*Other contact / exposure (specify)*

**TRAVEL HISTORY (INCUBATION PERIOD IS THE 6 MONTHS PRIOR TO ILLNESS ONSET)**

Did patient arrive into California during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify origin location (city, county, state, country)	Arrival Date (mm/dd/yyyy)
Did patient travel outside of county of residence during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates below.	

**TRAVEL HISTORY - DETAILS**

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

**CONTACTS / OTHER ILL PERSONS**

Any contacts with similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify details below.
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**ILL CONTACTS - DETAILS**

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
Street Address			Exposure Event		Illness Onset Date (mm/dd/yyyy)
City		State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	

(continued on page 6)



**CASE DEFINITION****BRUCELLOSIS (2010)****CLINICAL DESCRIPTION**

An illness characterized by acute or insidious onset of fever and one or more of the following: night sweats, arthralgia, headache, fatigue, anorexia, myalgia, weight loss, arthritis/spondylitis, meningitis, or focal organ involvement (endocarditis, orchitis/epididymitis, hepatomegaly, splenomegaly).

**LABORATORY CRITERIA FOR DIAGNOSIS****- Definitive**

- Culture and identification of *Brucella* spp. from clinical specimens
- Evidence of a fourfold or greater rise in *Brucella* antibody titer between acute- and convalescent-phase serum specimens obtained greater than or equal to 2 weeks apart

**- Presumptive**

- *Brucella* total antibody titer of greater than or equal to 160 by standard tube agglutination test (SAT) or *Brucella* microagglutination test (BMAT) in one or more serum specimens obtained after onset of symptoms
- Detection of *Brucella* DNA in a clinical specimen by PCR assay

**CASE CLASSIFICATION**

- **Probable:** A clinically compatible illness with at least one of the following:
  - Epidemiologically linked to a confirmed human or animal brucellosis case
  - Presumptive laboratory evidence, but without definitive laboratory evidence, of *Brucella* infection
- **Confirmed:** A clinically compatible illness with definitive laboratory evidence of *Brucella* infection

<b>RACE DESCRIPTIONS</b>	
<b>Race</b>	<b>Description</b>
American Indian or Alaska Native	Patient has origins in <b>any</b> of the original peoples of North and South America (including Central America).
Asian	Patient has origins in <b>any</b> of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in <b>any</b> of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in <b>any</b> of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in <b>any</b> of the original peoples of Europe, the Middle East, or North Africa.
<b>OCCUPATION SETTING</b>	
<ul style="list-style-type: none"> <li>• Childcare/Preschool</li> <li>• Correctional Facility</li> <li>• Drug Treatment Center</li> <li>• Food Service</li> <li>• Health Care - Acute Care Facility</li> <li>• Health Care - Long Term Care Facility</li> <li>• Health Care - Other</li> </ul>	<ul style="list-style-type: none"> <li>• Homeless Shelter</li> <li>• Laboratory</li> <li>• Military Facility</li> <li>• Other Residential Facility</li> <li>• Place of Worship</li> <li>• School</li> <li>• Other</li> </ul>
<b>OCCUPATION</b>	
<ul style="list-style-type: none"> <li>• Adult film actor/actress</li> <li>• Agriculture - farmworker or laborer (crop, nursery, or greenhouse)</li> <li>• Agriculture - field worker</li> <li>• Agriculture - migratory/seasonal worker</li> <li>• Agriculture - other/unknown</li> <li>• Animal - animal control worker</li> <li>• Animal - farm worker or laborer (farm or ranch animals)</li> <li>• Animal - veterinarian or other animal health practitioner</li> <li>• Animal - other/unknown</li> <li>• Clerical, office, or sales worker</li> <li>• Correctional facility - employee</li> <li>• Correctional facility - inmate</li> <li>• Craftsman, foreman, or operative</li> <li>• Daycare or child care attendee</li> <li>• Daycare or child care worker</li> <li>• Dentist or other dental health worker</li> <li>• Drug dealer</li> <li>• Fire fighting or prevention worker</li> <li>• Flight attendant</li> <li>• Food service - cook or food preparation worker</li> <li>• Food service - host or hostess</li> <li>• Food service - server</li> <li>• Food service - other/unknown</li> <li>• Homemaker</li> <li>• Laboratory technologist or technician</li> <li>• Laborer - private household or unskilled worker</li> <li>• Manager, official, or proprietor</li> <li>• Manicurist or pedicurist</li> <li>• Medical - emergency medical technician or paramedic</li> <li>• Medical - health care worker</li> </ul>	<ul style="list-style-type: none"> <li>• Medical - medical assistant</li> <li>• Medical - pharmacist</li> <li>• Medical - physician assistant or nurse practitioner</li> <li>• Medical - physician or surgeon</li> <li>• Medical - nurse</li> <li>• Medical - other/unknown</li> <li>• Military</li> <li>• Police officer</li> <li>• Professional, technical, or related profession</li> <li>• Retired</li> <li>• Sex worker</li> <li>• Stay at home parent/guardian</li> <li>• Student - preschool or kindergarten</li> <li>• Student - elementary or middle school</li> <li>• Student - high school</li> <li>• Student - college or university</li> <li>• Student - other/unknown</li> <li>• Teacher/employee - preschool or kindergarten</li> <li>• Teacher/employee - elementary or middle school</li> <li>• Teacher/employee - high school</li> <li>• Teacher/instructor/employee - college or university</li> <li>• Teacher/instructor/employee - other/unknown</li> <li>• Unemployed - seeking employment</li> <li>• Unemployed - not seeking employment</li> <li>• Unemployed - other/unknown</li> <li>• Volunteer</li> <li>• Other</li> <li>• Refused</li> <li>• Unknown</li> </ul>