

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

PSITTACOSIS CASE REPORT

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Other: _____	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	Ethnicity (check one)	
<input type="checkbox"/> Years		<input type="checkbox"/> Months		<input type="checkbox"/> Days	
<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Non-Hispanic/Non-Latino		<input type="checkbox"/> Unk	
Address Number & Street - Residence		Apartment/Unit Number		Race*	
City/Town		State	Zip Code	(check all that apply, race descriptions on page 6)	
Census Tract		County of Residence		<input type="checkbox"/> African-American/Black	
Country of Birth		Country of Residence		<input type="checkbox"/> American Indian or Alaska Native	
If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)		<input type="checkbox"/> Asian (check all that apply)		<input type="checkbox"/> Asian Indian	
<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Japanese		<input type="checkbox"/> Cambodian	
<input type="checkbox"/> Cambodian		<input type="checkbox"/> Korean		<input type="checkbox"/> Chinese	
<input type="checkbox"/> Chinese		<input type="checkbox"/> Laotian		<input type="checkbox"/> Filipino	
<input type="checkbox"/> Filipino		<input type="checkbox"/> Thai		<input type="checkbox"/> Hmong	
<input type="checkbox"/> Hmong		<input type="checkbox"/> Vietnamese		<input type="checkbox"/> Other: _____	
Home Telephone		Cellular Phone/Pager		<input type="checkbox"/> Pacific Islander (check all that apply)	
Work/School Telephone		<input type="checkbox"/> Native Hawaiian		<input type="checkbox"/> Samoan	
E-mail Address		Other Electronic Contact Information		<input type="checkbox"/> Guamanian	
Work/School Location		Work/School Contact		<input type="checkbox"/> Other: _____	
Gender		<input type="checkbox"/> White		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		<input type="checkbox"/> Unk			
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 6)		Other Describe/Specify			
Occupation (see list on page 6)		Other Describe/Specify			
*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.					
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

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				
Photophobia				
Cough				
Myalgia				
Other symptom (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?
Was patient placed in respiratory isolation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If there were any ER or hospital stays related to this illness, specify details below.	

HOSPITALIZATION - DETAILS

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

TREATMENT / MANAGEMENT

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

Antibiotic 1	Dose	Date Started (mm/dd/yyyy)	Days Prescribed
Antibiotic 2	Dose	Date Started (mm/dd/yyyy)	Days Prescribed
Antibiotic 3	Dose	Date Started (mm/dd/yyyy)	Days Prescribed

OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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First three letters of patient's last name:

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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

<i>Specimen Type 1</i> <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Other: _____	<i>Type of Test</i> <input type="checkbox"/> MIF <input type="checkbox"/> CF <input type="checkbox"/> Culture <input type="checkbox"/> Other: _____	If Serum (acute) is submitted, then Serum (convalescent) must also be submitted	
	<i>C. psittaci IgM Titer</i>	<i>C. psittaci IgG Titer</i>	
	<i>Results</i>	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	
	<i>Laboratory Name</i>	<i>Telephone Number</i>	
<i>Specimen Type 2</i> <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Other: _____	<i>Type of Test</i> <input type="checkbox"/> MIF <input type="checkbox"/> CF <input type="checkbox"/> Culture <input type="checkbox"/> Other: _____	If Serum (acute) is submitted, then Serum (convalescent) must also be submitted	
	<i>C. psittaci IgM Titer</i>	<i>C. psittaci IgG Titer</i>	
	<i>Results</i>	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	
	<i>Laboratory Name</i>	<i>Telephone Number</i>	

IMAGING SUMMARY

<i>Anatomic site</i>	<i>Date (mm/dd/yyyy)</i>	<i>Type of Imaging</i> <input type="checkbox"/> X-Ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____	
	<i>Result</i>	<i>Interpretation</i>	
	<i>Laboratory Name</i>	<i>Telephone Number</i>	

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD IS 1 - 4 WEEKS PRIOR TO ILLNESS ONSET

EXPOSURES / RISK FACTORS

DID THE PATIENT HAVE CONTACT WITH ANY OF THE FOLLOWING DURING THE MONTH PRIOR TO ILLNESS ONSET?

Exposure	Yes	No	Unk	If Yes, Specify as Noted
Bird(s)				<i>Type of Bird</i> <input type="checkbox"/> Psittacines <input type="checkbox"/> Pigeons <input type="checkbox"/> Poultry <input type="checkbox"/> Other: _____
				<i>Type of Bird Exposure</i> <input type="checkbox"/> Household pet <input type="checkbox"/> Aviary <input type="checkbox"/> Pet store <input type="checkbox"/> Other: _____
				<i>Contact Dates (mm/dd/yyyy)</i> From ____/____/____ to ____/____/____
				<i>Source of Birds</i>
				<i>Date Birds Acquired (mm/dd/yyyy)</i>
				<i>Any birds ill?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<i>Any birds die?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Human psittacosis case				<i>Specify</i>
				<i>Specify</i>
Other contact or exposure				<i>Specify</i>

First three letters of patient's last name:

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CONTACTS / OTHER ILL PERSONS

Any contacts with similar illness?
 Yes No Unk If Yes, specify details below.

ILL CONTACTS - DETAILS

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

Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship		
	Street Address			Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)	
	City		State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
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First Reported By
 Clinician Laboratory Other (specify): _____

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number
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DISEASE CASE CLASSIFICATION

Case Classification (see case definition page 5)
 Confirmed Probable

STATE USE ONLY

Case Classification
 Confirmed Probable Not a case Need additional information

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

An illness characterized by fever, chills, headache, myalgia, and a dry cough with pneumonia often evident on chest x-ray. Severe pneumonia requiring intensive-care support, endocarditis, hepatitis, and neurologic complications occasionally occur.

LABORATORY CRITERIA FOR DIAGNOSIS

- Isolation of *Chlamydophila psittaci* from respiratory specimens (e.g., sputum, pleural fluid, or tissue), or blood, or
- Fourfold or greater increase in antibody (Immunoglobulin G [IgG]) against *C. psittaci* by complement fixation (CF) or microimmunofluorescence (MIF) between paired acute- and convalescent-phase serum specimens obtained at least 2-4 weeks apart , or
- Supportive serology (e.g. *C. psittaci* antibody titer [Immunoglobulin M (IgM)] of greater than or equal to 32 in at least one serum specimen obtained after onset of symptoms), or
- Detection of *C. psittaci* DNA in a respiratory specimen (e.g. sputum, pleural fluid or tissue) via amplification of a specific target by polymerase chain reaction (PCR) assay.

CASE CLASSIFICATION

Probable: An illness characterized by fever, chills, headache, cough and myalgia that has either:

- Supportive serology (e.g. *C. psittaci* antibody titer [Immunoglobulin M, IgM] of greater than or equal to 32 in at least one serum specimen obtained after onset of symptoms), or
- Detection of *C. psittaci* DNA in a respiratory specimen (e.g. sputum, pleural fluid or tissue) via amplification of a specific target by polymerase chain reaction (PCR) assay.

Confirmed: An illness characterized by fever, chills, headache, cough and myalgia, and laboratory confirmed by either:

- Isolation of *Chlamydophila psittaci* from respiratory specimens (e.g., sputum, pleural fluid, or tissue), or blood, or
- Fourfold or greater increase in antibody (Immunoglobulin G [IgG]) against *C. psittaci* by complement fixation (CF) or microimmunofluorescence (MIF) between paired acute- and convalescent-phase serum specimens obtained at least 2-4 weeks apart.

COMMENT

Although MIF has shown greater specificity to *C. psittaci* than CF, positive serologic findings by both techniques may occur as a result of infection with other Chlamydia species and should be interpreted with caution. To increase the reliability of test results, acute- and convalescent-phase serum specimens should be analyzed at the same time in the same laboratory. A realtime polymerase chain reaction (rtPCR) has been developed and validated in avian specimens but has not yet been validated for use in humans (1).

REFERENCES

1. Mitchell, S.L., Wolff, B.J., Thacker, W.L., Ciombor, P.G., Gregory, C.R., Everett, K.D., Ritchie, B.W., & Winchell, J.M. (2009). Genotyping of *Chlamydophila psittaci* by real-time PCR and high-resolution melt analysis. *J Clin Microbiol*, 47(1),175-181.

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