MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Send completed forms to
DPHHS CDEpi Program
Fax: 800-616-7460

Relapsing Fever

County

LHJ Use **ID** _____
☐ **Reported to DPHHS** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Epi Link:** _____

☐ **Outbreak-related**
LHJ Cluster# _____
LHJ Cluster Name: _____
DPHHS Outbreak # _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
Reporter (check all that apply) ☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other

Date of interview ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Zip code (school or occupation): _____ Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other ☐ Unk

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Fever** Highest measured temp: _____ °F
				Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	**Recurring fever**
				Number of attacks: _____
				Days between attacks: _____
☐	☐	☐	☐	**Chills**
☐	☐	☐	☐	**Headache**
☐	☐	☐	☐	**Muscle aches or pain (myalgia)**
☐	☐	☐	☐	Malaise
☐	☐	☐	☐	Fatigue
☐	☐	☐	☐	Arthritis or arthralgia
☐	☐	☐	☐	Other symptoms consistent with illness
				Specify: _____

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Pregnant
				Estimated delivery date ___/___/___
				OB name, address, phone: _____
				_____

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Complications
				Specify: _____

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized at least overnight for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Laboratory

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___
Source _____

P	N	I	O	NT	
☐	☐	☐	☐	☐	***Borrelia*** **blood culture by special methods**
☐	☐	☐	☐	☐	**Spirochetes in peripheral blood smear by dark field microscopy or Wright-Giemsa stain**

NOTES

This reporting form was adopted from the Washington State Department of Health on 6/17/2013

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

	Exposure period		
Days from onset:	-18	-2	onset
Calendar dates:			

EXPOSURE (Refer to dates above)

Y	N	DK	NA	
☐	☐	☐	☐	Travel out of the state, out of the country, or outside of usual routine Out of: ☐ County ☐ State ☐ Country Dates/Locations: _____ _____ _____
☐	☐	☐	☐	Case knows anyone with similar symptoms
☐	☐	☐	☐	**Epidemiologic link to a confirmed human case**
☐	☐	☐	☐	If infant, birth mother had febrile illness

Y	N	DK	NA	
☐	☐	☐	☐	Tick bite Location of tick exposure ☐MT county ☐ Other state ☐ Other country ☐ Multiple exposures ☐ Unk Date of exposure: ___/___/___
☐	☐	☐	☐	Slept in cabin or outside
☐	☐	☐	☐	Slept in places with evidence of rodents (e.g. animals, nest, excreta)
☐	☐	☐	☐	Wild rodent or wild rodent excreta exposure Where rodent exposure probably occurred: _____

Where did exposure probably occur? ☐ In MT (County: _____) ☐ US but not MT ☐ Not in US ☐ Unk

Exposure details: _____

☐ **No risk factors or exposures could be identified**

☐ **Patient could not be interviewed**

PATIENT PROPHYLAXIS/TREATMENT

Y	N	DK	NA	
☐	☐	☐	☐	Antibiotics prescribed for this illness Name: _____ Date antibiotic treatment began: ___/___/___ # days antibiotic actually taken: _____

PUBLIC HEALTH ISSUES

Y	N	DK	NA	
☐	☐	☐	☐	Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset? Date: ___/___/___ Agency and location: _____ Specify type of donation: _____

PUBLIC HEALTH ACTIONS

☐ Education on pest control
☐ Rodent ☐ Tick ☐ Other
☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___