



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

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

Outbreak-related

LHJ Cluster: _____

DPHHS Outbreak: _____

Brucellosis

County _____

REPORT SOURCE

Initial report date ___/___/___
 Reporter (check all that apply)
 Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No Don't know
 Investigation start date: ___/___/___
 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
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other

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: _____
 Sweats
 Headache
 Fatigue
 Arthritis or arthralgia
 Loss of appetite (anorexia)
 Weight loss with illness

Hospitalization

Y N DK NA
 Hospitalized for this illness
 Hospital name _____
 Admit date ___/___/___ Discharge date ___/___/___
Y N DK NA
 Died from illness Death date ___/___/___
 Autopsy Place of death _____

Laboratory

Collection date ___/___/___
 Source _____
 P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

Predisposing Conditions

Y N DK NA
 Pregnant
 Estimated delivery date ___/___/___
 OB name, address, phone: _____
 Miscarriage or stillbirth
 Neonatal
 Delivery location: _____
 Postpartum mother (≤ 6 weeks)

P N I O NT

Brucella antibodies ≥ 160 without 4-fold rise (serum) [Probable case]
 Brucella culture (clinical specimen)
 Brucella immunofluorescence (clinical specimen)
 Brucella antibodies elevated but < 4-fold rise (serum pair)
 Brucella antibodies with ≥ 4-fold rise (serum pair ≥ 2 wks apart)
 Confirmed at state or federal public health lab

NOTES

Clinical Findings

Y N DK NA
 Endocarditis
 Osteomyelitis
 Orchitis

INFECTION TIMELINE

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

Exposure period: Days from onset: -60 -5 o
n
s
e
t

Calendar dates:

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case knows anyone with similar symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologic link to a confirmed human case</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If infant, confirmed infection in birth mother</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized milk (cow)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other unpasteurized milk (e.g. sheep, goat)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized dairy products (e.g. soft cheese from raw milk, queso fresco or food made with these cheeses)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Use RB51 vaccine to vaccinate cattle?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient could not be interviewed</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No risk factors or exposures could be identified</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case or household member lives or works on farm or dairy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse) Animal birthing/placentas <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA Animal (specify): _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wildlife or wild animal exposure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any contact with animals at home or elsewhere</p> <p>Cattle, cow or calf <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p>Dog or puppy <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p>Goat <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p>Pigs or swine <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p>Sheep <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed in laboratory</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Parenteral or mucous membrane <i>Brucella</i> vaccine exposure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____</p>
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Most likely exposure/site: _____ Site name/address: _____

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

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

Prophylaxis given prior to illness onset

Antibiotics prescribed for this illness Name: _____

Date/time antibiotic treatment began: ___/___/___ AM PM # 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: _____

Potential bioterrorism exposure

PUBLIC HEALTH ACTIONS

Investigation of raw milk dairy

Notify blood or tissue bank

Follow-up/prophylaxis of laboratorians exposed to specimen

Other, specify: _____

NOTES

Investigator _____	Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____		Record complete date ___/___/___

Brucellosis: case defining variables are in **bold**. Answers are: Yes, No, Unknown to case, Not asked /Not answered