County of Los Angeles Public Health

Acute Communicable Disease Control
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GLANDERS AND MELIOIDOSIS CASE REPORT FORM

IRIS ID:

RESET FORM

REPORTING DISEASE: ◯ Glanders ◯ Melioidosis **INITIAL IMPRESSION:** ☐ Single Case ☐ Laboratory Exposure

Reporting Facility Name	Report Date	Time ☐ AM ☐ PM	Facility Type

Reporter Name	Title	Telephone	Alternate Telephone	Email Address

DEMOGRAPHIC INFORMATION

Patient Name-Last	First	Middle Initial	Date of Birth	Age	Gender

Address- Number, Street, Apt #	City	State	ZIP Code

County of Residence	Country of Usual Residence	Number of Years Residing in US	Country of Birth

Telephone Home: Cell:

Race
☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other:

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

If Asian/Pacific Islander, please check all that apply:
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawiian
☐ Japanese ☐ Korean ☐ Laotian ☐ Samoan ☐ Vietnamese ☐ Other:

Pregnant? (if Female) ☐ Yes ☐ No ☐ Unknown If Yes, due date:

Occupation: **Other:**

Occupational Location / Setting:

PRESENT ILLNESS

Symptomatic: ☐ Yes ☐ No ☐ Unknown *If No, Skip this section and go to Epidemiological Risk Factors section.*

Symptom onset date	Duration of symptoms	Date first sought medical attention	Admitted to ICU?	Intubated?
	days		☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk

Hospitalized	Hospital Name	Medical Record Number	Admit Date	Discharge Date
☐ Yes ☐ No ☐ Unk				

Select all symptoms and conditions experienced by the patient during this illness:

☐ Fever (highest temp _____ F°)
☐ Nodule
☐ Anorexia
☐ Seizure
☐ Periocardial effusion
☐ Muscle aches
☐ Swelling
☐ Pneumonia/pleural effusion
☐ Skin or soft tissue infection
☐ Bone or joint infection
☐ Joint pain
☐ Abdominal discomfort
☐ Chills
☐ Genitourinary infection
☐ Septic shock
☐ Fatigue
☐ Chest pain
☐ Cough
☐ Headache
☐ CNS infection
☐ Ulcer
☐ Respiratory distress
☐ Disorientation
☐ Weight loss ____ lbs)
☐ Sepsis
☐ Encephalomyelitis/meningitis

☐ Abscess / Organ Abscess(specify):

☐ Other symptom(s):

Antibiotics given?
☐ Yes
☐ No
☐ Unknown

	Start Date:	End date:
☐ Ceftazidime		
☐ Meropenem		
☐ Trimethoprim/Sulfamethoxazole		
☐ Amoxicillin/Clavulanate		
☐ Other:		

PAST MEDICAL HISTORY

Does the patient have any of the following pre-existing medical conditions? (select all that apply)

☐ Diabetes ☐ Liver disease ☐ Chronic lung disease ☐ Chronic kidney disease ☐ No pre-existing conditions
☐ Malignancy ☐ Thalassemia ☐ Systemic lupus erythematosus ☐ Chronic granulomatous disease ☐ Unknown
☐ Immunocompromised

☐ On immunosurpressive drugs:

☐ Other pre-existing condition:

Does the patient excessively use alcohol or have they in the past?
☐ Current excessive alcohol use ☐ No
☐ Former excessive alcohol use ☐ Unknown

Patient Name (last, first) _____ Date of Birth _____ IRIS ID: _____

EPIDEMIOLOGIC RISK FACTORS

Was this individual part of a recognized cluster or outbreak of glanders or melioidosis? ☐ Yes ☐ No ☐ Unk **Outbreak ID:** _____

Was this individual part of a recognized laboratory exposure of glanders or melioidosis? ☐ Yes ☐ No ☐ Unk

TRAVEL HISTORY

Has the patient EVER traveled or lived outside of the US in the lifetime (including military service)? ◯ Yes ◯ No ◯ Unknown

If yes, select all continents where patient has visited or lived in their lifetime and most recent year visited:

☐ **Asia**	Year:	☐ **Europe**	Year:	☐ **North America** *(outside US)*	Year:
☐ **Africa**	Year:	☐ **Middle East**	Year:	☐ **Central America**	Year:
☐ **Australia**	Year:	☐ **Caribbean**	Year:	☐ **South America**	Year:

List of endemic areas for glanders: https://www.cdc.gov/glanders/exposure/index.html
List of endemic areas for melioidosis: https://www.cdc.gov/melioidosis/risk-factors/index.html

Has the patient served overseas in the military? ◯ Yes ◯ No ◯ Unknown

Travel/Past Residence Notes

Has the patient EVER visited or lived in any of the following US states or territories in their lifetime?

☐ Alabama ☐ Florida ☐ Louisiana ☐ Mississippi ☐ Texas ☐ No/None ☐ Unknown Year most recently visited: _____
☐ Puerto Rico ☐ U.S. Virgin Islands ☐ Other: _____

In the 30 days prior to illness onset, did the patient travel 50 miles or more from their normal residence? ◯ Yes ◯ No ◯ Unknown

If yes, where? _____ Dates of Travel: _____ to: _____
If yes, where? _____ Dates of Travel: _____ to: _____
If yes, where? _____ Dates of Travel: _____ to: _____

ENVIRONMENTAL AND ANIMAL EXPOSURE

In the 30 days prior to illness onset, did the patient have contact with fresh water, mud, soil, compost, or sewage? ◯ Yes ◯ No ◯ Unknown

If yes, select all that apply:

☐ Running water *(e.g., river, stream)* ☐ Still water *(e.g. lake, pond)* ☐ Flood water ☐ Heavy rainfall ☐ Sewage
☐ Rainwater run-off/puddles ☐ Mud or wet soil ☐ Compost ☐ Other soil

Date: _____ **Specify locations:** _____
Date: _____ **Specify locations:** _____

In the 30 days prior to illness onset, did the patient own or have contact with any animals? ◯ Yes ◯ No ◯ Unknown

If yes, select all that apply:

☐ Iguana ☐ Fish, guppies ☐ Cat ☐ Dog ☐ Goat ☐ Other: _____
☐ Sheep ☐ Horse ☐ Mule ☐ Cow ☐ Pig, hogs, boar

Date of Exposure: _____

Type of exposure:
☐ Direct contact, handling or petting
☐ Direct contact, animal fluids or cleaning enclosure
☐ Indirect contact
☐ Patient owns animal(s)

Location of purchase or where animal was acquired: _____

What activities led to the indicated environmental or animal exposure(s)? [select all that apply]

☐ Swimming or bathing
☐ Fresh water fishing
☐ Adventure race, triathalon, or mud run
☐ Biking/motorcycle riding
☐ Pet or livestock ownership
☐ Boating, kayaking, or rafting
☐ Camping or hiking
☐ Playing sports in yard or park
☐ Gardening or yard work
☐ Petting/touching animals at farm/zoo/other location
☐ Drinking water
☐ Hunting
☐ Maintenance or house cleaning
☐ Washing dishes or laundry
☐ Occupational
☐ Other: _____
☐ Unknown
Date: _____
Location: _____

In the 30 days prior to illness onset, has the patient been in any areas experiencing significant/ severe weather? ◯ Yes ◯ No ◯ Unknown

If yes, select all that apply:

☐ Hurricane, cyclone, or typhoon ☐ Flooding ☐ Windstorm or tornado
☐ Mudslide ☐ Heavy rain ☐ Other: _____
☐ Earthquake

Date of Exposure: _____ **Specify location:** _____

In the 30 days prior to illness onset, has the patient used any aromatic therapy/ aromatherapy room spray? ◯ Yes ◯ No ◯ Unknown

What is the product(s)/ brand(s) name: _____
Where was the product bought? _____
What is the origin/manufacturing country of this product? _____
Where was this aromatic therapy used? _____
Others using this product? ◯ Yes ◯ No ◯ Unknown
First Date of Use: _____
Last/Most Recent Date of Use: _____

Please list any additional exposure information not captured above in "Notes" on page 4

Patient Name (last, first) | Date of Birth | IRIS ID:

DIAGNOSTIC TESTS

1st Test & Specimen

Test type: ○ PCR ○ IHC ○ Other ELISA IgM ○ Viteck or other automated clinical laboratory system ○ IHA ○ ImmunoDot/DotBlot IgM ○ Culture ○ Other:

Performing lab:

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Tissue ○ Urine ○ Other:

Specify tissue type:

Specimen collection date:

Qualitative result: ○ Positive ○ Borderline ○ Negative ○ Indeterminate ○ Other:

Quantitative result *(e.g., titer)*:

Organism name:

Lab result date:

Send to CDC? ○ Yes ○ No, isolate destroyed ○ No, specimen not available

AST requested? ○ Yes ○ No ○ Not applicable

2nd Test & Specimen

Test type: ○ PCR ○ IHC ○ Other ELISA IgM ○ Viteck or other automated clinical laboratory system ○ IHA ○ ImmunoDot/DotBlot IgM ○ Culture ○ Other:

Performing lab:

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Tissue ○ Urine ○ Other:

Specify tissue type:

Specimen collection date:

Qualitative result: ○ Positive ○ Borderline ○ Negative ○ Indeterminate ○ Other:

Quantitative result *(e.g., titer)*:

Organism name:

Lab result date:

Send to CDC? ○ Yes ○ No, isolate destroyed ○ No, specimen not available

AST requested? ○ Yes ○ No ○ Not applicable

3rd Test & Specimen

Test type: ○ PCR ○ IHC ○ Other ELISA IgM ○ Viteck or other automated clinical laboratory system ○ IHA ○ ImmunoDot/DotBlot IgM ○ Culture ○ Other:

Performing lab:

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Tissue ○ Urine ○ Other:

Specify tissue type:

Specimen collection date:

Qualitative result: ○ Positive ○ Borderline ○ Negative ○ Indeterminate ○ Other:

Quantitative result *(e.g., titer)*:

Organism name:

Lab result date:

Send to CDC? ○ Yes ○ No, isolate destroyed ○ No, specimen not available

AST requested? ○ Yes ○ No ○ Not applicable

4th Test & Specimen

Test type: ○ PCR ○ IHC ○ Other ELISA IgM ○ Viteck or other automated clinical laboratory system ○ IHA ○ ImmunoDot/DotBlot IgM ○ Culture ○ Other:

Performing lab:

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Tissue ○ Urine ○ Other:

Specify tissue type:

Specimen collection date:

Qualitative result: ○ Positive ○ Borderline ○ Negative ○ Indeterminate ○ Other:

Quantitative result *(e.g., titer)*:

Organism name:

Lab result date:

Send to CDC? ○ Yes ○ No, isolate destroyed ○ No, specimen not available

AST requested? ○ Yes ○ No ○ Not applicable

ENVIRONMENTAL SAMPLES

Specimen type: ☐ Water ☐ Soil ☐ Other:

Date of Collection: | Location of Collection:

Organism Identified: | Performing Lab:

Specimen type: ☐ Water ☐ Soil ☐ Other:

Date of Collection: | Location of Collection:

Organism | Performing Lab:

Notes:

Patient Name (last, first) _____ Date of Birth _____ IRIS ID: _____

POST-EXPOSURE PROPHYLAXIS

Did patient receive post-exposure prophylaxis (PEP)?
- ☐ Yes
- ☐ No
- ☐ Unknown

If patient did not receive PEP, why not?
- ☐ Not indicated
- ☐ Unaware of exposure
- ☐ Unavailable
- ☐ Allergic
- ☐ Pregnant
- ☐ Unknown
- ☐ Other: _____

If yes, antimicrobial taken:
- ☐ Ceftazidime
- ☐ Co-amoxicav
- ☐ Doxycycline
- ☐ Meropenem
- ☐ Trimethoprim/Sulfamethoxazole
- ☐ Amoxicillin/Clavulanate
- ☐ Other: _____

Did the patient complete the course?
- ☐ Yes
- ☐ No
- ☐ Unknown

If patient did not complete course, provide reason: _____

LABORATORY EXPOSURE

Was there a laboratory exposure? ☐ Yes ☐ No ☐ Unk

If Yes, Date of exposure _____ Total number exposed _____: High Risk _____ Low Risk _____

Laboratory name and location. _____

Activities resulting in exposure. _____

Describe potential exposure. _____

Date post-exposure prophylaxis (PEP) was offered/discussed _____ Risk Status: ☐ High ☐ Low ☐ Unknown

Date PEP initiated _____ PEP regimen used _____

Time between first exposure and start of PEP: _____ Dosing: _____ Duration: _____

Were any side effects reported with the PEP? ☐ Yes ☐ No ☐ Unk

If Yes, Date of onset _____

Describe side effects. _____

Did side effects result in the termination of PEP? ☐ Yes ☐ No ☐ Unk If Yes, how many days was prophylaxis administered? _____

Did side effects result in a switch to another antimicrobial agent? ☐ Yes ☐ No ☐ Unk

If Yes, Specify antimicrobial agent. _____

Date started. _____

Are serial serum specimens being collected? ☐ Yes ☐ No ☐ Unk

If Yes, Collection date of "baseline" serum sample? _____

Time between first exposure and initial serum collection: _____ ☐ Days ☐ Weeks

Dates of serum collection: Week 1 _____ Week 2 _____ Week 4 _____ Week 6 _____

ADDITIONAL DEMOGRAPHIC INFORMATION

Sex Assigned at Birth
- ☐ Female
- ☐ Male
- ☐ Unknown
- ☐ Declined to answer

Sexual Orientation
- ☐ Heterosexual or straight
- ☐ Gay, lesbian, or same-gender loving
- ☐ Bisexual
- ☐ Questioning, unsure, or patient doesn't know
- ☐ Orientation not listed
- ☐ Declined to answer
- ☐ Unknown

REMARKS

Clinical outcome:
- ☐ Died
- ☐ Still hospitalized
- ☐ Still sick (outpatient)
- ☐ Recovered
- ☐ Long-term disability
- ☐ Unknown

Date of Death: 05/10/2024

Pathogen: ☐ *B. mallei* ☐ *B. pseudomallei* ☐ Other: _____

Disease Case Classification
- ☐ Confirmed ☐ False
- ☐ New ☐ Recurrent ☐ Unknown

Notes: _____

Investigator: _____ **Title:** _____