State of California—Health and Human Services Agency

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

RELAPSING FEVER CASE REPORT

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐*Years* ☐*Months* ☐*Days*

Address Number & Street - Residence	*Apartment/Unit Number*

City/Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country*

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*

Gender
☐Male ☐Female ☐Other: _____

E-mail Address	*Other Electronic Contact Information*

Work/School Location	*Work/School Contact*

Pregnant? ☐Yes ☐No ☐Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Occupation Setting (see list on page 6)	*Other Describe/Specify*

Occupation (see list on page 6)	*Other Describe/Specify*

Primary Language
☐English
☐Spanish
☐Other:_____

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

*Race**
(check all that apply, race descriptions on page 6)
☐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.

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

First three letters of patient's last name: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐Yes ☐No ☐Unk	Onset Date (mm/dd/yyyy)	Date First Sought Medical Care (mm/dd/yyyy)

Signs and Symptoms	Yes	No	Unk	Signs and Symptoms	Yes	No	Unk
Fever *(specify details of febrile episodes below)*				Body aches			
Chills				Nausea or vomiting			
Sweats				Loss of appetite			
Headache				Dry cough			

Other signs / symptoms (specify)

FEBRILE EPISODES

Total Number of Febrile Episodes (specify details of febrile episodes below)

FEBRILE EPISODES - DETAILS

Episode 1	*Start Date (mm/dd/yyyy)*	*End Date (mm/dd/yyyy)*	*Highest Recorded Temperature (specify °F/°C)*
Episode 2	*Start Date (mm/dd/yyyy)*	*End Date (mm/dd/yyyy)*	*Highest Recorded Temperature (specify °F/°C)*
Episode 3	*Start Date (mm/dd/yyyy)*	*End Date (mm/dd/yyyy)*	*Highest Recorded Temperature (specify °F/°C)*

HOSPITALIZATION

Did patient visit emergency room for illness? ☐Yes ☐No ☐Unk	Was patient hospitalized? ☐Yes ☐No ☐Unk	If Yes, how many total hospital nights?

If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION - DETAILS

Hospital Name 1	*Street Address*			*Admit 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*			*Admit 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? ☐Yes ☐No ☐Unk	If Yes, specify the treatment below.

TREATMENT / MANAGEMENT - DETAILS

Treatment Type 1 ☐Antibiotic ☐Other	*Treatment Name*	*Date Started (mm/dd/yyyy)*	*Date Ended (mm/dd/yyyy)*
Treatment Type 2 ☐Antibiotic ☐Other	*Treatment Name*	*Date Started (mm/dd/yyyy)*	*Date Ended (mm/dd/yyyy)*

First three letters of patient's last name: | | | |

OUTCOME

Outcome?	If Survived,	Date of Death (mm/dd/yyyy)
☐Survived ☐Died ☐Unk	Survived as of _____ (mm/dd/yyyy)	

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Blood smear done? ☐Yes ☐No ☐Unk	Type of Test ☐Thick Smear ☐Thin Smear	Results ☐Spirochetes observed ☐No spirochetes observed ☐Unk ☐Other:_____	
	Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number
Serology done? ☐Yes ☐No ☐Unk	Type of Test ☐EIA ☐Western blot ☐Other:_____	Results ☐Positive ☐Negative ☐Unk ☐Other:_____	
	Collection Date (mm/dd/yyyy)	Laboratory Name	Telephone Number

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD IS 21 DAYS PRIOR TO ILLNESS ONSET

BITE HISTORY

Did the patient observe any rodents in or around residence?	Did the patient recall any insect bites during the incubation period?
☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk

If Yes, specify locations, type of bite, and dates below.

BITE HISTORY - DETAILS

	Location (county, state, country)	Date of Bite (mm/dd/yyyy)	Type of Bite
Bite 1			☐Tick ☐Other:_____ ☐Unk
Bite 2			☐Tick ☐Other:_____ ☐Unk

TRAVEL HISTORY

*Did patient travel **out of county of residence** during the incubation period?*
☐Yes ☐No ☐Unk

If Yes, specify all locations and dates in the Travel History - Details table below.

TRAVEL HISTORY - DETAILS

Location 1 (Facility Name)	Street Address		Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
	City		Name of Property Owner / Manager	Telephone Number
	State	Zip Code	Other relapsing fever cases known to be exposed at this location? ☐Yes ☐No ☐Unk	
Location 2 (Facility Name)	Street Address		Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
	City		Name of Property Owner / Manager	Telephone Number
	State	Zip Code	Other relapsing fever cases known to be exposed at this location? ☐Yes ☐No ☐Unk	

(continued on page 4)

First three letters of patient's last name: | | | |

TRAVEL HISTORY - DETAILS (continued)

Location 3 (Facility Name)	Street Address		Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
	City		Name of Property Owner / Manager	Telephone Number
	State	Zip Code	Other relapsing fever cases known to be exposed at this location? ☐Yes ☐No ☐Unk	

CONTACTS / OTHER ILL PERSONS

Any contacts or travel companions with similar illness? ☐Yes ☐No ☐Unk	If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	Illness Onset Date (mm/dd/yyyy)
	Street Address			Exposure Dates Shared with Index Case (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	Illness Onset Date (mm/dd/yyyy)
	Street Address			Exposure Dates Shared with Index Case (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)

First Reported By
☐Clinician ☐Laboratory ☐Other (specify):_____

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐Yes ☐No ☐Unk	Contact Name / Case Number

First three letters of patient's last name: | | | |

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐Confirmed ☐Probable ☐Suspect

OUTBREAK

Part of known outbreak?	*If Yes, extent of outbreak*
☐Yes ☐No ☐Unk	☐One CA jurisdiction ☐Multiple CA jurisdictions ☐Multistate ☐International ☐Unk ☐Other (specify):_____

Mode of Transmission	*Vehicle of Outbreak*	*Pattern 1 ID Number*	*Pattern 2 ID Number*
☐Point source ☐Person-to-person ☐Unk ☐Other (specify):_____			

STATE USE ONLY

State Case Classification
☐Confirmed ☐Suspect ☐Not a case ☐Need additional information

CASE DEFINITION

RELAPSING FEVER (California working definition, 2011)

CLINICAL EVIDENCE
One or more episodes of fever (>100.5 °F) lasting 2-7 days and separated by afebrile periods of 4-14 days, often accompanied by headache, muscle and joint aches, and nausea.

LABORATORY EVIDENCE
For the purpose of surveillance:

Laboratory confirmed

- Observation of *Borrelia sp*. spirochetes on thick or thin smear of peripheral blood collected during a febrile episode

Laboratory supportive

- Elevated IgM or IgG serum antibodies to *B. hermsii* detected by commercial EIA or IFA

CASE CLASSIFICATION

Confirmed: A clinically compatible case (meets clinical evidence criteria) that is laboratory confirmed

Probable: A clinically compatible case (meets clinical evidence criteria) that has supportive laboratory results and a history of being in the same location as a confirmed case 2 to 14 days prior to onset of first febrile episode

Suspect: A clinically compatible case (meets clinical evidence criteria) that has supportive laboratory results and a history of residing in or visiting an area in the western U.S. between 2000 and 9000 feet elevation 2 to 14 days prior to onset of first febrile episode

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

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- 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
- 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