

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	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
E-mail Address			Other Electronic Contact Information		
Work/School Location			Work/School Contact		
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
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		
*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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<b>SIGNS AND SYMPTOMS</b>													
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	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)													
<b>FEBRILE EPISODES</b>													
Total Number of Febrile Episodes (specify details of febrile episodes below)													
<b>FEBRILE EPISODES - DETAILS</b>													
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)						
<b>HOSPITALIZATION</b>													
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?					
If there were any ER or hospital stays related to this illness, specify details below.													
<b>HOSPITALIZATION - DETAILS</b>													
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			
<b>TREATMENT / MANAGEMENT</b>													
Received Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					If Yes, specify the treatment below.								
<b>TREATMENT / MANAGEMENT - DETAILS</b>													
Treatment Type 1 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other		Treatment Name				Date Started (mm/dd/yyyy)			Date Ended (mm/dd/yyyy)				
Treatment Type 2 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other		Treatment Name				Date Started (mm/dd/yyyy)			Date Ended (mm/dd/yyyy)				

First three letters of patient's last name: 

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**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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**LABORATORY INFORMATION**

**LABORATORY RESULTS SUMMARY**

Blood smear done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type of Test <input type="checkbox"/> Thick Smear <input type="checkbox"/> Thin Smear	Results <input type="checkbox"/> Spirochetes observed <input type="checkbox"/> No spirochetes observed <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	Telephone Number
Collection Date (mm/dd/yyyy)		Laboratory Name	Telephone Number
Serology done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type of Test <input type="checkbox"/> EIA <input type="checkbox"/> Western blot <input type="checkbox"/> Other: _____	Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	Telephone Number
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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Did the patient recall any insect bites during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
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If Yes, specify locations, type of bite, and dates below.

**BITE HISTORY - DETAILS**

Bite 1	Location (county, state, country)	Date of Bite (mm/dd/yyyy)	Type of Bite <input type="checkbox"/> Tick <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
Bite 2	Location (county, state, country)	Date of Bite (mm/dd/yyyy)	Type of Bite <input type="checkbox"/> Tick <input type="checkbox"/> Other: _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

(continued on page 4)



First three letters of patient's last name:

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**DISEASE CASE CLASSIFICATION**

Case Classification (see case definition below)  
 Confirmed  Probable  Suspect

**OUTBREAK**

Part of known outbreak?	If Yes, extent of outbreak
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____

Mode of Transmission	Vehicle of Outbreak	Pattern 1 ID Number	Pattern 2 ID Number
<input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> 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 <b>any</b> of the original peoples of North and South America (including Central America).
Asian	Patient has origins in <b>any</b> 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 <b>any</b> of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in <b>any</b> of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in <b>any</b> of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> <li>• Childcare/Preschool</li> <li>• Correctional Facility</li> <li>• Drug Treatment Center</li> <li>• Food Service</li> <li>• Health Care - Acute Care Facility</li> <li>• Health Care - Long Term Care Facility</li> <li>• Health Care - Other</li> </ul>	<ul style="list-style-type: none"> <li>• Homeless Shelter</li> <li>• Laboratory</li> <li>• Military Facility</li> <li>• Other Residential Facility</li> <li>• Place of Worship</li> <li>• School</li> <li>• Other</li> </ul>
OCCUPATION	
<ul style="list-style-type: none"> <li>• Adult film actor/actress</li> <li>• Agriculture - farmworker or laborer (crop, nursery, or greenhouse)</li> <li>• Agriculture - field worker</li> <li>• Agriculture - migratory/seasonal worker</li> <li>• Agriculture - other/unknown</li> <li>• Animal - animal control worker</li> <li>• Animal - farm worker or laborer (farm or ranch animals)</li> <li>• Animal - veterinarian or other animal health practitioner</li> <li>• Animal - other/unknown</li> <li>• Clerical, office, or sales worker</li> <li>• Correctional facility - employee</li> <li>• Correctional facility - inmate</li> <li>• Craftsman, foreman, or operative</li> <li>• Daycare or child care attendee</li> <li>• Daycare or child care worker</li> <li>• Dentist or other dental health worker</li> <li>• Drug dealer</li> <li>• Fire fighting or prevention worker</li> <li>• Flight attendant</li> <li>• Food service - cook or food preparation worker</li> <li>• Food service - host or hostess</li> <li>• Food service - server</li> <li>• Food service - other/unknown</li> <li>• Homemaker</li> <li>• Laboratory technologist or technician</li> <li>• Laborer - private household or unskilled worker</li> <li>• Manager, official, or proprietor</li> <li>• Manicurist or pedicurist</li> <li>• Medical - emergency medical technician or paramedic</li> <li>• Medical - health care worker</li> </ul>	<ul style="list-style-type: none"> <li>• Medical - medical assistant</li> <li>• Medical - pharmacist</li> <li>• Medical - physician assistant or nurse practitioner</li> <li>• Medical - physician or surgeon</li> <li>• Medical - nurse</li> <li>• Medical - other/unknown</li> <li>• Military</li> <li>• Police officer</li> <li>• Professional, technical, or related profession</li> <li>• Retired</li> <li>• Sex worker</li> <li>• Stay at home parent/guardian</li> <li>• Student - preschool or kindergarten</li> <li>• Student - elementary or middle school</li> <li>• Student - high school</li> <li>• Student - college or university</li> <li>• Student - other/unknown</li> <li>• Teacher/employee - preschool or kindergarten</li> <li>• Teacher/employee - elementary or middle school</li> <li>• Teacher/employee - high school</li> <li>• Teacher/instructor/employee - college or university</li> <li>• Teacher/instructor/employee - other/unknown</li> <li>• Unemployed - seeking employment</li> <li>• Unemployed - not seeking employment</li> <li>• Unemployed - other/unknown</li> <li>• Volunteer</li> <li>• Other</li> <li>• Refused</li> <li>• Unknown</li> </ul>