

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

## TYPHUS AND OTHER NON-SPOTTED FEVER RICKETTSIOSES CASE REPORT

- Check one:  Murine typhus (*Rickettsia typhi*)  
 Epidemic typhus (*Rickettsia prowazekii*)  
 Other non-spotted fever rickettsiosis

*This form should be completed only for cases of typhus and other non-spotted fever rickettsioses. Rocky Mountain spotted fever and other spotted fever rickettsioses should be reported on the Spotted Fever Rickettsioses Case Report form. Ehrlichiosis/anaplasmosis cases should be reported on the Ehrlichiosis/Anaplasmosis Case Report form.*

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk
Address Number & Street - Residence			Apartment/Unit Number		
City/Town		State	Zip Code		
Census Tract	County of Residence		Country of Residence		
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	
E-mail Address		Other Electronic Contact Information			
Work/School Location		Work/School Contact			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, Est. Delivery Date (mm/dd/yyyy)			
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 6)		Other Describe/Specify			
Occupation (see list on page 6)		Other Describe/Specify			
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

\*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.

First three letters of patient's last name:

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**SIGNS AND SYMPTOMS**

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	If Yes, Specify as Noted		
Fever				Highest temperature (specify °F/°C)		
Chills						
Sweats						
Headache						
Muscle pain						
Joint pain				Joint(s)		
Eye pain						
Abdominal pain						
Nausea or vomiting						
Diarrhea						
Rash or other cutaneous lesion				Location / size / appearance		
Cough						
Hypotension				Date measured (mm/dd/yyyy)		Systolic / Diastolic

Other signs / symptoms (specify)

**HOSPITALIZATION**

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?
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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

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

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**LABORATORY INFORMATION**

**LABORATORY RESULTS SUMMARY - SEROLOGY**

Specimen Type 1	Collection Date (mm/dd/yyyy)	Type of Test	Antigen
	Results	Laboratory Name	Telephone Number
Specimen Type 2	Collection Date (mm/dd/yyyy)	Type of Test	Antigen
	Results	Laboratory Name	Telephone Number

**LABORATORY RESULTS SUMMARY - OTHER**

Hematology? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Collection Date (mm/dd/yyyy)	WBC	HCT	Hb	Platelets
Serum chemistry? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Collection Date (mm/dd/yyyy)	ALT	AST		
Other laboratory diagnostics performed (e.g., PCR, buffy coat smear)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, describe			

**EPIDEMIOLOGIC INFORMATION**

**ANIMAL AND INSECT EXPOSURES**

Observe any of the following at or around home? <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Rodents <input type="checkbox"/> Opossums <input type="checkbox"/> Fleas <input type="checkbox"/> Ticks	Observe any of the following at place of employment? <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Rodents <input type="checkbox"/> Opossums <input type="checkbox"/> Fleas <input type="checkbox"/> Ticks
Did patient recall any insect bites in the 10 days prior to illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations, type of insect bite, and dates below.

**INSECT BITE HISTORY - DETAILS**

Bite 1	Location (city, county, state, country)	Date of Insect Bite (mm/dd/yyyy)	Type of Insect Bite <input type="checkbox"/> Flea <input type="checkbox"/> Other: _____ <input type="checkbox"/> Tick
Bite 2	Location (city, county, state, country)	Date of Insect Bite (mm/dd/yyyy)	Type of Insect Bite <input type="checkbox"/> Flea <input type="checkbox"/> Other: _____ <input type="checkbox"/> Tick

**TRAVEL HISTORY**

Did patient travel <b>out of county of residence</b> during the <b>incubation period</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates in the Travel History - Details Table.
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**TRAVEL HISTORY - DETAILS**

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

First three letters of patient's last name:

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**NOTES / REMARKS**


**REPORTING AGENCY**

<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
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*First Reported By*  
 Clinician    Laboratory    Other (specify): \_\_\_\_\_

**DISEASE CASE CLASSIFICATION**

*Case Classification (see case definition below)*  
 Confirmed    Probable    Suspected

**STATE USE ONLY**

*State Case Classification*  
 Confirmed    Probable    Suspected    Not a case    Need additional information

**CASE DEFINITION**

**TYPHUS AND OTHER NON-SPOTTED FEVER RICKETTSIOSES (CDPH working definition, 2011)**

**CLINICAL EVIDENCE**

Acute onset of fever (≥100.4 °F) and at least one of the following signs/symptoms: headache, myalgia, or rash; and at least one of the following lab parameters: leukopenia, thrombocytopenia, or elevation of hepatic transaminases, in the absence of any other known cause.

**LABORATORY CRITERIA FOR DIAGNOSIS**

Because serologies for rickettsial diseases can be cross-reactive, specimens should be tested against a panel of *Rickettsia* antigens, including, at minimum, *R. rickettsii* and *R. typhi*, to differentiate between disease due to spotted fever group (SFG) and non-SFG *Rickettsia* spp. Specimens should be submitted to CDPH VRDL or another public health laboratory for confirmation whenever possible.

For the purposes of surveillance:

- Laboratory confirmed:**
- Serological evidence in paired acute and convalescent serum specimens of a four-fold or greater change in immunoglobulin G (IgG)-specific antibody titer reactive with *Rickettsia typhi* or other *Rickettsia* species antigen by indirect immunofluorescence assay (IFA). Convalescent titers must be ≥ 128; OR
  - Serologic evidence in a single serum specimen of elevated IgM and IgG antibody reactive to *R. typhi* or other *Rickettsia* species antigen by IFA. Titers must be ≥ 128; OR
  - Detection of *R. typhi* or other *Rickettsia* species\* DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay; OR
  - Detection of *R. typhi* or other *Rickettsia* species antigen in tissue or skin lesion biopsy or autopsy specimen by immunohistochemistry (IHC); OR
  - Isolation of *R. typhi* or other *Rickettsia* species\* from a clinical specimen in cell culture.

\*Cases with recovery of *R. rickettsii* DNA by PCR, detection of *R. rickettsii* antigen by IHC, or isolation of *R. rickettsii* by culture should be reported as spotted fever rickettsiosis.

- Laboratory supportive:**
- Serologic evidence in a single serum specimen of elevated IgM or IgG antibody reactive to *R. typhi* or other *Rickettsia* species antigen by IFA with a titer of ≥ 128.

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**CASE DEFINITION (continued)****EXPOSURE**

Rickettsioses are typically transmitted by biting arthropods such as fleas and ticks; however, recognized arthropod bite is not required.

**CASE CLASSIFICATION**

- Confirmed: a) a clinically compatible case (meets clinical evidence criteria) that is laboratory confirmed, or b) a clinically compatible case that has supportive laboratory results and an epi-link to a confirmed case (e.g., was in same household/same suspect defined exposure as a confirmed case within the past 14 days before onset of symptoms).
- Probable: A clinically compatible case (meets clinical evidence criteria) that has supportive laboratory results.
- Suspected: a) a clinically compatible case with epi-link to a confirmed case (e.g., was in same household/same suspect defined exposure as a confirmed case within the past 14 days before onset of symptoms) but no laboratory testing, or b) a case with laboratory evidence of past or present infection but no clinical information available (e.g., a laboratory report).

<b>RACE DESCRIPTIONS</b>	
<b>Race</b>	<b>Description</b>
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.
<b>OCCUPATION SETTING</b>	
<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>
<b>OCCUPATION</b>	
<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>