

LEPTOSPIROSIS CASE REPORT FORM

Georgia Department of Public Health

(Leave this section blank for state health department use) Confirmed Probable Not a case

Date of Interview: ____/____/____

A. Demographic Information

Name:	DOB: ____/____/____	Age:
Address:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City/State/Zip:	Occupation:	
County:	Home Phone:	Other Phone:
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Unknown		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		

B. Clinical Information

Name of Physician: _____ Physician Phone: _____
 Address: _____ City/State/Zip: _____

Have you experienced any of the following symptoms?

Fever <input type="checkbox"/> Y <input type="checkbox"/> N	Abdominal Pain <input type="checkbox"/> Y <input type="checkbox"/> N	Headache <input type="checkbox"/> Y <input type="checkbox"/> N	Icterus <input type="checkbox"/> Y <input type="checkbox"/> N
Chills/Shakes <input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N	Meningitis <input type="checkbox"/> Y <input type="checkbox"/> N	Rash <input type="checkbox"/> Y <input type="checkbox"/> N
Joint Aches <input type="checkbox"/> Y <input type="checkbox"/> N	Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N	Conjunctivitis <input type="checkbox"/> Y <input type="checkbox"/> N	Hemorrhage <input type="checkbox"/> Y <input type="checkbox"/> N
Muscle Aches <input type="checkbox"/> Y <input type="checkbox"/> N	Discolored Urine <input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis <input type="checkbox"/> Y <input type="checkbox"/> N	
Other symptoms _____		Number of stools in the past 24 hours ____	

What was the first symptom(s)? _____ Date of Onset: ____/____/____
 Duration of symptoms? _____ Days Weeks Months

Did you receive any treatment? Y N Date of Diagnosis: ____/____/____
 Treatment (specify products, dosage, and duration): _____
 Dates of treatment: ____/____/____ to ____/____/____

Were you hospitalized? Y N Name of Hospital/Facility: _____
 Dates of hospitalization: ____/____/____ to ____/____/____

Outcome: Recovered Died Unknown Date of Death (if patient died): ____/____/____

C. Diagnostic Criteria

Fits clinical description: Y N Unknown

Test/Specimen Type	Date Specimen Collected	Results	Name of Laboratory
PCR <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	____/____/____		
Culture <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	____/____/____		
Acute-phase serum Convalescent-phase serum	____/____/____ ____/____/____	Fourfold increase <input type="checkbox"/> Y <input type="checkbox"/> N	
ELISA (IgM)	____/____/____		
LEPTO Dipstick (IgM)	____/____/____		

D. Exposure Information

Did you travel out of the state or country in the 20 days prior to onset of symptoms? Y N
If yes, where? _____

Did you participate in any of the following activities in the 20 days prior to onset of symptoms?

Wading or swimming in natural waters Y N
If yes, where? _____

Boating/Kayaking/Rafting Y N
If yes, where? _____

Camping/Hiking Y N
If yes, where? _____

Outdoor race or competition Y N
If yes, where? _____

Did you have contact with the following animals or their wastes in the 20 days prior to onset of symptoms?

Livestock Y N
If yes, specify species: _____ Location of livestock: _____

Rodents Y N
If yes, what type of exposure (e.g., pet store, personal pet, infestation)? _____

Dogs Y N
If yes, what type of exposure (e.g., pet store, personal pet, infestation)? _____

Cats Y N
If yes, what type of exposure (e.g., pet store, personal pet, infestation)? _____

Wildlife Y N
If yes, specify species: _____

If exposure to livestock or pets, were animals seen by a veterinarian? Y N
Name: _____ Phone number: _____

E. Additional Information

Submitted by:	Title:	Agency:
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Phone:	Fax:	Date: ____/____/____
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(Leave this section blank for state health department use)
Reviewed by epidemiologist: Y N Name: _____ Date of review: ____/____/____