



Tickborne Rickettsial Disease Case Report

CDC# _____

Use for Spotted Fever Rickettsiosis (SFR) including Rocky Mountain spotted fever (RMSF), Anaplasmosis, and Ehrlichiosis case reporting. Visit <https://ndc.services.cdc.gov/event-codes-other-surveillance-resources/> for complete case definitions or visit the disease website(s) for a fillable/downloadable PDF version of this case report form.

Patient Name: _____				Date submitted (mm/dd/yyyy): _____																	
Address: _____				Healthcare provider's name: _____																	
City: _____				Local Patient ID.: (if reported) _____ Local ID _____ Site _____ State _____																	
1. State of residence (postal abbrev.): _____		2. County of residence: _____		3. Sex: 1 Male 2 Female 9 Undetermined																	
4. Patient age (years) at time of case investigation: _____	5. Race (check all that apply): 1 White 4 Asian 7 Unknown 2 Black or African American 5 Native Hawaiian or Other Pacific Islander 8 Refused 3 American Indian or Alaska Native 6 Other race			6. Hispanic or Latino ethnicity: 1 Yes 2 No 9 Unknown																	
7. In the two weeks before symptom onset or diagnosis (use earlier date), did the patient travel out of their county, state, or country of residence? 1 Yes 2 No 9 Unknown Destination (county, state, or country): _____ When did they arrive? (mm/dd/yyyy) _____ When did they depart? (mm/dd/yyyy) _____																					
8. In the two weeks before symptom onset or diagnosis (use earlier date), did the patient notice any tick bites? 1 Yes 2 No 9 Unknown		If yes, date (mm/dd/yyyy): _____		If the patient removed a tick from their body, what was the geographic location at the time (county, state, or country)? _____																	
9. Clinical evidence of tickborne rickettsial disease: <table border="0" style="width: 100%;"><tr><td style="width: 50%;">Fever 1 Yes 2 No 9 Unknown</td><td style="width: 50%;">Anemia 1 Yes 2 No 9 Unknown</td></tr><tr><td>Chills/sweats 1 Yes 2 No 9 Unknown</td><td>Thrombocytopenia 1 Yes 2 No 9 Unknown</td></tr><tr><td>Rash 1 Yes 2 No 9 Unknown</td><td>Hepatic transaminase elevation 1 Yes 2 No 9 Unknown</td></tr><tr><td>Eschar 1 Yes 2 No 9 Unknown</td><td>Leukopenia 1 Yes 2 No 9 Unknown</td></tr><tr><td>Headache 1 Yes 2 No 9 Unknown</td><td>Elevated C-reactive proteins 1 Yes 2 No 9 Unknown</td></tr><tr><td>Myalgia 1 Yes 2 No 9 Unknown</td><td>Other, specify: _____</td></tr><tr><td>Fatigue/malaise 1 Yes 2 No 9 Unknown</td><td></td></tr><tr><td>Nausea/vomiting 1 Yes 2 No 9 Unknown</td><td></td></tr></table>						Fever 1 Yes 2 No 9 Unknown	Anemia 1 Yes 2 No 9 Unknown	Chills/sweats 1 Yes 2 No 9 Unknown	Thrombocytopenia 1 Yes 2 No 9 Unknown	Rash 1 Yes 2 No 9 Unknown	Hepatic transaminase elevation 1 Yes 2 No 9 Unknown	Eschar 1 Yes 2 No 9 Unknown	Leukopenia 1 Yes 2 No 9 Unknown	Headache 1 Yes 2 No 9 Unknown	Elevated C-reactive proteins 1 Yes 2 No 9 Unknown	Myalgia 1 Yes 2 No 9 Unknown	Other, specify: _____	Fatigue/malaise 1 Yes 2 No 9 Unknown		Nausea/vomiting 1 Yes 2 No 9 Unknown	
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10. Date of illness onset(mm/dd/yyyy): _____																					
11. Did the patient experience any severe complications in the clinical course of this illness? 1 Yes 2 No 9 Unknown If the patient experienced severe complications due to this illness, specify the complication(s): 1 Acute respiratory distress syndrome (ARDS) 2 Disseminated intravascular coagulation (DIC) 3 Meningitis/encephalitis 4 Organ failure 5 Other, specify: _____			12. At the time of diagnosis, was the patient immunocompromised due to medical condition(s) or treatment(s) (such as one of the following: chemotherapy for current illness, HIV, anti-rejection drugs post-transplant, corticosteroids >14 days [such as prednisone, methylprednisolone, or dexamethasone], rheumatoid arthritis [with use of immunomodulator])? 1 Yes 2 No 9 Unknown Specify condition(s) or treatment(s): _____																		
13. Was the patient hospitalized because of this illness? 1 Yes 2 No 9 Unknown		Admission date (mm/dd/yyyy): _____	Discharge date (mm/dd/yyyy): _____	14. Did the patient die from this illness or complications of this illness? 1 Yes 2 No 9 Unknown If yes, date (mm/dd/yyyy): _____																	
15. Were antibiotics prescribed for this infection? 1 Yes 2 No 9 Unknown	Specify antibiotic (if multiple antibiotics were prescribed, please specify in comments): _____		Date treatment was prescribed (mm/dd/yyyy): _____		Prescribed duration (days): _____																
16. In the year before symptom onset or diagnosis (use earlier date), did the patient receive a blood transfusion? 1 Yes 2 No 9 Unknown <i>If no or unknown, skip to Q. 17 below. Otherwise, continue with 16a, 16b, and 16c.</i>		16a. Date of blood transfusion (mm/dd/yyyy) (If multiple antibiotics were prescribed, please specify in comments): _____		16b. Was the patient's infection transfusion-associated? 1 Yes 2 No 9 Unknown																	
		16c. If a blood product was implicated in the infection, specify which type(s): 1 Plasma product 2 Platelet product 3 Red blood cells 4 Unknown 5 Other, specify: _____																			

17. In the year before symptom onset or diagnosis (use earlier date), did the patient receive an organ transplant? 1 Yes 2 No 9 Unknown <i>If no or unknown, skip to Q. 18 below. Otherwise, continue with 17a, 17b, and 17c.</i>	17a. Date of transplant (mm/dd/yyyy): _____ 17c. If the patient received an organ transplant, specify which organ(s): _____	17b. Was the patient's infection transplant-associated? 1 Yes 2 No 9 Unknown
18. Did the patient donate blood in the 30 days prior to symptom onset? 1 Yes 2 No 9 Unknown <i>If no or unknown, skip to Q. 19 below. Otherwise, continue with 18a, 18b, 18c, and 18d.</i>	18a. Date of blood donation (mm/dd/yyyy): _____ 18c. If a blood product was implicated in the infection, specify which type(s): 1 Plasma product 2 Platelet product 3 Red blood cells 4 Unknown 5 Other, specify: _____	18b. Was the patient a blood donor identified during an investigation into a transfusion-associated infection? 1 Yes 2 No 9 Unknown 18d. Was the blood bank/hospital/transplant service notified? 1 Yes 2 No 9 Unknown

19. Performing laboratory name (organization that performed diagnostic testing): _____	State (postal abbrev.): _____
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20. Serology 1 collection date (mm/dd/yyyy): _____	Serology 2 collection date* (mm/dd/yyyy): _____																								
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If additional serology testing performed, please specify in comments.	*Was there a fourfold change in antibody titer between the two IgG serum specimens? Yes No																								

21. Other Diagnostic Tests:			
Tests	Date Collected (mm/dd/yyyy)	Specimen Type	Results
PCR			Positive Negative Not performed
Other molecular detection*			Positive Negative Not performed
Morulae visualization			Positive Negative Not performed
Immunostain			Positive Negative Not performed
Culture (confirmed by PCR)			Positive Negative Not performed

*Other molecular detection can include nucleic acid amplification tests or genetic sequencing. Please enter specific type of test in comments.

22. If PCR, immunostain, or sequencing performed, specify genus or species identified:		
1 <i>Anaplasma phagocytophilum</i> 2 <i>Ehrlichia chaffeensis</i> 3 <i>Ehrlichia ewingii</i> 4 <i>Ehrlichia muris euclairensis</i> 5 <i>Ehrlichia</i> species (pan- <i>Ehrlichia</i>)	6 Genera <i>Ehrlichia</i> / <i>Anaplasma</i> 7 <i>Rickettsia africae</i> 8 <i>Rickettsia parkeri</i> 9 <i>Rickettsia rickettsii</i>	10 <i>R. rickettsii</i> subsp. <i>californica</i> 11 <i>Rickettsia</i> species (pan- <i>Rickettsia</i>) 12 Spotted fever group <i>Rickettsiae</i> 13 Other, specify: _____

23. Condition or event that constitutes the reason the notification is being sent: 1 SFR (including RMSF) 4 Ehrlichiosis - <i>E.ewingii</i> 2 Ehrlichiosis - <i>E. chaffeensis</i> 7 Ehrlichiosis - <i>E. muris euclairensis</i> 3 Anaplasmosis - <i>A. phagocytophilum</i> 8 Other <i>Ehrlichia</i> spp. or unspciated	24. Case Outcome (only confirmed and probable cases to be reported to CDC): 1 Confirmed 3 Suspect 9 Unknown 2 Probable 4 Not a Case
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State Health Department Official who reviewed this report:	
Name: _____	Phone number: _____
Title: _____	Email address: _____
Date: _____	
Comments: _____	