

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

**BRUCELLOSIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 5**

**ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.**

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN



Verify if lab results for this event are in NC EDSS. If not present, enter results.

Isolation of Brucella from clinical specimen? Y N U Not done
 Brucella IgG Titre ≥ 160 in serum obtained after onset of illness? Y N U Not done
 Four-fold or greater rise in agglutination titer between acute and convalescent sera, ≥2 weeks apart? Y N U Not done
 Give details below.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? Y N U
 If yes, symptom onset date (mm/dd/yyyy): / /
Fever Y N U
 Yes, subjective No
 Yes, measured Unknown
 Highest measured temperature _____
 Fever onset date (mm/dd/yyyy): / / /
 Was fever recurring, remittent, or intermittent? Y N U
Fatigue or malaise or weakness Y N U
Loss of appetite (anorexia) Y N U
Weight loss with illness Y N U
Sweats (diaphoresis) Y N U
 Night sweats Y N U
Chills or rigors Y N U
Swollen lymph nodes (lymphadenopathy or lymphadenitis) Y N U
 Location: _____
 Tenderness: Tender Non-tender
Altered mental status Y N U
 Patient displayed depression? Y N U
Headache Y N U
Meningitis Y N U
Encephalitis Y N U
Acute onset of peripheral neuropathy Y N U
Joint pains (arthralgias) Y N U
Arthritis Y N U
Osteomyelitis Y N U
Muscle aches/pains (myalgias) Y N U
Backache/back pain Y N U

Chest x-ray? Y N U
 If yes, describe (check all that apply):
 Normal
 Infiltrate
 Diffuse infiltrates/findings suggestive of ARDS
 Mediastinal widening
 Pleural effusion
 Hilar adenopathy
 Other _____
Chest CT scan performed Y N U
 If yes, describe (check all that apply):
 Normal
 Infiltrate
 Pleural effusion
 Hilar adenopathy
 Mediastinal adenopathy
 Other _____
Pneumonia Y N U
Pericarditis Y N U
Myocarditis Y N U
Aneurysm Y N U
Endocarditis Y N U
Echocardiography performed Y N U
 Echocardiography abnormal Y N U
 Please describe: _____
Nausea Y N U
Vomiting Y N U
Diarrhea Y N U
Constipation Y N U
Enlarged spleen (splenomegaly) Y N U
Enlarged liver (hepatomegaly) Y N U
Hepatitis (inflamed liver) Y N U

Epididymitis Y N U
Orchitis Y N U
Acute pyelonephritis Y N U
Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U
 Please specify: _____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U
 Specify _____
Cardiovascular/heart disease Y N U
Valvular heart disease or vascular graft Y N U
Congenital heart disease Y N U
Other cardiovascular/heart disease: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

PREGNANCY

Is the patient currently pregnant? ... Y N U

Estimated delivery date (mm/dd/yyyy): ____/____/____

Has the patient been pregnant in the past 12 months? Y N U

Pregnancy outcome:

Where was the child born?

Hospital
 Home
 Other
 Unknown

Hospital or facility where infant was born: _____

Infant gestational age at birth:

Full term
 Premature
 Unknown

Number of weeks gestation _____

Vital status:

Born alive and still alive
 Born alive and then died
 Stillborn
 Unknown

Date of infant death (mm/dd/yyyy): ____/____/____

Give cause of death from death certificate: _____

Was an autopsy performed? Y N U

If yes, give final pathological diagnosis: _____

Did patient experience onset of symptoms within 6 weeks of delivery? Y N U

MATERNAL INFORMATION

If the case is a child, has the child been breastfed? Y N U

HEALTH CARE FACILITY AND BLOOD & BODILY FLUID EXPOSURE RISKS

During the 60 days prior to onset of symptoms, did the patient work in a laboratory? Y N U

If yes, specify and give details: _____

During the 60 days prior to onset of symptoms, did the patient have the following exposures?

Blood or blood product recipient? Y N U

Date (mm/dd/yyyy): ____/____/____

Facility name: _____

Bone marrow recipient? Y N U

Date (mm/dd/yyyy): ____/____/____

Facility name: _____

TREATMENT

Did the patient receive an antibiotic(s) for this illness? Y N U

Specify antibiotic name(s): _____

Was antibiotic prophylaxis given prior to illness onset? Y N U

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (____) _____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy): ____/____/____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ____/____/____

Autopsy performed? Y N U

Patient autopsied in NC? Y N U

County of autopsy: _____

Autopsied outside NC, specify where: _____

Source of death information (select all that apply):

Death certificate
 Autopsy report final conclusions
 Hospital/discharge physician summary
 Other

TRAVEL/IMMIGRATION

The patient is:

Resident of NC
 Resident of another state or US territory
 Foreign Visitor
 Refugee
 Recent Immigrant
 Foreign Adoptee
 None of the above

Did patient travel during the 60 days prior to onset of symptoms? Y N U

List travel dates and destinations:
From ____/____/____ to ____/____/____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

List persons and contact information:

Additional travel/residency information: _____

BEHAVIORAL RISK & CONGREGATE LIVING

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/ Detention Center	

Since disease onset, has the patient had sexual contact with other(s)? ... Y N U

During the 60 days prior to onset of symptoms, has the patient had sexual contact with a confirmed or suspected case of this disease? . Y N U

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U

If yes, specify: _____

During the 60 days prior to onset of symptoms, did the patient serve in the U.S. military? Y N U

If yes, dates of service: _____

Where: _____

FOOD RISKS & EXPOSURES

During the 60 days prior to onset of symptoms, did the patient consume any of the following:

Unpasteurized milk? Y N U

If yes, specify: _____

Unpasteurized dairy products? Y N U

If yes, specify: _____

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ANIMAL EXPOSURE

During the 60 days prior to onset of symptoms, did the patient have exposure to any of the following animals (includes animal tissues, animal products, or animal excreta):

- If yes, specify and give details:
- Cattle
 - Swine
 - Goats
 - Sheep
 - Bison
 - Elk
 - Caribou
 - Deer

Household pets (dogs only)? Y N U
 Was pet sick? Y N U

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor? Y N U
 If yes, specify and give details:

Did patient work with animal importation? Y N U
 If yes, specify and give details:

Did patient work at, live on, or visit a farm, ranch, or dairy? Y N U
 If yes, specify and give details:

Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)? Y N U
 If yes, specify and give details:

Did patient skin/eviscerate (gut) wild animal or have contact with wild animal carcass? ... Y N U
 If yes, specify and give details:

Did patient work at or visit a slaughterhouse (abattoir), meat-packing plant, or wild game processing facility? Y N U
 Visited or worked?
 If yes, specify and give details:

Has patient otherwise slaughtered animals or been a butcher, meat cutter, or meat processor? Y N U
 If yes, specify and give details:

Did the patient work at or visit a fair with livestock or a petting zoo? Y N U
 If yes, specify and give details:

Did the patient work at or visit a zoo or zoological park? Y N U
 If yes, specify and give details:

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? Y N U
 If yes, specify and give details:

Did patient work with brucella vaccines? Y N U
 If yes, specify and give details:

Did patient necropsy animals? Y N U
 If yes, specify and give details:

Did patient work with brucella species? Y N U
 If yes, specify and give details:

Notes:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

- Specify location:
- In NC
 City _____
 County _____
 - Outside NC, but within US
 City _____
 State _____
 County _____
 - Outside US
 City _____
 Country _____
 - Unknown

Is the patient part of an outbreak of this disease? Y N

VACCINE

Has the patient/contact ever received brucellosis vaccine? Y N U

If yes, provide the vaccine name, source of vaccine, date of vaccination, and source of vaccination information.

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? Y N

If yes, specify: _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U
 Who was interviewed?

Were health care providers consulted? Y N U
 Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? Y N U
 Specify reason if medical records were not reviewed:

Notes on medical record verification:

Brucellosis (*Brucella* spp.)

1997 CDC Case Definition

Clinical description

An illness characterized by acute or insidious onset of fever, night sweats, undue fatigue, anorexia, weight loss, headache, and arthralgia

Laboratory criteria for diagnosis

- Isolation of *Brucella* spp. from a clinical specimen, or
- Fourfold or greater rise in *Brucella* agglutination titer between acute- and convalescent-phase serum specimens obtained greater than or equal to 2 weeks apart and studied at the same laboratory, or
- Demonstration by immunofluorescence of *Brucella* spp. in a clinical specimen

Case classification

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case or that has supportive serology (i.e., *Brucella* agglutination titer of greater than or equal to 160 in one or more serum specimens obtained after onset of symptoms)

Confirmed: a clinically compatible illness that is laboratory confirmed