

**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.

**LEPTOSPIROSIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 20**

**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

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

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 the fever diphasic? Y N U

Fatigue or malaise or weakness Y N U

Chills or rigors Y N U

Altered mental status Y N U

Confusion Depression Other

Headache Y N U

Meningitis Y N U

Joint pains (arthralgias) Y N U

Muscle aches/pains (myalgias) Y N U

Skin rash Y N U

Conjunctival suffusion or redness (hyperemia) Y N U

Cough Y N U

Productive Y N U

Describe (check all that apply)

Clear Purulent Bloody (hemoptysis)

Pneumonia Y N U

Confirmed by x-ray or CT Y N U

Myocarditis Y N U

Jaundice (yellow skin, eyes, light or gray stools, hyperbilirubinemia) Y N U

Acute liver failure Y N U

Pancreatitis Y N U

Peritonitis Y N U

Hematuria (urinalysis > 5 RBC/hpf or positive for blood) Y N U

Acute renal insufficiency Y N U

Acute renal failure Y N U

Elevated creatinine Y N U

Anemia Y N U

Acute hemolytic anemia Y N U

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U

Specify _____

Injury/Wound/Break in skin Y N U

Anatomic site _____

Circumstances _____

Principal wound type:

Abrasion Other _____

Unknown

TREATMENT

Did the patient take an antibiotic as treatment for this illness? Y N U

Specify antibiotic name: _____

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 30 days prior to onset of symptoms, did the patient work in a laboratory? Y N U

If yes, specify and give details: _____

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

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

TRAVEL/IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 None of the above

Did patient travel during the 30 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:

VACCINE

Has patient/contact ever received vaccine for this disease? Y N U
 If yes, provide the vaccine name, source of vaccine, date of vaccination, and source of vaccine information:

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:

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

Notes:

OUTDOOR EXPOSURE

During the 30 days prior to onset of symptoms, did the patient participate in any outdoor activities? Y N U
 If yes, specify:

Was patient exposed to wild animals? . Y N U
 Specify animal(s) _____

Did patient handle the animal? Y N U
 Animal was:
 Alive Dead Unknown
 Was animal sick? Y N U

ANIMAL EXPOSURE

During the 30 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)? Y N U

Household pets? Y N U
 If yes, specify pet(s) _____
 Was pet sick? Y N U
 Was pet free-ranging? 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 at or visit a slaughterhouse (abattoir), meat-packing plant, poultry or wild game processing facility? Y N U
 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:

WATER EXPOSURE

During the 30 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water (natural waters only)? Y N U
 Activity(ies): _____

Type(s) of water (water sources):
 Freshwater (stream, river, pond, lake, pool)
 Estuarine or marine water (brackish or salt water sound, estuary, ocean)

Route of exposure (agent entry) for recreational exposure (check all that apply):
 Accidental ingestion
 Intentional ingestion
 Skin contact
 Inhalation
 Other
 Unknown

Water source(s) / setting(s) (select all sources and settings that apply):
 Spring / hot spring
 River, stream
 Lake, pond, reservoir
 Estuary / tidal area (brackish / salty water)
 Ocean
 Other
 Unknown

Factors contributing to water contamination
 Overflow or release of sewage (observed or signage)
 Flooding / heavy rains
 Stagnant water
 Animal feces observed near site
 Agricultural / animal production in watershed
 Other
 Unknown

Did the patient handle any animals? Y N U
 Species: _____
 Did it/they appear sick? Y N U

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 have exposure to animal excreta (urine or feces)? Y N U
 If yes, specify and give details:

Was patient exposed to animal birthing or placental/placental products? 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 vaccines for leptospirosis? 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 zoonotic agents? Y N U
 If yes, specify and give details:

Leptospirosis (*Leptospira interrogans*)

1997 CDC Case Definition

Clinical description

An illness characterized by fever, headache, chills, myalgia, conjunctival suffusion, and less frequently by meningitis, rash, jaundice, or renal insufficiency. Symptoms may be biphasic.

Laboratory criteria for diagnosis

- Isolation of *Leptospira* from a clinical specimen, or
- Fourfold or greater increase in *Leptospira* 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 of *Leptospira* in a clinical specimen by immunofluorescence

Case classification

Probable: a clinically compatible case with supportive serologic findings (i.e., a *Leptospira* agglutination titer of greater than or equal to 200 in one or more serum specimens)

Confirmed: a clinically compatible case that is laboratory confirmed