

**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.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**CREUTZFELDT-JAKOB DISEASE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 66**

**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): / /

Altered mental status Y N U

Patient displayed (select all that apply)

Confusion Anxiety/apprehension
 Dementia Depression
 Coma Hallucinations

Psychiatric / behavioral problems Y N U

Memory loss Y N U

Muteness Y N U

Aphasia Y N U

Apraxia Y N U

Ataxia Y N U

Gait disturbance Y N U

Dyscoordination Y N U

Myoclonus Y N U

Tremor Y N U

Nystagmus Y N U

Cortical blindness Y N U

Spasticity Y N U

Babinski's sign Y N U

Insomnia Y N U

Cranial nerve or bulbar weakness or paralysis Y N U

Difficulty speaking
 Other, specify _____

EEG performed Y N U

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

Result _____

Official interpretation of EEG consistent with CJD Y N U

Head CT performed Y N U

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

Result: _____

MRI performed Y N U

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

Result: _____

Bilateral pulvinar high signal Y N U

Positive 14-3-3 CSF assay? Y N U

If yes, give details: _____

Brain biopsy? Y N U

If yes, give details: _____

Tongue biopsy? Y N U

If yes, give details: _____

Immunocytochemical testing? Y N U

If yes, give details: _____

Western blot confirmed protease-resistant PrP? Y N U

If yes, give details: _____

Scrapie associated fibrils? Y N U

If yes, give details: _____

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

Immunocytotesting? Y N U

Immunoblot, western blot? Y N U

If yes, was abnormal protease resistant PrP present? Y N U

Additional details: _____

Immunostaining with 3F4 monoclonal antibody? Y N U

If yes, were granular deposits seen? Y N U

Prion protein (PrP) gene sequencing? Y N U

If yes, provide details: _____
(? sporadic CJD, including genotype or other classification)

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

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): ____/____/____

OTHER EXPOSURE INFORMATION

Has the patient ever served in the U.S. military? Y N U
 If yes, dates of service:
 From ____/____/____ to ____/____/____
 During the 30 years prior to onset of symptoms, did the patient work in any of the following occupations or settings? (check all that apply):
 Health care worker
 Other sensitive occupation or setting
 Unknown
 Nature of work/contact: _____

 Name of facility: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Telephone: (____) _____

CASE INTERVIEW

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:

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N
 Specify _____
 Did local health director or designee implement additional control measures (eg: precautions/notifications to funeral home, medical examiner, etc.)? Y N
 If yes, specify: _____

 Were written isolation orders issued? Y N
 If yes, where was the patient isolated? _____

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 30 years prior to onset of symptoms, did the patient have any of the following health care exposures?
Blood or blood products (transfusion) recipient Y N U
 Date received (mm/dd/yyyy) ____/____/____
 Was date before 1992? Y N U
 Facility name _____
 City _____
 State _____
 Country _____
Human pituitary growth hormone recipient Y N U
 Date last administered (mm/dd/yyyy) ____/____/____
 Provider name _____
 Facility name _____
 City _____
 State _____
 Country _____
 Specify frequency and length of time that human pituitary growth hormone was administered:

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:

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 have a travel history to the UK, Europe, or the Middle East during the 30 years 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:

Surgery (besides oral surgery), obstetrical or invasive procedure Y N U
 Admission date (mm/dd/yyyy) ____/____/____
 Type of procedure _____
 Provider name _____
 Facility name _____
 City _____
 State _____
 Country _____
 Was facility notified regarding ill patient? Y N U N/A
 Name of person notified _____
 Date notified (mm/dd/yyyy) ____/____/____
Transplant recipient (tissue/organ/bone/ bone marrow, corneal graft, dura mater graft, or other tissue) Y N U
 If yes, specify type:
 Date received (mm/dd/yyyy) ____/____/____
 Was date before 1992? Y N U
 Facility name _____
 City _____
 State _____
 Country _____

Notes:

Creutzfeldt-Jakob Disease (CJD)

2007 Case Definition (North Carolina)

1. Sporadic CJD

Confirmed:

A person who had clinically compatible illness diagnosed by one or more of the following:

- Standard neuropathological techniques
- Immunocytochemically
- Western blot confirmed protease-resistant PrP
- Presence of scrapie-associated fibrils

Probable:

A person with progressive dementia **and** at least two of the following four clinical features:

- Myoclonus
- Visual or cerebellar signs
- Pyramidal/extrapyramidal signs
- Akinetic mutism

and

- Typical EEG during an illness of any duration, **or**
- Positive 14-3-3 CSF assay plus a clinical duration to death of <2 years

and

- Routine investigation does not suggest an alternative diagnosis

Suspect:

A person with progressive dementia **and** at least two of the following four clinical features:

- Myoclonus
- Visual or cerebellar signs
- Pyramidal/extrapyramidal signs
- Akinetic mutism

and

- No EEG **or** an atypical EEG
- Duration to death of <2 years

2. Iatrogenic CJD

- A person with progressive cerebellar syndrome with a history of receiving human cadaveric-derived pituitary hormone, **or**
- A person with sporadic CJD with history of a recognized exposure risk such as antecedent neurosurgery with dura mater implantation

3. Familial CJD

A person with confirmed or probable CJD who has a first degree relative with a history of either:

- Confirmed or probable CJD, **or**
- Neuropsychiatric disorder and disease-specific PrP gene mutation.