

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

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



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

Table with 8 columns: 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?
If yes, symptom onset date (mm/dd/yyyy):
Fever: Yes, subjective; Yes, measured; No; Unknown
Highest measured temperature
Fever onset date (mm/dd/yyyy):
Was the fever diphasic?
Fatigue or malaise or weakness
Chills or rigors
Altered mental status
Headache
Meningitis
Joint pains (arthralgias)
Muscle aches/pains (myalgias)
Skin rash
Conjunctival suffusion or redness (hyperemia)
Cough
Pneumonia
Myocarditis
Jaundice
Acute liver failure
Pancreatitis
Peritonitis
Hematuria
Acute renal insufficiency
Acute renal failure
Elevated creatinine
Anemia
Acute hemolytic anemia

PREDISPOSING CONDITIONS

Any immunosuppressive conditions?
Specify
Injury/Wound/Break in skin
Anatomic site
Circumstances
Principal wound type:
Abrasion; Other; Unknown

TREATMENT

Did the patient take an antibiotic as treatment for this illness?
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?
If yes, specify and give details:

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours?
Hospital name:
City, State:
Hospital contact name:
Telephone:
Admit date (mm/dd/yyyy):
Discharge date (mm/dd/yyyy):

CLINICAL OUTCOMES

Discharge/Final diagnosis:
Survived?
Died?
Died from this illness?
Date of death (mm/dd/yyyy):
Autopsy performed?
Patient autopsied in NC?
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