

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

Local ID Number _____

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

TYPHUS CASE REPORT

Check one: Flea-borne (murine) typhus (*Rickettsia typhi*)
 Epidemic typhus (*Rickettsia prowazekii*)

This form should be completed only for typhus cases. Rocky Mountain spotted fever and other spotted fever rickettsioses cases should be reported on the Spotted Fever Rickettsioses Case Report form. Ehrlichiosis/anaplasmosis cases should be reported on the Ehrlichiosis/Anaplasmosis Case Report form.

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence		Apartment/Unit Number		Ethnicity (check one)	
City/Town		State	Zip Code	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk	
Census Tract	County of Residence	Country of Residence		Race* (check all that apply, race descriptions on page 6)	
Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)		<input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply)		
Home Telephone	Cellular Phone/Pager	Work/School Telephone		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Thai <input type="checkbox"/> Hmong <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____	
E-mail Address		Other Electronic Contact Information		<input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other: _____	
Work/School Location		Work/School Contact		<input type="checkbox"/> White <input type="checkbox"/> Other: _____	
Gender				<input type="checkbox"/> Unk	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 6)		Other Describe/Specify		*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.	
Occupation (see list on page 6)		Other Describe/Specify			
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

First three letters of patient's last name:

--	--	--

SIGNS AND SYMPTOMS

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)			Date First Sought Medical Care (mm/dd/yyyy)	
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted		
Fever				Highest temperature (specify °F/°C)		
Muscle pain						
Headache						
Nausea or vomiting						
Rash or other cutaneous lesion				Location / size / appearance		
Chills						
Sweats						
Joint pain				Joint(s)		
Eye pain						
Abdominal pain						
Diarrhea						
Cough						
Hypotension				Date measured (mm/dd/yyyy)	Systolic / Diastolic	

Other signs / symptoms (specify)

HOSPITALIZATION

Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, how many total hospital nights?
--	--	---

If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION - DETAILS

Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis
Hospital Name 2	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

First three letters of
patient's last name:

--	--	--

TREATMENT / MANAGEMENT					
Received treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, specify the treatments below.			
TREATMENT / MANAGEMENT DETAILS					
Treatment Type 1 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other		If Antibiotic, specify route	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Treatment Type 2 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other		If Antibiotic, specify route	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
OUTCOME					
Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk		If Survived, Survived as of _____ (mm/dd/yyyy)		Date of Death (mm/dd/yyyy)	
LABORATORY INFORMATION					
LABORATORY RESULTS SUMMARY - SEROLOGY					
Specimen Type 1		Collection Date (mm/dd/yyyy)		Type of Test	Antigen
		Results		Laboratory Name	Telephone Number
Specimen Type 2		Collection Date (mm/dd/yyyy)		Type of Test	Antigen
		Results		Laboratory Name	Telephone Number
LABORATORY RESULTS SUMMARY - OTHER					
Hematology? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Collection Date (mm/dd/yyyy)		WBC	HCT
Serum chemistry? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Collection Date (mm/dd/yyyy)		ALT	AST
Other laboratory diagnostics performed (e.g., PCR, buffy coat smear)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				If Yes, describe	
EPIDEMIOLOGIC INFORMATION					
INCUBATION PERIOD: UP TO 14 DAYS BEFORE ILLNESS ONSET					
ANIMAL AND INSECT EXPOSURES					
Observe any of the following during incubation period <u>at or around home</u> ? <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Rodents <input type="checkbox"/> Opossums <input type="checkbox"/> Fleas <input type="checkbox"/> Ticks				Describe	
If pets in the home, how often are they treated with flea prevention medication?			Type(s) of Treatment		Date(s) of Last Treatment (mm/dd/yyyy)
Observe any of the following during incubation period <u>away from home</u> ? <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Rodents <input type="checkbox"/> Opossums <input type="checkbox"/> Fleas <input type="checkbox"/> Ticks				Describe	
If any cats were observed, were they feral / stray, indoor, or outdoor cats? <input type="checkbox"/> Feral / stray <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor <input type="checkbox"/> Other: _____					
Did the patient spend any nights living outside, without shelter, in the past 21 days (including in a car, unsheltered on the street, or in a temporary shelter)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				Describe	
Did patient recall any insect bites in the 10 days prior to illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				If Yes, specify all locations, type of insect bite, and dates on page 4.	

First three letters of patient's last name:

--	--	--

INSECT BITE HISTORY - DETAILS

Bite 1	Location (city, county, state, country)	Date of Insect Bite (mm/dd/yyyy)	Type of Insect Bite <input type="checkbox"/> Flea <input type="checkbox"/> Tick <input type="checkbox"/> Other: _____
Bite 2	Location (city, county, state, country)	Date of Insect Bite (mm/dd/yyyy)	Type of Insect Bite <input type="checkbox"/> Flea <input type="checkbox"/> Tick <input type="checkbox"/> Other: _____

TRAVEL HISTORY

Did patient travel out of county of residence during the incubation period ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates in the Travel History - Details Table.
---	--

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

ILL CONTACTS

Any contacts with similar illness (including household contacts)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify details below.
--	--------------------------------

ILL CONTACTS - DETAILS

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City		State	Zip Code	Occupation
Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City		State	Zip Code	Occupation

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number
For flea-borne (murine) typhus only: Did the patient have likely vector exposure in an area with suitable seasonal and ecological conditions for potential local vector-borne transmission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Describe

NOTES / REMARKS

First three letters of
patient's last name:

--	--	--

REPORTING AGENCY			
<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
<i>First Reported By</i> <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			
DISEASE CASE CLASSIFICATION			
<i>Case Classification (see case definition below)</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect			
STATE USE ONLY			
<i>State Case Classification</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information			
CASE DEFINITION			
<u>TYPHUS (CDPH working definition, 2020)</u>			
CLINICAL CRITERIA (For the purpose of surveillance) Fever as reported by the patient or healthcare provider, AND two or more of the following: myalgia, headache, nausea/vomiting, elevated liver enzymes, rash, or thrombocytopenia.			
LABORATORY CRITERIA FOR DIAGNOSIS			
Confirmatory laboratory evidence: <ul style="list-style-type: none"> • Detection of <i>Rickettsia typhi</i> or <i>R. prowazekii</i> nucleic acid in a clinical specimen via amplification of <i>R. typhi</i> or <i>R. prowazekii</i> target by rt-PCR assay, OR • Serological evidence of a fourfold increase in immunoglobulin G (IgG)-specific antibody titer reactive with <i>R. typhi</i> or <i>R. prowazekii</i> by indirect immunofluorescence assay (IFA) between paired serum specimens (one taken in the first two weeks of illness and a second up to 10 weeks later) and with the second serum sample having a titer of $\geq 1:128$, OR • Demonstration of typhus fever group antigen in a biopsy or autopsy specimen by IHC, OR • Isolation of <i>R. typhi</i> or <i>R. prowazekii</i> organisms from a clinical specimen in cell culture and molecular confirmation (e.g., PCR or sequence). 			
Presumptive laboratory evidence: <ul style="list-style-type: none"> • Has serologic evidence of elevated IgG at a titer of $\geq 1:128$ reactive with <i>R. typhi</i> or <i>R. prowazekii</i> antigen by IFA in a sample taken within 60 days of illness onset, OR • Has serologic evidence of elevated IgM at a titer of $\geq 1:256$ reactive with <i>R. typhi</i> or <i>R. prowazekii</i> antigen by IFA in a sample taken within 60 days of illness onset. 			
EPIDEMIOLOGIC LINKAGE CRITERIA. A clinically compatible case that: <ul style="list-style-type: none"> • Was in same household/same defined exposure as a confirmed case within the past 14 days before onset of symptoms, OR • Likely had vector exposure in an area with suitable seasonal and ecological conditions for potential local vector-borne transmission 			
CASE CLASSIFICATION			
Confirmed: A clinically compatible case (meets clinical criteria) that is laboratory confirmed.			
Probable: A clinically compatible case (meets clinical criteria) that has presumptive laboratory evidence and evidence of epidemiologic link.			
Suspect: A case with presumptive or confirmatory laboratory evidence of infection but no clinical information available, OR A clinically compatible case (meets clinical criteria) that has evidence of epidemiologic link but no laboratory testing or equivocal results.			
NOTES <ul style="list-style-type: none"> • Because antibodies for rickettsial diseases can be cross-reactive, specimens should be tested against a panel of <i>Rickettsia</i> antigens, including, at a minimum, <i>R. rickettsii</i> and <i>R. typhi</i> to differentiate between Spotted Fever Group <i>Rickettsia</i> (SFGR) and non-SFGR species. In addition, according to CDC, rickettsial IgM tests lack specificity (resulting in false positives); thus, IgG titers are considered to be much more reliable. • A case should not be counted as new if the case has ever previously been reported for the same condition. 			

RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • Adult film actor/actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker 	<ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other/unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent/guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Volunteer • Other • Refused • Unknown