Spotted Fever Rickettsioses Case Report

Call (or fax) MCDH CD Program to report cases

Phone: 815.334.4500 Fax: 815.334.0191 (Fax lab result with this form)

Demographics:

Patient's last name_____ First name_____ DOB_____/_____/_____

Parent/Guardian Name, if applicable_____

Home Phone_____Cell Phone_____Work Phone_____

Street Address _____ City_____ ZIP Code_____

Sex ☐ Male ☐ Female

Race ☐ White ☐ Black ☐ Asian/ Pacific Islander ☐ Native American ☐ Unknown

Ethnic origin ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Occupation: _____

Physician_____Phone_____

General Illness:

Date of onset: (mo/day/yr)_____/_____/_____

Diagnosis Date: (mo/day/yr)_____/_____/_____

Was the patient seen in an emergency department? ☐ YES ☐ NO

ER Hospital: _____

Was the patient admitted to a hospital? ☐ YES ☐ NO

Hospital: _____

Admission Date: (mo/day/yr) ___/___/_____

Discharge Date: (mo/day/yr) ___/___/_____

Clinical

Symptoms

Fever ☐ Yes ☐ No

Highest fever measurement: _____

Headache ☐ Yes ☐ No

Rash ☐ Yes ☐ No

Rash onset date: _____/_____/_____

Eschar ☐ Yes ☐ No

Myalgia ☐ Yes ☐ No

Meningitis/Encephalitis ☐ Yes ☐ No

Impaired immune function ☐ Yes ☐ No

Labs

Anemia (hemoglobin < 12g/dl) ☐ Yes ☐ No

Thrombocytopenia (platelet count <100,000/mm3) ☐ Yes ☐ No

Leukopenia (WBC count <4.5/ul) ☐ Yes ☐ No

Elevated liver enzymes (AST>35 U/L); ALT>35U/L) ☐ Yes ☐ No

If other symptoms, please indicate: _____

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Laboratory Reports:

Name of Laboratory_____ Date Specimen Collected_____/_____/_____
Test type _____ Test Method_____ Result _____

Tick Habitat:

Was the patient in a potential or known tick habitat? (e.g., tall grass, pasture, woods) □ Yes □ No
If yes, when did patient enter tick habitat? _____/_____/_____
If yes, when did patient leave tick habitat? _____/_____/_____
Tick habitat location (city and state): _____
Types of activity related to tick exposure: (e.g. bird watching, fishing, gardening, hiking etc.)
_____

Tick Bite:

Was there a recognized tick bite? □ Yes □ No
If yes, when? _____/_____/_____
Where was the tick bite obtained?
□ Campground □ City Park □ Farm □ Forest/Nature Preserve □ Own Property
□ Scout Camp □ State Park □ Out of State □ Other: _____
Name and Address of specific location _____

Travel:

Has the patient had any unusual or significant travel? □ Yes □ No
If yes, where? _____
If yes, dates? _____/_____/_____ - _____/_____/_____

Treatment: (Please indicate what antibiotic the patient was treated with and for how long):

O Doxycycline O Other: _____ Duration: _____

Please fax positive lab result with this form. Thank you.
MCDH Fax: 815-334-0191

Revised: 2/17/2017