State of California—Health and Human Services Agency

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*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ *Years* ☐ *Months* ☐ *Days*

Address Number & Street - Residence	*Apartment/Unit Number*

City/Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone/Pager*	*Work/School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work/School Location	*Work/School Contact*

Gender
☐ Male ☐ Female ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 6)	*Other Describe/Specify*

Occupation (see list on page 6)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other:_____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unk

*Race**
(check all that apply, race descriptions on page 6)
☐ African-American/Black
☐ American Indian or Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ Other:_____

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian
- ☐ Other:_____

☐ White
☐ Other:_____
☐ Unk

*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.

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

First three letters of patient's last name: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ Unk	*Was patient hospitalized?* ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ Unk	If Yes, specify the treatments below.

TREATMENT / MANAGEMENT DETAILS

Treatment Type 1 ☐ Antibiotic ☐ Other	If Antibiotic, specify route	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Treatment Type 2 ☐ Antibiotic ☐ Other	If Antibiotic, specify route	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ 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? ☐ Yes ☐ No ☐ Unk	Collection Date (mm/dd/yyyy)	WBC	HCT	Hb	Platelets
Serum chemistry? ☐ Yes ☐ No ☐ Unk	Collection Date (mm/dd/yyyy)	ALT		AST	
Other laboratory diagnostics performed (e.g., PCR, buffy coat smear)? ☐ Yes ☐ No ☐ 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 at or around home? ☐ Dogs ☐ Cats ☐ Rodents ☐ Opossums ☐ Fleas ☐ 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 away from home? ☐ Dogs ☐ Cats ☐ Rodents ☐ Opossums ☐ Fleas ☐ Ticks	Describe

If any cats were observed, were they feral / stray, indoor, or outdoor cats?
☐ Feral / stray ☐ Indoor ☐ Outdoor ☐ 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)? ☐ Yes ☐ No ☐ Unk	Describe
Did patient recall any insect bites in the 10 days prior to illness? ☐ Yes ☐ No ☐ 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* ☐ Flea ☐ Tick ☐ Other:_____
Bite 2	*Location (city, county, state, country)*	*Date of Insect Bite (mm/dd/yyyy)*	*Type of Insect Bite* ☐ Flea ☐ Tick ☐ Other:_____

TRAVEL HISTORY

*Did patient travel **out of county of residence** during the **incubation period** ?* ☐ Yes ☐ No ☐ 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)? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ 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?* ☐ Yes ☐ No ☐ Unk	*Describe*

NOTES / REMARKS

First three letters of patient's last name: | | | |

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*

First Reported By

☐ Clinician ☐ Laboratory ☐ Other (specify):_____

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)

☐ Confirmed ☐ Probable ☐ Suspect

STATE USE ONLY

State Case Classification

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Need additional information

CASE DEFINITION

TYPHUS (CDPH working definition, 2020)

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:

- Detection of *Rickettsia typhi* or *R. prowazekii* nucleic acid in a clinical specimen via amplification of *R. typhi* or *R. prowazekii* target by rt-PCR assay, **OR**
- Serological evidence of a fourfold increase in immunoglobulin G (IgG)-specific antibody titer reactive with *R. typhi or R. prowazekii* 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 ≥1:128, **OR**
- Demonstration of typhus fever group antigen in a biopsy or autopsy specimen by IHC, **OR**
- Isolation of *R. typhi or R. prowazekii* organisms from a clinical specimen in cell culture and molecular confirmation (e.g., PCR or sequence).

Presumptive laboratory evidence:

- Has serologic evidence of elevated IgG at a titer of ≥1:128 reactive with *R. typhi or R. prowazekii* antigen by IFA in a sample taken within 60 days of illness onset, **OR**
- Has serologic evidence of elevated IgM at a titer of ≥1:256 reactive with *R. typhi or R. prowazekii* antigen by IFA in a sample taken within 60 days of illness onset.

EPIDEMIOLOGIC LINKAGE CRITERIA

A clinically compatible case that:

- 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

- Because antibodies for rickettsial diseases can be cross-reactive, specimens should be tested against a panel of *Rickettsia* antigens, including, at a minimum, *R. rickettsii and R. typhi* to differentiate between Spotted Fever Group *Rickettsia* (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

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- 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
- 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