COUNTY OF LOS ANGELES
Public Health

GLANDERS AND MELIOIDOSIS CASE REPORT FORM

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
213-240-7941 (phone) 213-482-4856 (facsimile)
www.publichealth.lacounty.gov/acd

IRIS ID: ___________

REPORTING DISEASE: ☐ **Glanders** ☐ **Melioidosis** **INITIAL IMPRESSION:** Single Case Laboratory Exposure

Reporting Facility Name	Report Date	Time AM PM	Facility Type

Reporter Name	Title	Telephone	Alternate Telephone	Email Address

DEMOGRAPHIC INFORMATION

Patient Name-Last	First	Middle Initial	Date of Birth	Age	Gender

Address- Number, Street, Apt #	City	State	ZIP Code

County of Residence	Country of Usual Residence	Number of Years Residing in US	Country of Birth

Telephone Home: Cell:

Race
☐African-American/Black ☐Asian/Pacific Islander Native American White Other:___________

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

If Asian/Pacific Islander, please check all that apply: ☐ Asian Indian Cambodian Chinese Filipino ☐Guamanian ☐ Hawiian ☐Japanese Korean Laotian Samoan Vietnamese ☐ Other:

Pregnant? (if Female) ☐ Yes ☐ No ☐ Unknown If Yes, due date: ___________

Occupation: **Other:**

Occupational Location / Setting:

PRESENT ILLNESS

Symptomatic: ☐Yes ☐No ☐Unknown *If No, Skip this section and go to Epidemiological Risk Factors section.*

Symptom onset date	Duration of symptoms	Date first sought medical attention	Admitted to ICU?	Intubated?
	days		☐ Yes No Unk	Yes No Unk

Hospitalized	Hospital Name	Medical Record Number	Admit Date	Discharge Date
☐Yes ☐No ☐Unk				

Select all symptoms and conditions experienced by the patient during this illness:

Fever (highest temp ________ F°)
Nodule
Anorexia
Seizure
Periocardial effusion
Muscle aches
Swelling
Pneumonia/pleural effusion
Skin or soft tissue infection
Bone or joint infection
Joint pain
Abdominal discomfort
Chills
Genitourinary infection
Septic shock
Fatigue
Chest pain
Cough
Headache
CNS infection
Ulcer
Respiratory distress
Disorientation
Weight loss lbs)
Sepsis
Encephalomyelitis/meningitis

Abscess / Organ Abscess(specify):

Other symptom(s):

Antibiotics given?
Yes
No
Unknown

Antibiotic	Start Date	End date
Ceftazidime	____________	____________
Meropenem	____________	____________
Trimethoprim/Sulfamethoxazole	____________	____________
Amoxicillin/Clavulanate	____________	____________
Other:	____________	____________

PAST MEDICAL HISTORY

Does the patient have any of the following pre-existing medical conditions? (select all that apply)

Diabetes
Malignancy
Liver disease
Thalassemia
Chronic lung disease
Systemic lupus erythematosus
Immunocompromised
Chronic kidney disease
Chronic granulomatous disease
No pre-existing conditions
Unknown

On immunosurpressive drugs:

Other pre-existing condition:

Does the patient excessively use alcohol or have they in the past?
Current excessive alcohol use
Former excessive alcohol use
No
Unknown

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Patient Name (last, first) ____ Date of Birth ________________ IRIS ID: ______________

EPIDEMIOLOGIC RISK FACTORS

Was this individual part of a recognized cluster or outbreak of glanders or melioidosis? Yes No Unk

Was this individual part of a recognized laboratory exposure of glanders or melioidosis? Yes No Unk

Outbreak ID:

TRAVEL HISTORY

Has the patient EVER traveled or lived outside of the US in the lifetime (including military service)? Yes No Unknown

If yes, select all continents where patient has visited or lived in their lifetime and most recent year visited:

Asia	Year: ______	**Europe**	Year: ______	**North America** *(outside US)*	Year: ______
Africa	Year: ______	**Middle East**	Year: ______	**Central America**	Year: ______
Australia	Year: ______	**Caribbean**	Year: ______	**South America**	Year: ______

List of endemic areas for glanders: https://www.cdc.gov/glanders/exposure/index.html
List of endemic areas for melioidosis: https://www.cdc.gov/melioidosis/risk-factors/index.html

Has the patient served overseas in the military? Yes No Unknown

Travel/Past Residence Notes

Has the patient EVER visited or lived in any of the following US states or territories in their lifetime?

Alabama Florida Louisiana Mississippi Texas No/None Unknown Year most recently visited:
Puerto Rico U.S. Virgin Islands Other:

In the 30 days prior to illness onset, did the patient travel 50 miles or more from their normal residence? Yes No Unknown

If yes, where? ____________________________________ Dates of Travel: __________ to: __________

If yes, where? ____________________________________ Dates of Travel: __________ to: __________

If yes, where? Dates of Travel: to:

ENVIRONMENTAL AND ANIMAL EXPOSURE

In the 30 days prior to illness onset, did the patient have contact with fresh water, mud, soil, compost, or sewage? Yes No Unknown

If yes, select all that apply:

Running water *(e.g., river, stream)* Still water *(e.g. lake, pond)* Flood water Heavy rainfall Sewage
Rainwater run-off/puddles Mud or wet soil Compost Other soil

Date: **Specify locations:**

Date: **Specify locations:**

In the 30 days prior to illness onset, did the patient own or have contact with any animals? Yes No Unknown

If yes, select all that apply:

Iguana Fish, guppies Cat Dog Goat ■ Other:
Sheep Horse Mule Cow Pig, hogs, boar

Date of Exposure:

Type of exposure:
Direct contact, handling or petting
Direct contact, animal fluids or cleaning enclosure
Indirect contact
Patient owns animal(s)

Location of purchase or where animal was acquired:

What activities led to the indicated environmental or animal exposure(s)? [select all that apply]

Swimming or bathing
Fresh water fishing
Adventure race, triathalon, or mud run
Biking/motorcycle riding
Pet or livestock ownership
Boating, kayaking, or rafting

Camping or hiking
Playing sports in yard or park
Gardening or yard work
Petting/touching animals at farm/zoo/other location
Drinking water
Hunting

Maintenance or house cleaning
Washing dishes or laundry
Occupational
Other:
Unknown
Date:
Location:

In the 30 days prior to illness onset, has the patient been in any areas experiencing significant/ severe weather? Yes No Unknown

If yes, select all that apply:

Hurricane, cyclone, or typhoon Flooding Windstorm or tornado
Mudslide Heavy rain Other:
Earthquake

Date of Exposure: **Specify location:**

In the 30 days prior to illness onset, has the patient used any aromatic therapy/ aromatherapy room spray? Yes No Unknown

What is the product(s)/ brand(s) name:

Where was the product bought?

What is the origin/manufacturing country of this product?

Where was this aromatic therapy used?

Others using this product? Yes No Unknown

First Date of Use:

Last/Most Recent Date of Use:

Please list any additional exposure information not captured above in "Notes" on page 4

DIAGNOSTIC TESTS

1st Test & Specimen

Test type: PCR IHC Other ELISA IgM Viteck or other automated clinical laboratory system
IHA ImmunoDot/DotBlot IgM Culture Other:

Performing lab: ______________________ ______________________

Specimen type: Whole blood Cerebrospinal fluid **Specify tissue type:** **Specimen collection date:**
Serum Tissue
Urine Other: ____________ ____________ ____________

Qualitative result: Positive Borderline
Negative Indeterminate Other: ____________ **Quantitative result** (*e.g., titer*)**:** ____________

Organism name: ______________________ **Lab result date:** ____________

Send to CDC? Yes No, isolate destroyed No, specimen not available **AST requested?** Yes No Not applicable

2nd Test & Specimen

Test type: PCR IHC Other ELISA IgM Viteck or other automated clinical laboratory system
IHA ImmunoDot/DotBlot IgM Culture Other:

Performing lab: ______________________ ______________________

Specimen type: Whole blood Cerebrospinal fluid **Specify tissue type:** **Specimen collection date:**
Serum Tissue
Urine Other: ____________ ____________ ____________

Qualitative result: Positive Borderline
Negative Indeterminate Other: ____________ **Quantitative result** (*e.g., titer*)**:** ____________

Organism name: ______________________ **Lab result date:** ____________

Send to CDC? Yes No, isolate destroyed No, specimen not available **AST requested?** Yes No Not applicable

3rd Test & Specimen

Test type: PCR IHC Other ELISA IgM Viteck or other automated clinical laboratory system
IHA ImmunoDot/DotBlot IgM Culture Other:

Performing lab: ______________________ ______________________

Specimen type: Whole blood Cerebrospinal fluid **Specify tissue type:** **Specimen collection date:**
Serum Tissue
Urine Other: ____________ ____________ ____________

Qualitative result: Positive Borderline
Negative Indeterminate Other: ____________ **Quantitative result** (*e.g., titer*)**:** ____________

Organism name: ______________________ **Lab result date:** ____________

Send to CDC? Yes No, isolate destroyed No, specimen not available **AST requested?** Yes No Not applicable

4th Test & Specimen

Test type: PCR IHC Other ELISA IgM Viteck or other automated clinical laboratory system
IHA ImmunoDot/DotBlot IgM Culture Other:

Performing lab: ______________________ ______________________

Specimen type: Whole blood Cerebrospinal fluid **Specify tissue type:** **Specimen collection date:**
Serum Tissue
Urine Other: ____________ ____________ ____________

Qualitative result: Positive Borderline
Negative Indeterminate Other: ____________ **Quantitative result** (*e.g., titer*)**:** ____________

Organism name: ______________________ **Lab result date:** ____________

Send to CDC? Yes No, isolate destroyed No, specimen not available **AST requested?** Yes No Not applicable

ENVIRONMENTAL SAMPLES

Specimen type: Water Date of Collection: Location of Collection:
Soil Organism Identified:
Other: Performing Lab:

Specimen type: Water Date of Collection: Location of Collection:
Soil Organism
Other: Performing Lab:

Notes:

POST-EXPOSURE PROPHYLAXIS

Did patient receive post-exposure prophylaxis (PEP)?
Yes
No
Unknown

If patient did not receive PEP, why not?
Not indicated | Allergic | Other:
Unaware of exposure | Pregnant
Unavailable | Unknown

If yes, antimicrobial taken:
Ceftazidime
Co-amoxicav
Doxycycline
Meropenem
Trimethoprim/Sulfamethoxazole
Amoxicillin/Clavulanate
Other:

Did the patient complete the course?
Yes
No
Unknown

If patient did not complete course, provide reason:

LABORATORY EXPOSURE

Was there a laboratory exposure? Yes No Unk

If Yes, Date of exposure ____________________ Total number exposed _______ : High Risk _______ Low Risk ______

Laboratory name and location. ____

Activities resulting in exposure. ____

Describe potential exposure. ____

Date post-exposure prophylaxis (PEP) was offered/discussed _____________ Risk Status: High Low Unknown

Date PEP initiated _______________ PEP regimen used ____

Time between first exposure and start of PEP: ______________ Dosing: _____________ Duration: _____________

Were any side effects reported with the PEP? Yes No Unk

If Yes, Date of onset _____________

Describe side effects. ____

Did side effects result in the termination of PEP? ☐ Yes ☐ No ☐ Unk If Yes, how many days was prophylaxis administered? _____________

Did side effects result in a switch to another antimicrobial agent? ☐ Yes ☐ No ☐ Unk

If Yes, Specify antimicrobial agent. ____

Date started. _________________

Are serial serum specimens being collected? ☐ Yes ☐ No ☐ Unk

If Yes, Collection date of "baseline" serum sample? _____________

Time between first exposure and initial serum collection: __________ ☐ Days ☐ Weeks

Dates of serum collection: Week 1 _____________ Week 2 _____________ Week 4 _____________ Week 6 _____________

ADDITIONAL DEMOGRAPHIC INFORMATION

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight
☐ Gay, lesbian, or same-gender loving
☐ Bisexual
☐ Questioning, unsure, or patient doesn't know
☐ Orientation not listed
Declined to answer
☐ Unknown

REMARKS

Clinical outcome:	Died Still hospitalized Still sick (outpatient)	Recovered Long-term disability Unknown	Date of Death: __________
Pathogen:	*B. mallei*	*B. pseudomallei*	Other:
Disease Case Classification	Confirmed New	False Recurrent	 Unknown

Notes:

Investigator: **Title:** **Date of Final Report:**