State of California—Health and Human Services Agency

Local ID Number: ________________

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

TULAREMIA
CASE REPORT

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
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	*If Yes, Est. Delivery Date (mm/dd/yyyy)*
Medical Record Number	*Patient's Parent/Guardian Name*
Occupation Setting (see list on page 9)	*Other Describe/Specify*
Occupation (see list on page 9)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other: ____________________

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

Race(s)
(check all that apply, race descriptions on page 8)

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.

☐ American Indian or Alaska Native

☐ Asian *(check all that apply, see list on page 8)*
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: ____________________

☐ Black or African-American

☐ Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 8)*
- ☐ Native Hawaiian
- ☐ Fijian
- ☐ Guamanian
- ☐ Samoan
- ☐ Tongan
- ☐ Other: ____________________

☐ White

☐ Other: ____________________

☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

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

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

CLINICAL INFORMATION

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

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

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown	*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)*
Cutaneous ulcer				*Location*
Other skin lesion				*Location*
Lymphadenopathy				*Location*
Sepsis				
Pharyngitis				
Pleuropneumonia				
Cough				
Conjunctivitis				
Stomatitis				
Tonsilitis				
Abdominal pain				
Vomiting				
Diarrhea				
Other signs / symptoms (specify)				

PAST MEDICAL HISTORY

Mucous membrane/skin cut or abrasion? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify location*
Immunocompromised? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify condition*
Other (specify)	

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

HOSPITALIZATION

Did the patient visit the emergency room for illness?
☐ Yes ☐ No ☐ Unknown

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown	*If Yes, how many total hospital nights?*	*During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)?* ☐ Yes ☐ No ☐ Unknown

If there were any ER or hospital stays related to this illness, specify details in the Hospitalization – Details section 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*

TREATMENT / MANAGEMENT

Received treatment? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify the treatments below.*

TREATMENT / MANAGEMENT DETAILS

Treatment Type 1 ☐ Antibiotic ☐ Other	*Treatment Name*	*Date Started (mm/dd/yyyy)*	*Date Ended (mm/dd/yyyy)*
Treatment Type 2 ☐ Antibiotic ☐ Other	*Treatment Name*	*Date Started (mm/dd/yyyy)*	*Date Ended (mm/dd/yyyy)*

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unknown	*If Survived,* *Survived as of* ________________________________*(mm/dd/yyyy)*	*Date of Death (mm/dd/yyyy)*

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 ☐ Blood ☐ Biopsy or scraping of ulcer ☐ Swab of ulcer ☐ Tissue aspirate ☐ Serum (acute) IgM ☐ Serum (convalescent) IgM ☐ Serum (acute) IgG ☐ Serum (convalescent) IgG ☐ Isolate ☐ Other:________________ If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.	*Type of Test* ☐ Culture ☐ PCR ☐ ELISA ☐ Immunofluorescence antibody ☐ Agglutination ☐ CF ☐ DFA ☐ Other:_________________		*Collection Date (mm/dd/yyyy)*
	Result	*Specify (if applicable)* *Result Unit:* ☐ Titer ☐ O.D. *Result Type:* ☐ DNA ☐ mRNA	*Interpretation* ☐ Positive ☐ Equivocal ☐ Negative
	Laboratory Name		*Telephone Number*

Specimen Type 2 ☐ Blood ☐ Biopsy or scraping of ulcer ☐ Swab of ulcer ☐ Tissue aspirate ☐ Serum (acute) IgM ☐ Serum (convalescent) IgM ☐ Serum (acute) IgG ☐ Serum (convalescent) IgG ☐ Isolate ☐ Other:________________ If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.	*Type of Test* ☐ Culture ☐ PCR ☐ ELISA ☐ Immunofluorescence antibody ☐ Agglutination ☐ CF ☐ DFA ☐ Other:_________________		*Collection Date (mm/dd/yyyy)*
	Result	*Specify (if applicable)* *Result Unit:* ☐ Titer ☐ O.D. *Result Type:* ☐ DNA ☐ mRNA	*Interpretation* ☐ Positive ☐ Equivocal ☐ Negative
	Laboratory Name		*Telephone Number*

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

LABORATORY RESULTS SUMMARY - OTHER

Was the biotype identified? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify biotype* ☐ Type A ☐ Type B ☐ Other:__________	*Laboratory Name*	*Telephone Number*

IMAGING SUMMARY

Anatomic Site 1	*Type of Imaging* ☐ X-ray ☐ CT ☐ MRI ☐ Other:_________________			*Date (mm/dd/yyyy)*
	Result	*Interpretation*	*Facility Name*	*Telephone Number*
Anatomic Site 2	*Type of Imaging* ☐ X-ray ☐ CT ☐ MRI ☐ Other:_________________			*Date (mm/dd/yyyy)*
	Result	*Interpretation*	*Facility Name*	*Telephone Number*

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 3 WEEKS PRIOR TO ILLNESS ONSET

FOOD HISTORY

DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?

Food Item	Yes	No	Unk	If Yes, Specify as Noted
Undercooked meat				*Animal species and meat product*
Untreated water				*Location*
Other (specify)				

OCCUPATIONAL / RECREATIONAL EXPOSURE

DID THE PATIENT EXPERIENCE ANY OF THE FOLLOWING EVENTS OR OCCUPATIONS DURING THE INCUBATION PERIOD?

Event / Occupation	Yes	No	Unk	If Yes, Specify as Noted
Known tick contact				*Address where tick contact occurred*
Known deerfly contact				*Address where deerfly contact occurred*
Contact with untreated water				*Location*
Microbiology laboratory				*Laboratory name and location*
Veterinary medicine				*Animal species and location*
Farmer / livestock owner				*Animal species and location*
Hunting / animal trapping / fishing				*Animal species and location*
Landscape / gardening				*Location*
Hiking / camping				*Location*
Other (specify)				

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

ANIMAL EXPOSURES

DID THE PATIENT HAVE CONTACT WITH ANY OF THE FOLLOWING ANIMALS DURING THE INCUBATION PERIOD?

Animal Exposures	Yes	No	Unk	If Yes, Specify as Noted	
Wild rabbit				*Species*	*Contact type(s)* ☐ Handling ☐ Skinning ☐ Bite ☐ Other:________
Domestic rabbit				*Breed*	*Contact type(s)* ☐ Handling ☐ Skinning ☐ Bite ☐ Other:________
Wild rodent				*Species*	*Contact type(s)* ☐ Handling ☐ Skinning ☐ Bite ☐ Other:________
Domestic rodent				*Species*	*Contact type(s)* ☐ Handling ☐ Skinning ☐ Bite ☐ Other:________
Other wild animal(s)				*Species*	*Contact type(s)* ☐ Handling ☐ Skinning ☐ Bite ☐ Other:________
Other domestic animal(s)				*Species*	*Contact type(s)* ☐ Handling ☐ Skinning ☐ Bite ☐ Other:________

TRAVEL HISTORY

*Did the patient travel **outside county of residence** during the **incubation period**?* ☐ Yes ☐ No ☐ Unknown	*If Yes, specify all locations and dates below.*

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.)	Date Travel Started *(mm/dd/yyyy)*	Date Travel Ended *(mm/dd/yyyy)*
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					

ILL CONTACTS

Any contacts with similar illness (including household contacts)? ☐ Yes ☐ No ☐ Unknown	*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*	*Date First Reported to Public Health (mm/dd/yyyy)*	

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*	*Date First Reported to Public Health (mm/dd/yyyy)*	

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

NOTES / REMARKS

REPORTING AGENCY

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

First Reported By
☐ Clinician ☐ Laboratory ☐ Other (specify):___________________

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐ Yes ☐ No ☐ Unknown	*Contact Name / Case Number*

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐ Confirmed ☐ Probable ☐ Suspect

Disease Type
☐ Ulceroglandular ☐ Glandular ☐ Oculoglandular ☐ Oropharyngeal ☐ Intestinal ☐ Pneumonic ☐ Typhoidal ☐ Other:___________________

OUTBREAK

Part of known outbreak? ☐ Yes ☐ No ☐ Unknown	*If Yes, extent of outbreak* ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other:________________

Mode of Transmission ☐ Point source ☐ Person-to-person ☐ Unknown ☐ Other:_________________	*Vehicle of Outbreak*	*Pattern 1 ID number*	*Pattern 2 ID number*

STATE USE ONLY

State Case Classification
☐ Confirmed ☐ Probable ☐ Not a case ☐ Need additional information

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

CASE DEFINITION

TULAREMIA (2017)

CLINICAL CRITERIA

An illness characterized by several distinct forms, including the following:

- Ulceroglandular: cutaneous ulcer with regional lymphadenopathy
- Glandular: regional lymphadenopathy with no ulcer
- Oculoglandular: conjunctivitis with preauricular lymphadenopathy
- Oropharyngeal: stomatitis or pharyngitis or tonsillitis and cervical lymphadenopathy
- Pneumonic: primary pleuropulmonary disease
- Typhoidal: febrile illness without localizing signs and symptoms

LABORATORY CRITERIA FOR DIAGNOSIS

Supportive

- Elevated serum antibody titer(s) to *F. tularensis* antigen (without documented fourfold or greater change) in a patient with no history of tularemia vaccination, **OR**
- Detection of *F. tularensis* in a clinical or autopsy specimen by fluorescent assay, **OR**
- Detection of *F. tularensis* in a clinical or autopsy specimen by a polymerase chain reaction (PCR)

Confirmatory

- Isolation of *F. tularensis* in a clinical or autopsy specimen, **OR**
- Fourfold or greater change in serum antibody titer to *F. tularensis* antigen between acute and convalescent specimens

EPIDEMIOLOGIC LINKAGE

Clinical diagnosis is supported by evidence or history of a tick or deerfly bite, exposure to tissues of a mammalian host of *F. tularensis*, including via an animal bite, or exposure to potentially contaminated water.

CRITERIA TO DISTINGUISH A NEW CASE FROM AN EXISTING CASE

Serial or subsequent cases of tularemia experienced by one individual should only be counted if there is an additional epidemiologically compatible exposure and new onset of symptoms. Because the duration of antibodies to *F. tularensis* is not known, mere presence of antibodies without a clinically-compatible illness **AND** an epidemiologically compatible exposure within 12 months of onset may not indicate a new infection, especially among persons who live in endemic areas.

CASE CLASSIFICATION

Probable

A clinically-compatible case with supportive laboratory evidence.

Confirmed

A clinically-compatible case with confirmatory laboratory evidence.

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

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.

ASIAN GROUPS

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

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

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

- 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 - waiter or waitress
- 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 - registered nurse
- Medical - other/unknown
- Military - officer
- Military - recruit or trainee
- Protective service - police officer
- Protective service - other
- Professional, technical, or related profession
- Retired
- Sex worker
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high (secondary) school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high (secondary) school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Other
- Refused
- Unknown