

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

## EHRlichiosis CASE REPORT

- Check one:       *Ehrlichia chaffeensis*  
 *Ehrlichia ewingii*  
 *Ehrlichia muris eauclairensis*  
 *Ehrlichia*, other spp. or unspiciated

*Jurisdictions that choose to use this form should send completed forms to the Surveillance and Statistics Section by mail through your communicable disease reporting staff. For jurisdictions participating in CalREDIE, entry of information into the CalREDIE form will facilitate investigations and surveillance. This form is only for cases of ehrlichiosis. Anaplasmosis cases should be reported using the Anaplasmosis Case Report Form. Spotted fever rickettsioses (such as Rocky Mountain spotted fever) should be reported on the appropriate Spotted Fever Rickettsioses Case Report form. Cases of typhus and other non-spotted fever rickettsioses should be reported on the Typhus and Other Non-Spotted Fever Rickettsioses 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		
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 <input type="checkbox"/> Female <input type="checkbox"/> Trans female / transwoman <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Trans male/ transman <input type="checkbox"/> Identity not listed <input type="checkbox"/> Declined to answer					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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			
Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> 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.					
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply, see list on page 8) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Malaysian <input type="checkbox"/> Chinese <input type="checkbox"/> Pakistani <input type="checkbox"/> Filipino <input type="checkbox"/> Sri Lankan <input type="checkbox"/> Hmong <input type="checkbox"/> Taiwanese <input type="checkbox"/> Indonesian <input type="checkbox"/> Thai <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 8) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Fijian <input type="checkbox"/> Tongan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other: _____					
<input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown					

First three letters of patient's last name:

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<b>ADDITIONAL PATIENT DEMOGRAPHICS</b>				
<b>Sex Assigned at Birth</b> <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Declined to answer	<b>Sexual Orientation</b> <input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Questioning, unsure, or patient doesn't know <input type="checkbox"/> Declined to answer <input type="checkbox"/> Gay, lesbian, or same-gender loving <input type="checkbox"/> Orientation not listed <input type="checkbox"/> Unknown <input type="checkbox"/> Bisexual			
<b>CLINICAL INFORMATION</b>				
<i>Physician Name - Last Name</i>		<i>First Name</i>		<i>Telephone Number</i>
<b>SIGNS AND SYMPTOMS</b>				
<b>Symptomatic?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<i>Onset Date (mm/dd/yyyy)</i>		<i>Date First Sought Medical Care (mm/dd/yyyy)</i>
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Fever				<i>Highest temperature (specify °F/°C)</i>
Muscle pain				
Headache				
Nausea or vomiting				
Rash or other cutaneous lesion				<i>Location / size / appearance</i>
Chills				
Sweats				
Joint pain				<i>Joint(s)</i>
Eye pain				
Abdominal pain				
Diarrhea				
Cough				
Hypotension				<i>Date measured (mm/dd/yyyy)</i> <i>Systolic / Diastolic</i>
<i>Other signs / symptoms (specify)</i>				
<b>HOSPITALIZATION</b>				
<b>Did patient visit the emergency room for illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<b>Was the patient hospitalized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>If Yes, how many total hospital nights?</b> <input type="checkbox"/> Still hospitalized as of _____ (mm/dd/yyyy)		
<b>During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<i>If there were any ER visits or hospital stays related to this illness, specify details in the Hospitalization – Details section on next page.</i>				

First three letters of  
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<b>HOSPITALIZATION – DETAILS</b>					
<i>Hospital Name 1</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>
<i>Hospital Name 2</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>
<b>TREATMENT / MANAGEMENT</b>					
<i>Received treatment?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<i>If Yes, specify the treatments below.</i>			
<b>TREATMENT / MANAGEMENT DETAILS</b>					
<i>Treatment Type 1</i> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	<i>If Antibiotic, specify route</i>	<i>Treatment Name</i>	<i>Date Started (mm/dd/yyyy)</i>	<i>Date Ended (mm/dd/yyyy)</i>	
<i>Treatment Type 2</i> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	<i>If Antibiotic, specify route</i>	<i>Treatment Name</i>	<i>Date Started (mm/dd/yyyy)</i>	<i>Date Ended (mm/dd/yyyy)</i>	
<b>OUTCOME</b>					
<i>Outcome?</i> <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown		<i>If Survived,</i> <i>Survived as of</i> _____ <i>(mm/dd/yyyy)</i>		<i>Date of Death (mm/dd/yyyy)</i>	
<b>LABORATORY INFORMATION</b>					
<b>LABORATORY RESULTS SUMMARY - SEROLOGY</b>					
<i>Specimen Type 1</i>	<i>Collection Date (mm/dd/yyyy)</i>	<i>Type of Test</i>		<i>Antigen</i>	
	<i>Results</i>	<i>Laboratory Name</i>		<i>Telephone Number</i>	
<i>Specimen Type 2</i>	<i>Collection Date (mm/dd/yyyy)</i>	<i>Type of Test</i>		<i>Antigen</i>	
	<i>Results</i>	<i>Laboratory Name</i>		<i>Telephone Number</i>	
<b>LABORATORY RESULTS SUMMARY - OTHER</b>					
<i>Hematology?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>Collection Date (mm/dd/yyyy)</i>	<i>WBC</i>	<i>HCT</i>	<i>Hb</i>	<i>Platelets</i>
<i>Serum chemistry?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>Collection Date (mm/dd/yyyy)</i>	<i>ALT</i>		<i>AST</i>	
<i>Other laboratory diagnostics performed (e.g., PCR, buffy coat smear)?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<i>If Yes, describe</i>			

First three letters of patient's last name:

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**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"/> Unknown		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"/> Unknown		If Yes, specify all locations, type of insect bite, and dates below.

**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: _____

**EXPOSURES / RISK FACTORS – TRANSFUSION / TRANSPLANTATION**

Was patient's infection transfusion or solid-organ-transplantation associated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, describe
Was patient a blood donor identified during a transfusion investigation or a solid-organ donor identified during a transplantation investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, describe

**TRAVEL HISTORY**

Did patient travel <b>outside county of residence</b> during the <b>incubation period</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, specify all locations and dates below.
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**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)
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					
<input type="checkbox"/> Domestic <input type="checkbox"/> Unknown <input type="checkbox"/> International					

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**ILL CONTACTS**

Any contacts with similar illness (including household contacts)?  
 Yes  No  Unknown If Yes, specify details below.

**ILL CONTACTS - DETAILS**

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

**EPIDEMIOLOGICAL LINKAGE**

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

**NOTES / REMARKS**

**REPORTING AGENCY**

<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
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*First Reported By*  
 Clinician  Laboratory  Other (specify): \_\_\_\_\_

**DISEASE CASE CLASSIFICATION**

*Case Classification (see case definition on page 6)*  
 Confirmed  Probable  Suspect

**STATE USE ONLY**

*State Case Classification*  
 Confirmed  Probable  Suspect  Not a case  Need additional information

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**CASE DEFINITION****EHRlichiosis (2024)****SUBTYPES**

*Ehrlichia chaffeensis*  
*Ehrlichia ewingii*  
*Ehrlichia muris eauclairensis*  
*Ehrlichia, other spp. or unspiciated*

**BACKGROUND**

Ehrlichiosis is the general name given to the diseases caused by obligate intracellular bacteria in the genus *Ehrlichia* within the family Anaplasmataceae. *Ehrlichia* species are tickborne pathogens and are the most commonly reported species transmitted by *Amblyomma americanum*, the lone star tick<sup>1</sup>. The majority of reported human infections are caused by either *Ehrlichia chaffeensis* or *Ehrlichia ewingii*. Most cases of ehrlichiosis occur across the south-central, southeastern, and mid-Atlantic states, although *Ehrlichia muris eauclairensis*, which is transmitted by *Ixodes scapularis*, the blacklegged tick, has been reported from travelers to, or residents of, Minnesota and Wisconsin<sup>2,3</sup>. Ehrlichiosis typically presents 5 to 14 days after a tick bite with a combination of nonspecific clinical symptoms, such as fever, fatigue, and headache. Illness is often accompanied by laboratory abnormalities including leukopenia, thrombocytopenia, and mildly elevated liver enzymes. Ehrlichiosis may result in severe illness or even death in older or immunocompromised individuals or if treatment is delayed. Serologic testing is commonly used to diagnosis ehrlichiosis, but antibodies to *Anaplasma* and *Ehrlichia* spp. can cross-react.

**CLINICAL CRITERIA**

**Objective clinical evidence:** A tick-borne illness characterized by acute onset of fever and one or more of the following symptoms or signs: headache, myalgia, malaise, anemia, leukopenia, thrombocytopenia, or elevated hepatic transaminases. Nausea, vomiting, or rash may be present in some cases.

**Subjective clinical evidence:** Any reported fever and one or more of the following: headache, myalgia, anemia, leukopenia, thrombocytopenia, or any hepatic transaminase elevation.

**LABORATORY CRITERIA****Confirmatory laboratory evidence:**

- Detection of *E. chaffeensis*\*, *E. ewingii*\*, *E. muris eauclairensis*\*, unspiciated *Ehrlichia* spp., or other *Ehrlichia* spp. DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay, nucleic acid amplification tests (NAAT), or other molecular method, **OR**
- Serological evidence of a fourfold change\*\* in immunoglobulin G (IgG)-specific antibody titer to *Ehrlichia* spp. antigen by indirect immunofluorescence assay (IFA) in paired serum samples (one taken in first two weeks after illness onset and a second taken two to ten weeks after acute specimen collection)\*\*\*, **OR**
- Demonstration of ehrlichial antigen in a biopsy or autopsy sample by immunohistochemical methods **OR**
- Isolation of *E. chaffeensis*\*, *E. ewingii*\*, *E. muris eauclairensis*\*, unspiciated *Ehrlichia* spp., or other *Ehrlichia* spp. from a clinical specimen in cell culture with molecular confirmation (e.g., PCR or sequence).

**Presumptive laboratory evidence:**

- Serological evidence of elevated IgG antibody reactive with *Ehrlichia* spp. antigen by IFA at a titer  $\geq 1:128$  in a sample taken within 60 days of illness onset, **OR**
- Microscopic identification of intracytoplasmic morulae in leukocytes in a sample taken within 60 days of illness onset.

Note: The categorical labels used here to stratify laboratory evidence are intended to support the standardization of case classifications for public health surveillance. The categorical labels should not be used to interpret the utility or validity of any laboratory test methodology.

\* *Ehrlichia chaffeensis* infection was formerly included in the category Human Monocytic Ehrlichiosis (HME); *Ehrlichia ewingii* infection was formerly included in the category Ehrlichiosis (unspecified, or other agent); *Ehrlichia muris eauclairensis* infection was formerly included in the category Undetermined Anaplasmosis/Ehrlichiosis.

\*\* A four-fold change in titer is equivalent to a change of two dilutions\* (e.g., 1:64 to 1:256).

\*\*\* A four-fold rise in titer should not be excluded as confirmatory laboratory criteria if the acute and convalescent specimens are collected within two weeks of one another.

**CRITERIA TO DISTINGUISH A NEW CASE FROM AN EXISTING CASE**

A person previously reported as a probable or confirmed case-patient may be counted as a new case-patient when there is an episode of new clinically compatible illness with confirmatory laboratory evidence.

(continued on page 7)

First three letters of  
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**CASE DEFINITION (continued)****CASE CLASSIFICATION****Confirmed**

- Meets confirmatory laboratory evidence **AND** at least one of the objective or subjective clinical evidence criteria.

**Probable**

- Meets presumptive laboratory evidence with fever as reported by patient or healthcare provider **AND** at least one other objective or subjective clinical evidence criterion (excluding chills/sweats), **OR**
- Meets presumptive laboratory evidence without a reported fever but with chills/sweats **AND**
  - at least one objective clinical evidence criterion, **OR**
  - two other subjective clinical evidence criteria.

**Suspect**

- Meets confirmatory or presumptive laboratory evidence with no or insufficient clinical information to classify as a confirmed or probable case (e.g., a laboratory report only).

**COMMENTS**

- Ehrlichiosis is reported at the species level only if molecular testing is performed, as antibodies to closely-related species of *Ehrlichia* can cross-react with multiple antigens; serologic assays cannot definitively distinguish between species. Therefore, *E. chaffeensis*, *E. ewingii*, and *E. muris eauclairensis* ehrlichiosis reported cases should only be classified as "Confirmed." Cases reported within the "*Ehrlichia*, other spp. or unspciated" can be classified as either "Probable" or "Confirmed".
- Patients should not be classified as cases for both anaplasmosis and ehrlichiosis based on serologic evidence alone.
- *Ehrlichia* spp. bacteria are closely related to *A. phagocytophilum*, and many patients are tested using serologic panels that include targets for both species. As a result, it is not uncommon for jurisdictions to receive positive antibody results for both *Ehrlichia* spp. and *Anaplasma* with the same collection date for a single patient. Public health agencies should use a combination of titer levels, information about the location of possible exposures, clinical manifestations, and the incidence of a particular disease in the geographic areas of exposure to help determine the appropriate disease type for individual patients.

**REFERENCES**

1. Killmaster LF, Loftis AD, Zemtsova GE, Levin ML. Detection of Bacterial Agents in *Amblyomma americanum* (Acari: Ixodidae) From Georgia, USA, and the Use of a Multiplex Assay to Differentiate *Ehrlichia chaffeensis* and *Ehrlichia ewingii*. *J Med Entomol* 2014 Jul;51(4):868-872.
2. Pritt BS, Allerdice MEJ, Sloan LM, et al. Proposal to reclassify *Ehrlichia muris* as *Ehrlichia muris* subsp. *nov.* and description of *Ehrlichia muris* subsp. *eauclairensis* subsp. *nov.*, a newly recognized tick-borne pathogen of humans. *Int J Syst Evol Microbiol* 2017 Jul;67(7):2121-2126.
3. Lynn GE, Burkhardt NY, Felsheim RF, et al. *Ehrlichia* Isolate from a Minnesota Tick: Characterization and Genetic Transformation. *Appl Environ Microbiol* 2019 Jul;85(14).

First three letters of  
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RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in <b>any</b> of the original peoples of North and South America (including Central America).
Asian	Patient has origins in <b>any</b> 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 <b>any</b> of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in <b>any</b> of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in <b>any</b> of the original peoples of Europe, the Middle East, or North Africa.
ASIAN GROUPS	
<ul style="list-style-type: none"> <li>• Bangladeshi</li> <li>• Bhutanese</li> <li>• Burmese</li> <li>• Cambodian</li> <li>• Chinese</li> <li>• Filipino</li> <li>• Hmong</li> <li>• Indian</li> <li>• Indonesian</li> <li>• Iwo Jiman</li> <li>• Japanese</li> <li>• Korean</li> <li>• Laotian</li> <li>• Madagascar</li> <li>• Malaysian</li> <li>• Maldivian</li> <li>• Nepalese</li> <li>• Okinawan</li> <li>• Pakistani</li> <li>• Singaporean</li> <li>• Sri Lankan</li> <li>• Taiwanese</li> <li>• Thai</li> <li>• Vietnamese</li> </ul>	
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS	
<ul style="list-style-type: none"> <li>• Carolinian</li> <li>• Chamorro</li> <li>• Chuukese</li> <li>• Fijian</li> <li>• Guamanian</li> <li>• Kiribati</li> <li>• Kosraean</li> <li>• Mariana Islander</li> <li>• Marshallese</li> <li>• Melanesian</li> <li>• Micronesian</li> <li>• Native Hawaiian</li> <li>• New Hebrides</li> <li>• Palauan</li> <li>• Papua New Guinean</li> <li>• Pohnpeian</li> <li>• Polynesian</li> <li>• Saipanese</li> <li>• Samoan</li> <li>• Solomon Islander</li> <li>• Tahitian</li> <li>• Tokelauan</li> <li>• Tongan</li> <li>• Yapese</li> </ul>	



First three letters of patient's last name:

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**OCCUPATION SETTING**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Childcare/Preschool</li> <li>• Correctional Facility</li> <li>• Drug Treatment Center</li> <li>• Food Service</li> <li>• Health Care - Acute Care Facility</li> <li>• Health Care - Long Term Care Facility</li> <li>• Health Care - Other</li> </ul> | <ul style="list-style-type: none"> <li>• Homeless Shelter</li> <li>• Laboratory</li> <li>• Military Facility</li> <li>• Other Residential Facility</li> <li>• Place of Worship</li> <li>• School</li> <li>• Other</li> </ul> |
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**OCCUPATION**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Agriculture - farmworker or laborer (crop, nursery, or greenhouse)</li> <li>• Agriculture - field worker</li> <li>• Agriculture - migratory/seasonal worker</li> <li>• Agriculture - other/unknown</li> <li>• Animal - animal control worker</li> <li>• Animal - farm worker or laborer (farm or ranch animals)</li> <li>• Animal - veterinarian or other animal health practitioner</li> <li>• Animal - other/unknown</li> <li>• Clerical, office, or sales worker</li> <li>• Correctional facility - employee</li> <li>• Correctional facility - inmate</li> <li>• Craftsman, foreman, or operative</li> <li>• Daycare or child care attendee</li> <li>• Daycare or child care worker</li> <li>• Dentist or other dental health worker</li> <li>• Drug dealer</li> <li>• Fire fighting or prevention worker</li> <li>• Flight attendant</li> <li>• Food service - cook or food preparation worker</li> <li>• Food service - host or hostess</li> <li>• Food service - waiter or waitress</li> <li>• Food service - other/unknown</li> <li>• Homemaker</li> <li>• Laboratory technologist or technician</li> <li>• Laborer - private household or unskilled worker</li> <li>• Manager, official, or proprietor</li> <li>• Manicurist or pedicurist</li> <li>• Medical - emergency medical technician or paramedic</li> <li>• Medical - health care worker</li> </ul> | <ul style="list-style-type: none"> <li>• Medical - medical assistant</li> <li>• Medical - pharmacist</li> <li>• Medical - physician assistant or nurse practitioner</li> <li>• Medical - physician or surgeon</li> <li>• Medical - registered nurse</li> <li>• Medical - other/unknown</li> <li>• Military - officer</li> <li>• Military - recruit or trainee</li> <li>• Protective service - police officer</li> <li>• Protective service - other</li> <li>• Professional, technical, or related profession</li> <li>• Retired</li> <li>• Sex worker</li> <li>• Student - preschool or kindergarten</li> <li>• Student - elementary or middle school</li> <li>• Student - high (secondary) school</li> <li>• Student - college or university</li> <li>• Student - other/unknown</li> <li>• Teacher/employee - preschool or kindergarten</li> <li>• Teacher/employee - elementary or middle school</li> <li>• Teacher/employee - high (secondary) school</li> <li>• Teacher/instructor/employee - college or university</li> <li>• Teacher/instructor/employee - other/unknown</li> <li>• Unemployed - seeking employment</li> <li>• Unemployed - not seeking employment</li> <li>• Unemployed - other/unknown</li> <li>• Other</li> <li>• Refused</li> <li>• Unknown</li> </ul> |
|--|--|