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

RELAPSING FEVER 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 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
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 5)

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 5)*
- ☐ 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 5)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Fijian
- ☐ Tongan
- ☐ Guamanian
- ☐ 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	Signs and Symptoms	Yes	No	Unk
Fever *(specify details of febrile episodes below)*				Body aches			
Chills				Nausea or vomiting			
Sweats				Loss of appetite			
Headache				Dry cough			

Other signs / symptoms (specify)

FEBRILE EPISODES

Total Number of Febrile Episodes (specify details of febrile episodes below)

FEBRILE EPISODES - DETAILS

Episode 1	*Start Date (mm/dd/yyyy)*	*End Date (mm/dd/yyyy)*	*Highest Recorded Temperature (specify °F/°C)*
Episode 2	*Start Date (mm/dd/yyyy)*	*End Date (mm/dd/yyyy)*	*Highest Recorded Temperature (specify °F/°C)*
Episode 3	*Start Date (mm/dd/yyyy)*	*End Date (mm/dd/yyyy)*	*Highest Recorded Temperature (specify °F/°C)*

HOSPITALIZATION

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

Was 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 visits 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 treatment 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)*

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

OUTCOME

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

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen 1 Collection Date (mm/dd/yyyy)

Type of Test
☐ Thick Smear ☐ EIA ☐ *B. hermsii*-specific polymerase chain reaction (PCR)
☐ Thin Smear ☐ Western blot ☐ Other (specify): _____

Results
☐ Spirochetes observed ☐ Positive ☐ Unknown
☐ No spirochetes observed ☐ Negative ☐ Other (specify): _____

Laboratory Name	Telephone Number

Specimen 2 Collection Date (mm/dd/yyyy)

Type of Test
☐ Thick Smear ☐ EIA ☐ *B. hermsii*-specific polymerase chain reaction (PCR)
☐ Thin Smear ☐ Western blot ☐ Other (specify): _____

Results
☐ Spirochetes observed ☐ Positive ☐ Unknown
☐ No spirochetes observed ☐ Negative ☐ Other (specify): _____

Laboratory Name	Telephone Number

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD IS 21 DAYS PRIOR TO ILLNESS ONSET

BITE HISTORY

Did the patient observe any rodents in or around residence?	Did the patient recall any insect bites during the incubation period?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐Unknown

If Yes, specify locations, type of bite, and dates below.

BITE HISTORY - DETAILS

	Location (county, state, country)	Date of Bite (mm/dd/yyyy)	Type of Bite
Bite 1			☐ Tick ☐ Other:_____ ☐ Unknown
Bite 2			☐ Tick ☐ Other:_____ ☐ Unknown

TRAVEL HISTORY

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

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 ☐ International ☐ Unknown					
☐ Domestic ☐ International ☐ Unknown					
☐ Domestic ☐ International ☐ Unknown					

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

CONTACTS / OTHER ILL PERSONS

Any contacts or travel companions with similar illness? ☐ Yes ☐ No ☐ Unknown	If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	Illness Onset Date (mm/dd/yyyy)
	Street Address			Exposure Dates Shared with Index Case (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	Illness Onset Date (mm/dd/yyyy)
	Street Address			Exposure Dates Shared with Index Case (mm/dd/yyyy)	
	City	State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	

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 on page 5)
☐ Confirmed ☐ Probable ☐ Suspect

OUTBREAK

Part of known outbreak? ☐ Yes ☐ No ☐ Unknown	If Yes, extent of outbreak ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other (specify):_____		
Mode of Transmission ☐ Point source ☐ Person-to-person ☐ Unknown ☐ Other (specify):_____	Vehicle of Outbreak	Pattern 1 ID Number	Pattern 2 ID Number

STATE USE ONLY

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

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

CASE DEFINITION

RELAPSING FEVER (CDPH working definition, 2023)

CLINICAL EVIDENCE
One or more episodes of fever (>100.5 ℉) lasting 2-7 days and separated by afebrile periods of 4-14 days, often accompanied by headache, muscle and joint aches, and nausea.

LABORATORY EVIDENCE
For the purpose of surveillance:

Laboratory confirmed

- Observation of *Borrelia sp*. spirochetes on thick or thin smear of peripheral blood collected during a febrile episode, OR
- *B. hermsii* relapsing fever-specific PCR positive taken within 30 days of disease onset

Laboratory supportive

- Elevated IgM or IgG serum antibodies to *B. hermsii* detected by commercial EIA or IFA

CASE CLASSIFICATION

Confirmed: A clinically compatible case (meets clinical evidence criteria) that is laboratory confirmed

Probable: A clinically compatible case (meets clinical evidence criteria) that has supportive laboratory results and a history of being in the same location as a confirmed case 2 to 14 days prior to onset of first febrile episode

Suspect: A clinically compatible case (meets clinical evidence criteria) that has supportive laboratory results and a history of residing in or visiting an area in the western U.S. between 2000 and 9000 feet elevation 2 to 14 days prior to onset of first febrile episode

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