

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

SPOTTED FEVER RICKETTSIOSES CASE REPORT

- Check one: Rocky Mountain spotted fever (*Rickettsia rickettsii*)
 Pacific Coast tick fever, caused by *Rickettsia* species 364D
 Other spotted fever rickettsiosis (including *Rickettsia parkeri*, etc.)

This form should be completed only for cases of Rocky Mountain spotted fever and other spotted fever rickettsioses. Ehrlichiosis and anaplasmosis cases should be reported on the Ehrlichiosis/Anaplasmosis 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If Yes, Est. Delivery Date (mm/dd/yyyy)		
Medical Record Number			Patient's Parent/Guardian Name		
Occupation Setting (see list on page 8)			Other Describe/Specify		
Occupation (see list on page 8)			Other Describe/Specify		
Race(s) (check all that apply, race descriptions on page 7) 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 7) <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 7) <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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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

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 Yes No Unk Highest temperature (specify °F/°C)Muscle pain Yes No UnkHeadache Yes No UnkNausea or vomiting Yes No UnkRash or other cutaneous lesion Yes No Unk Location / size / appearanceChills Yes No UnkSweats Yes No UnkJoint pain Yes No Unk Joint(s)Eye pain Yes No UnkAbdominal pain Yes No UnkDiarrhea Yes No UnkCough Yes No UnkHypotension Yes No Unk Date measured (mm/dd/yyyy) Systolic / Diastolic

Other signs / symptoms (specify)

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 on next page.

First three letters of
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HOSPITALIZATION – DETAILS					
<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>
TREATMENT / MANAGEMENT					
<i>Received treatment?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<i>If Yes, specify the treatments below.</i>			
TREATMENT / MANAGEMENT DETAILS					
<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>	
OUTCOME					
<i>Outcome?</i> <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown		<i>If Survived, Survived as of</i> _____ <i>(mm/dd/yyyy)</i>		<i>Date of Death (mm/dd/yyyy)</i>	
LABORATORY INFORMATION					
LABORATORY RESULTS SUMMARY - SEROLOGY					
<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>	
LABORATORY RESULTS SUMMARY - OTHER					
<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:

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
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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)
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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
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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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe
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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 on page 4.
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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: _____

TRAVEL HISTORY

Did patient travel outside county of residence during the incubation period ? <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					

ILL CONTACTS

Any contacts with similar illness (including household contacts)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, specify details below.
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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	

First three letters of patient's last name:

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EPIDEMIOLOGICAL LINKAGE

<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>Contact Name / Case Number</i>
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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**SPOTTED FEVER RICKETTSIOSES (INCLUDING ROCKY MOUNTAIN SPOTTED FEVER) (SFR, INCLUDING RMSF) (2020)****BACKGROUND**

Spotted fever rickettsioses (SFR), which captures cases of Rocky Mountain spotted fever (RMSF), *Rickettsia parkeri* rickettsiosis, Pacific Coast tick fever (caused by infection with *Rickettsia* species 364D), and others, are a group of diseases caused by spotted fever group *Rickettsiae* (SFGR). These pathogens cause acute febrile illnesses, with headache, malaise, thrombocytopenia, rash, and occasionally eschars (dark necrotic scabs at the site of tick or mite bite). RMSF, caused by *R. rickettsii*, is well recognized as the most severe rickettsial illness.

Currently, only 3% of SFR cases are reported as confirmed, with most probable cases supported by a single serology titer. Antibodies to SFGR can rise in the first week of illness and stay elevated for months to years following infection. Data suggest that the prevalence of IgG antibodies reactive to SFGR in asymptomatic individuals may be more common than previously thought. The use of a single elevated IgG titer result for diagnosis may produce a skewed understanding of SFR epidemiology and national disease burden.

CLINICAL CRITERIA

Fever as reported by the patient or a healthcare provider, **AND one** or more of the following: rash, eschar, headache, myalgia, anemia, thrombocytopenia, or any hepatic transaminase elevation.

LABORATORY CRITERIA FOR DIAGNOSIS**Confirmatory laboratory evidence:**

- Detection of SFGR nucleic acid in a clinical specimen via amplification of a *Rickettsia* genus- or species-specific target by Polymerase Chain Reaction (PCR) assay, **OR**
- Serological evidence of a fourfold increase in IgG-specific antibody titer reactive with SFGR antigen by indirect immunofluorescence antibody assays (IFA) between paired serum specimens (one taken in the first two weeks after illness onset and a second taken two to ten weeks after acute specimen collection)*, **OR**
- Demonstration of SFGR antigen in a biopsy or autopsy specimen by immunohistochemical methods (IHC), **OR**
- Isolation of SFGR from a clinical specimen in cell culture and molecular confirmation (e.g., PCR or sequence).

Presumptive laboratory evidence:

- Serologic evidence of elevated IgG antibody at a titer $\geq 1:128$ reactive with SFGR antigen by IFA in a sample taken within 60 days of illness onset.**

Supportive laboratory evidence:

- Serologic evidence of elevated IgG antibody at a titer $< 1:128$ reactive with SFGR antigen by IFA in a sample taken within 60 days of illness onset.

* 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.

** This includes paired serum specimens without evidence of fourfold rise in titer, but with at least one single titer $\geq 1:128$ in IgG-specific antibody titers reactive with SFGR antigen by IFA.

EPIDEMIOLOGIC LINKAGE

None.

Criteria to distinguish a new case of this disease or condition from reports or notifications which should not be enumerated as a new case for surveillance

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.

CASE CLASSIFICATION**Confirmed**

- A clinically compatible case (meets clinical evidence criteria) that is laboratory confirmed.

Probable

- A clinically compatible case (meets clinical criteria) that has presumptive laboratory evidence.

Suspect

- A case with confirmatory or presumptive laboratory evidence of infection with no clinical information available, **OR**
- A clinically compatible case (meets clinical criteria) that has supportive laboratory evidence.

First three letters of
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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	
<ul style="list-style-type: none"> <li style="width: 20%;">• Bangladeshi <li style="width: 20%;">• Filipino <li style="width: 20%;">• Japanese <li style="width: 20%;">• Maldivian <li style="width: 20%;">• Sri Lankan <li style="width: 20%;">• Bhutanese <li style="width: 20%;">• Hmong <li style="width: 20%;">• Korean <li style="width: 20%;">• Nepalese <li style="width: 20%;">• Taiwanese <li style="width: 20%;">• Burmese <li style="width: 20%;">• Indian <li style="width: 20%;">• Laotian <li style="width: 20%;">• Okinawan <li style="width: 20%;">• Thai <li style="width: 20%;">• Cambodian <li style="width: 20%;">• Indonesian <li style="width: 20%;">• Madagascar <li style="width: 20%;">• Pakistani <li style="width: 20%;">• Vietnamese <li style="width: 20%;">• Chinese <li style="width: 20%;">• Iwo Jiman <li style="width: 20%;">• Malaysian <li style="width: 20%;">• Singaporean 	
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS	
<ul style="list-style-type: none"> <li style="width: 20%;">• Carolinian <li style="width: 20%;">• Kiribati <li style="width: 20%;">• Micronesian <li style="width: 20%;">• Pohnpeian <li style="width: 20%;">• Tahitian <li style="width: 20%;">• Chamorro <li style="width: 20%;">• Kosraean <li style="width: 20%;">• Native Hawaiian <li style="width: 20%;">• Polynesian <li style="width: 20%;">• Tokelauan <li style="width: 20%;">• Chuukese <li style="width: 20%;">• Mariana Islander <li style="width: 20%;">• New Hebrides <li style="width: 20%;">• Saipanese <li style="width: 20%;">• Tongan <li style="width: 20%;">• Fijian <li style="width: 20%;">• Marshallese <li style="width: 20%;">• Palauan <li style="width: 20%;">• Samoan <li style="width: 20%;">• Yapese <li style="width: 20%;">• Guamanian <li style="width: 20%;">• Melanesian <li style="width: 20%;">• Papua New Guinean <li style="width: 20%;">• Solomon Islander 	

First three letters of patient's last name:

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OCCUPATION SETTING

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

- | | |
|--|--|
| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |
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