Brucellosis Case Report Form General Instructions

Please complete as much of the form as possible. The instructions below explain each variable.
If you have questions, please contact Bacterial Special Pathogens Branch at (404) 639-1711 or bspb@cdc.gov.

Send the completed form with all personal identifiers removed to CDC either by:

Email: bspb@cdc.gov

Fax: (404) 929-1590

DCIPHER: contact bspb@cdc.gov for more information

NOTE: All Sections: record date as MM/DD/YYYY

Reporting Information	Description
Date of Notification	Date case was first reported to jurisdiction.
Reporting Jurisdiction	State, territory, or jurisdiction reporting to CDC.
State Case ID	Unique identifier given by the state health department.
NNDSS Case ID	If different from State Case ID, provide the Case Identifier transmitted in NNDSS.
Reporter Name, Phone number, and Email	Contact information for person reporting the case to CDC.

Demographic Information	Description
Sex	Genetic sex of patient.
Pregnant	Pregnancy status at onset of current illness.
Date of Birth	Patient's date of birth, if known.
Age	Age of patient at time of diagnosis.
Residence	State, territory, county and zip code of residence.
Country of Birth	Indicate country of birth, if not U.S. If unknown, please enter "Unknown."
Occupation	List the patient's current occupation.
Race and Ethnicity	Race and ethnicity of patient as noted in the chart or reported by physician or infection control personnel (ICP). Multiple boxes may be checked. Do not make assumptions based on name or native language. If race or ethnicity is unknown, please check "Unknown."

Clinical Information	Description
Illness onset	Date of the beginning of this illness or date of the onset of symptoms of this illness as reported to the public health system.
Clinical Manifestations	Select patient-described symptoms or clinician-identified conditions associated with illness.

Treatment and Outcome	Description
Antibiotics	Indicate if the patient received antibiotics for this illness.
Treatment	Select all antibiotics the patient was prescribed, list the start date for each and the number of days the antibiotic was taken by the patient. If prescribed antibiotic is not listed, list the name of the medication, and start date.
Treatment Completion	Indicate if the patient completed prescribed antibiotic treatment for this illness.
Hospitalization	Indicate whether the patient was admitted to a hospital for this illness. Enter admission and discharge dates, if applicable.
Death	Indicate if the patient died from this illness. If yes, list the date of death.

Risk Factors	Description
Travel	Select whether the patient traveled out of state or country in the 6 months prior to illness onset, and where and when if applicable.
Animal Contact	Indicate if the patient had animal contact in the 6 months prior to illness onset. If yes, select the type of animals, type of contact, type of animal ownership and location of exposure.
Dairy and Meat Products	Indicate if the patient consumed unpasteurized dairy products or undercooked meats in the 6 months prior to illness onset. If yes, select the food product consumed, type of animal the food came from and the country the food was produced.
Epi-Linked	Select if the patient is linked to a confirmed case. If yes, select the relationship to the patient.
Similar Illness	Select if the patient is aware of a contact having a similar illness. If yes, select the relationship to the patient.
Risk Status	If the patient had a known exposure to *Brucella*, indicate the location of exposure. Also indicate the assessed risk status of the exposure. Finally, if exposed to a *Brucella* vaccine, indicate to which vaccine the case was exposed.
Post-Exposure Prophylaxis	If the patient was exposed to *Brucella*, indicate if the patient received PEP, reasons for not taking PEP and medication taken.
Completed PEP	If exposed, indicate if the patient completed the entire course of PEP as prescribed.
Case Classification	Indicate the patient's case classification based on the brucellosis case definition. Confirmed and Probable brucellosis cases must be reported to CDC following the notification criteria outlined in the CSTE position statement (24-ID-03).

Test & Specimen Information *(Please complete a new test section for each laboratory test performed)*	Description
Test Type	Indicate the laboratory test performed.
Performing Laboratory	Indicate the laboratory that performed the test.
Specimen Type	Identify the type of specimen collected for testing, and date specimen collected.
Specimen Collection Date	Indicate the date the specimen was collected (mm/dd/yyyy).
Result	Indicate any quantitative, qualitative or other results acquired from the test above. If determined by the test, report what organism was identified in the sample and the date of the result.
Specimen Culture	Indicate if the specimen for culture was collected prior to administration of antibiotic therapy.
Specimens to CDC	Indicate if the specimen was sent to CDC for testing.
Laboratory Exposures	Select if laboratory workers were possibly exposed during specimen processing. The CDC exposure guidelines are available at https://www.cdc.gov/brucellosis/media/pdfs/brucellosis-risk-assessment-chart.pdf?CDC_AAref_Val=https://www.cdc.gov/brucellosis/laboratories/risk-level.html. If a laboratory exposure did occur, review these assessment, monitoring, and prophylaxis recommendations. For assistance, please contact the Bacterial Special Pathogens Branch (404-639-1711, bspb@cdc.gov).

BRUCELLOSIS CASE REPORTING FORM

NOTE: Enter all dates as MM/DD/YYYY

Form Version Sept 2024

REPORTING INFORMATION

Date of Notification: _____ Reporting Jurisdiction: _____ State Case ID: _____

NNDSS Case ID: _____ Reporter Name: _____ Reporter Phone Number: _____

Reporter Email: _____

DEMOGRAPHIC INFORMATION

Sex: ○ Male ○ Female ○ Refused ○ Unknown DOB: _____ Age: _____ ○ Years ○ Months ○ Days

Pregnant: ○ Yes ○ No ○ Unknown RESIDENCE: State: _____ County: _____ Zip Code: _____

Country of Birth: _____ Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown

Race:

☐ American Indian/Alaskan Native
☐ Asian
☐ White
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Unknown
☐ Other: _____

Occupation: _____ Other: _____

CLINICAL INFORMATION

Date of illness onset: _____

Select all clinical manifestations associated with this illness *(select all that apply)*:

☐ Fever
☐ Arthralgia
☐ Fatigue
☐ Myalgia
☐ Endocarditis
☐ Epididymitis
☐ Splenomegaly
☐ Meningitis
☐ Night sweats
☐ Headaches
☐ Anorexia
☐ Weight loss
☐ Orchitis/epididymitis
☐ Hepatomegaly
☐ Arthritis
☐ Spondylitis
☐ Encephalitis
☐ Discitis
☐ Osteomyelitis
☐ Other, specify: _____

TREATMENT AND OUTCOME

Did the patient receive antibiotics for this illness? ○ Yes ○ No ○ Unknown

Select all medications the patient received for treatment

☐ Doxycycline Start Date: _____ Days: ____
☐ Rifampin Start Date: _____ Days: ____
☐ Streptomycin Start Date: _____ Days: ____
☐ Other: _____ Start Date: _____ Days: ____
☐ Other: _____ Start Date: _____ Days: ____
☐ Unknown

Did the patient complete the course of antibiotics received?

○ Yes
○ Medication not started
○ Medication partially completed
○ Unknown

Was the patient hospitalized for this illness?

○ Yes
○ No
○ Unknown

If yes, admission date: _____

Discharge date: _____

Did the patient die from this illness?

○ Yes
○ No
○ Unknown

If yes, date of death: _____

RISK FACTORS

Did the patient travel in the 6 months prior to illness onset? ○ Yes ○ No ○ Unknown

If Yes,

U.S. State: _____ or Country: _____ Dates of Travel: _____ to _____

U.S. State: _____ or Country: _____ Dates of Travel: _____ to _____

U.S. State: _____ or Country: _____ Dates of Travel: _____ to _____

In the 6 months prior to illness onset, did the patient have contact with any animals or their body fluids? ○ Yes ○ No ○ Unknown

Indicate type of animals and animal contact that patient had in the 6 months prior to illness onset.

Contact Type	Cattle	Deer	Dog	Goat	Pig	Sheep	Other Animal, Specify: _____	Unknown Animal
Birthing Products	☐	☐	☐	☐	☐	☐	☐	☐
Skinning/Slaughter	☐	☐	☐	☐	☐	☐	☐	☐
Hunting	☐	☐	☐	☐	☐	☐	☐	☐
Other, Specify: _____	☐	☐	☐	☐	☐	☐	☐	☐

Animal Ownership

Ownership	Cattle	Deer	Dog	Goat	Pig	Sheep	Other Animal, Specify: _____	Unknown Animal
Domestic/Commercial	☐	☐	☐	☐	☐	☐	☐	☐
Wild	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐

Location of Exposure

Location	Cattle	Deer	Dog	Goat	Pig	Sheep	Other Animal, Specify: _____	Unknown Animal
Domestic (U.S.)	☐	☐	☐	☐	☐	☐	☐	☐
International	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐

In the 6 months prior to illness onset, did the patient consume unpasteurized dairy products or undercooked meat?

○ Yes ○ No ○ Unknown

Indicate type of unpasteurized dairy or undercooked meat the patient consumed

Food product consumed	Cattle	Goat	Sheep	Other Animal, Specify: _____	Unknown Animal	In what Country was product produced?
Milk	☐	☐	☐	☐	☐	
Fresh/soft cheese	☐	☐	☐	☐	☐	
Undercooked meat	☐	☐	☐	☐	☐	
Unknown	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	

Is the case epi-linked to a laboratory-confirmed case? ○ Yes ○ No ○ Unknown

How is the patient related to the other case?

☐ Coworker ☐ Neighbor ☐ Unknown Specify other: _____

☐ Household ☐ Other

Does the patient know of a contact with a similar illness? ○ Yes ○ No ○ Unknown

How is the patient related to the contact with similar illness?
☐ Coworker ☐ Neighbor ☐ Unknown
☐ Household ☐ Other
Specify other: _____

Did the patient have a known exposure to *Brucella*?
○ Body Fluids or Tissue ○ Isolate ○ No
○ Clinical specimen ○ Vaccine ○ Unknown

If exposed to *Brucella* animal vaccine, indicate which one.
○ S19 ○ REV1 ○ Unknown
○ RB51 ○ Other vaccine type

Where did the known exposure occur?
○ Clinical setting ○ Laboratory ○ Unknown ○ Other: _____
○ Farm/Ranch ○ Surgery

Was the exposure classified as high or low risk? ○ High ○ Low ○ Unknown

Did the patient receive post-exposure prophylaxis? ○ Yes ○ No ○ Unknown
If yes, specify name of medications:

_____

If the patient did not receive PEP, why?
○ Unaware of exposure ○ Allergic ○ Unknown ○ Other: _____
○ Unavailable ○ Pregnant

Case Status: ○ Confirmed ○ Probable ○ Suspect ○ Not a Case ○ Unknown

Please list any additional exposure information not captured above:

TEST AND SPECIMEN INFORMATION– *Please complete a new section for each test performed*

1st Test & Specimen

Test Type 1:
○ Total Antibody (agglutination) ○ IgM ELISA or EIA ○ Other: _____
○ IgG (agglutination) ○ PCR ○ Unknown
○ IgG ELISA or EIA ○ Culture

Performing Lab:
○ CDC ○ State Public Health Laboratory ○ Unknown
○ Commercial Laboratory ○ Other ○ Other LRN

Specimen Type:
○ Whole Blood ○ Serum ○ Other
○ Cerebrospinal Fluid ○ Isolate ○ Unknown
Specify other: _____
Date of collection: _____

Qualitative Result:
○ Positive ○ Negative ○ Borderline ○ Indeterminate

Quantitative Results
Acute titers: _____ : _____ _____ : _____
Convalescent titer: _____ : _____ _____ : _____
○ Other: _____ ○ Unknown
Cut off value: _____

Organism Name:
○ *B. abortus* ○ *B. suis* ○ Other: _____
○ *B. melitensis* ○ *Brucella spp.* ○ Unknown

Lab Result Date: _____

Was the specimen for culture collected prior to antimicrobial therapy? ○ Yes ○ No ○ Unknown

Was specimen(s) sent to CDC? ○ Yes ○ No ○ Unknown

Did a possible laboratory exposure occur in the laboratory performing the test? ○ Yes ○ No ○ Unknown

2nd Test & Specimen

Test Type 2:
- ○ Total Antibody (agglutination)
- ○ IgG (agglutination)
- ○ IgG ELISA or EIA
- ○ IgM ELISA or EIA
- ○ PCR
- ○ Culture
- ○ Other: _____
- ○ Unknown

Performing Lab:
- ○ CDC
- ○ Commercial Laboratory
- ○ State Public Health Laboratory
- ○ Other
- ○ Unknown
- ○ Other LRN

Specimen Type:
- ○ Whole Blood
- ○ Cerebrospinal Fluid
- ○ Serum
- ○ Isolate
- ○ Other
- ○ Unknown

Specify other: _____

Date of collection: _____

Qualitative Result:
- ○ Positive
- ○ Negative
- ○ Borderline
- ○ Indeterminate

Quantitative Results

Acute titers: _____ : _____ ; _____ : _____

Convalescent titer: _____ : _____ ; _____ : _____

○ Other: _____ : _____ ; _____ : _____

○ Unknown

Cut off value: _____

Organism Name:
- ○ *B. abortus*
- ○ *B. melitensis*
- ○ *B. suis*
- ○ *Brucella spp.*
- ○ Other: _____
- ○ Unknown

Lab Result Date: _____

Was the specimen for culture collected prior to antimicrobial therapy? ○ Yes ○ No ○ Unknown

Was specimen(s) sent to CDC? ○ Yes ○ No ○ Unknown

Did a possible laboratory exposure occur in the laboratory performing the test? ○ Yes ○ No ○ Unknown

3rd Test & Specimen

Test Type 3:
- ○ Total Antibody (agglutination)
- ○ IgG (agglutination)
- ○ IgG ELISA or EIA
- ○ IgM ELISA or EIA
- ○ PCR
- ○ Culture
- ○ Other: _____
- ○ Unknown

Performing Lab:
- ○ CDC
- ○ Commercial Laboratory
- ○ State Public Health Laboratory
- ○ Other
- ○ Unknown
- ○ Other LRN

Specimen Type:
- ○ Whole Blood
- ○ Cerebrospinal Fluid
- ○ Serum
- ○ Isolate
- ○ Other
- ○ Unknown

Specify other: _____

Date of collection: _____

Qualitative Result:
- ○ Positive
- ○ Negative
- ○ Borderline
- ○ Indeterminate

Quantitative Results

Acute titers: _____ : _____ ; _____ : _____

Convalescent titer: _____ : _____ ; _____ : _____

○ Other: _____ : _____ ; _____ : _____

○ Unknown

Cut off value: _____

Organism Name:
- ○ *B. abortus*
- ○ *B. melitensis*
- ○ *B. suis*
- ○ *Brucella spp.*
- ○ Other: _____
- ○ Unknown

Lab Result Date: _____

Was the specimen for culture collected prior to antimicrobial therapy? ○ Yes ○ No ○ Unknown

Was specimen(s) sent to CDC? ○ Yes ○ No ○ Unknown

Did a possible laboratory exposure occur in the laboratory performing the test? ○ Yes ○ No ○ Unknown

4th Test & Specimen

Test Type 4:
- ○ Total Antibody (agglutination)
- ○ IgG (agglutination)
- ○ IgG ELISA or EIA
- ○ IgM ELISA or EIA
- ○ PCR
- ○ Culture
- ○ Other: _____
- ○ Unknown

Performing Lab:
- ○ CDC
- ○ Commercial Laboratory
- ○ State Public Health Laboratory
- ○ Other
- ○ Unknown
- ○ Other LRN

Specimen Type:
- ○ Whole Blood
- ○ Cerebrospinal Fluid
- ○ Serum
- ○ Isolate
- ○ Other
- ○ Unknown

Specify other: _____

Date of collection: _____

Qualitative Result:
- ○ Positive
- ○ Negative
- ○ Borderline
- ○ Indeterminate

Quantitative Results

Acute titers	Convalescent titer	Other: _____	○ Unknown
_____ : _____	_____ : _____	_____ : _____	
_____ : _____	_____ : _____	_____ : _____	**Cut off value:** _____

Organism Name:
- ○ *B. abortus*
- ○ *B. melitensis*
- ○ *B. suis*
- ○ *Brucella spp.*
- ○ Other: _____
- ○ Unknown

Lab Result Date: _____

Was the specimen for culture collected prior to antimicrobial therapy?	○ Yes	○ No	○ Unknown
Was specimen(s) sent to CDC?	○ Yes	○ No	○ Unknown
Did a possible laboratory exposure occur in the laboratory performing the test?	○ Yes	○ No	○ Unknown