



# Leptospirosis Case Report Form

Form Approved  
OMB 0920-0728  
Exp. 2/28/2021

**Redact Patient's Name and Address prior to sending a copy of the form to CDC.**

Send completed form by fax to (404) 929-1590, encrypted email to [bspb@cdc.gov](mailto:bspb@cdc.gov), secure FTP, or to CDC / Bacterial Special Pathogens Branch, 1600 Clifton Road NE, MS H24-12 Atlanta, GA 30329-4027. Call (404) 639-1711 or email [bspb@cdc.gov](mailto:bspb@cdc.gov) with questions about a case, lab testing, or form submission.

Patient's Name: \_\_\_\_\_ Date First Submitted: \_\_\_\_\_ Investigators's Name: \_\_\_\_\_

Address: \_\_\_\_\_ State Case ID: \_\_\_\_\_ Investigators's Phone: \_\_\_\_\_

City: \_\_\_\_\_ Reporting State/Territory: \_\_\_\_\_

## Demographics

State/Territory of Residence	Zip Code	County/Municipality	Sex			Pregnant		Birth Date	Age	days months years
			Male	Female	Unknown	Yes	No			
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

**Race** (select all that apply):  
 Alaska Native or American Indian    Black/African American    White  
 Asian    Native Hawaiian or Other Pacific Islander    Unknown

**Ethnicity**  
 Hispanic or Latino    Not Hispanic or Latino    Unknown

## Clinical Presentation

Was the patient symptomatic?    Yes    No    Unknown    If yes, Date of Onset \_\_\_\_\_

Select all clinical manifestations the patient experienced:

Fever	Vomiting/nausea	Skin rash (petechial or maculopapular)	Pulmonary hemorrhage
Headache	Conjunctival suffusion	Cardiac arrhythmia/ECG abnormalities	Other pulmonary complications (e.g.cough, dyspnea)
Myalgia	Jaundice	Acute renal insufficiency or failure	Other hemorrhage (e.g. blood in vomit, stool, or urine; petechiae/ecchymosis)
Calf Pain	Thrombocytopenia	Acutely elevated liver enzymes/liver insufficiency or failure	
Diarrhea	Aseptic meningitis		

Other, specify: \_\_\_\_\_

## Outcome

Was the patient hospitalized?    Yes    No    Unknown    If yes, date admitted \_\_\_\_\_    Number of days hospitalized \_\_\_\_\_

Was antimicrobial treatment given for this infection?    Yes    No    Unknown    If yes, date started \_\_\_\_\_

Which drugs (select all that apply)?    Doxycycline    Penicillin    Ceftriaxone    Ampicillin    Amoxicillin    Other, specify: \_\_\_\_\_

Clinical Outcome:    Still hospitalized    Died    Discharged/Recovered    Other, specify: \_\_\_\_\_

Date of Discharge \_\_\_\_\_    Date of Death \_\_\_\_\_    Illness Duration (days) \_\_\_\_\_

## Laboratory Results

PCR 1	Specimen Type				Collection date	Result			
	Blood	CSF	Urine	Other _____		Positive	Negative	Indeterminate	
PCR 2	Specimen Type				Collection date	Result			
	Blood	CSF	Urine	Other _____		Positive	Negative	Indeterminate	
MAT	Acute serum			Convalescent serum (≥ 2 weeks later)			Met MAT case criteria (check all that apply) 4-fold rise in titer Single titer ≥ 800 Single titer 200–400		
	Collection Date _____			Collection Date _____					
	Highest Titer _____			Highest Titer _____					
Culture	Specimen Type				Collection date	Result			
	Blood	Urine	Tissue _____	Other _____		Positive	Negative		
<i>Leptospira</i> serovar^ _____					^identified by PFGE, MLST, or other molecular typing method of culture isolate				
Other test	ELISA	Immunohistochemistry (IHC)	Lateral flow test	Result					
	Other (Specify): _____				Positive	Negative	Borderline	Indeterminate	
If ELISA, choose type:		IgG	IgM	IgG & IgM	ImmunoDot (IgM)	Not Applicable	Titer* _____ *If applicable		

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329-4027; ATTN: PRA (0920-0728).

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## Exposures in 30 days prior to illness onset, specify if the patient had:

Contact with animals <i>(select all that apply)</i>	Rodents	Dogs	Cows	Sheep/goats	Pigs	Horses	No known contact	Unknown
	Wildlife, specify: _____							
	Other, specify: _____							
	Where did animal contact(s) occur <i>(specify location)</i> ? _____							
Contact with fresh water <i>(select all that apply)</i>	Standing water <i>(e.g. lake, pond)</i>	Running water <i>(e.g. river, stream)</i>	Wet soil/mud	Flood water, rainwater run-off	Sewage			
	No known contact	Unknown	Other, specify: _____					
	Body of water name <i>(if applicable)</i> : _____							
	Where did water contact(s) occur <i>(specify location)</i> ? _____							

## If the patient had contact with animals or water, select the type(s) of contact:

Occupational <i>(select all that apply)</i>	Farmer (crops)	Farmer (animals)	Fisherman	Veterinary services	Pet care (e.g. boarding, grooming)			
	Landscaping/Yardcare	Slaughterhouse Worker	Military/First Responder	Sanitation Worker	Sewer Worker			
Other, Specify: _____								
Recreational/ Avocational <i>(select all that apply)</i>	Swimming	Boating	Outdoor competition	Camping/hiking	Hunting	Fishing		
	Gardening	Pet ownership						
	Other, Specify: _____							
Unknown type of contact								
Other type of contact, specify: _____								

## In the 30 days prior to illness onset:

Did the patient stay in housing with evidence of rodents?    Yes    No    Unknown

Did the patient stay in a rural area?    Yes    No    Unknown

Did the patient travel outside of county/municipality, state, or country?    Yes    No    Unknown    Travel destination(s): \_\_\_\_\_

Was there heavy rainfall near the patient's place of residence, work site, activities, or travel?    Yes    No    Unknown

Was there flooding near the patient's place of residence, work site, activities, or travel?    Yes    No    Unknown

If the patient knows anyone recently diagnosed with leptospirosis, did they have similar exposures in the past 30 days?    Yes    No    Unknown    N/A

Has the patient ever previously been diagnosed with leptospirosis?    Yes    No    Unknown

Is this patient part of an outbreak?    Yes    No    Unknown    If yes, describe outbreak: \_\_\_\_\_

## Classify case based on the CSTE/CDC case definition (see criteria below)

Confirmed    Probable

### Comments

**Confirmed:** Isolation of *Leptospira* from a clinical specimen, OR fourfold or greater increase in *Leptospira* agglutination titer between acute- and convalescent-phase serum specimens studied at the same laboratory, OR demonstration of *Leptospira* in tissue by direct immunofluorescence, OR *Leptospira* agglutination titer of  $\geq 800$  by Microscopic Agglutination Test (MAT) in one or more serum specimens, OR detection of pathogenic *Leptospira* DNA (e.g., by PCR) from a clinical specimen.

**Probable:** A clinically compatible case with involvement in an exposure event (e.g., adventure race, triathlon, flooding) with known associated cases, OR *Leptospira* agglutination titer of  $\geq 200$  but  $< 800$  by Microscopic Agglutination Test (MAT) in one or more serum specimens, OR demonstration of anti-*Leptospira* antibodies in a clinical specimen by indirect immunofluorescence, OR demonstration of *Leptospira* in a clinical specimen by darkfield microscopy, OR detection of IgM antibodies against *Leptospira* in an acute phase serum specimen, but without confirmatory laboratory evidence of *Leptospira* infection.