

# LEPTOSPIROSIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health  
State Form 52346 (8-05)

## DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill in circles like this:  Not like this:   Mark mistakes like this:
- 4 Print capital letters only and numbers completely inside boxes. A 2 C 3
- 5 Please complete all items on form.
- 6 Date format: MM/DD/YY

## Section 1. Demographic Information

ISDH Action:  A case  Not a case

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Number & Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ - \_\_\_\_\_

County \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

Race:  Asian  Black or African American  American Indian or Alaska Native  Native Hawaiian or Other Pacific Islander

Ethnicity:  White  Other/Multiracial  Unknown  Hispanic or Latino  Not Hispanic or Latino  Unknown

Sex:  Male  Female  Unknown

Is Age in day/mo/yr?  Days  Months  Years

Occupation \_\_\_\_\_ Phone of Employer/School/Day Care \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of  Employer  School  Day Care \_\_\_\_\_

Address of Employer/School/Day Care \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

## Section 2. Clinical Information

Symptoms (check all that apply):

- Fever \_\_\_\_\_ (degrees)
- Headache
- Chills
- Muscle Aches
- Malaise
- Abdominal Pain
- Nausea
- Vomiting
- Ocular Pain
- Diarrhea
- Cough
- Delirium
- Confusion
- Joint Pain
- Other, specify: \_\_\_\_\_

Date of Onset \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Duration of Symptoms in Days \_\_\_\_\_

Date First Positive Specimen Collected \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Clinical Findings (check all that apply):

- Diphasic Fever
- Hematuria
- Conjunctival Suffusion
- Elevated CSF Protein
- Elevated CSF Cell Count
- Rash (physician observed)  
Distribution: \_\_\_\_\_
- Type of rash: \_\_\_\_\_
- Splenomegaly
- Lymphadenopathy
- Pharyngitis
- Hepatomegaly
- Nuchal Rigidity
- Jaundice
- Meningitis
- Kidney (renal) Abnormality or Failure

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Section 2. Clinical Information (continued)

Diagnostic Testing

Culture:

- Positive
- Negative
- Not Done

PCR:

- Positive
- Negative
- Not Done

Darkfield Microscopy:

- Positive
- Negative
- Not Done

Microscopic Agglutination:

- Positive
- Titer
- Negative
- Not Done

Source of culture

Serological Testing

1. IgM Testing

Acute Specimen Taken Acute Value

Convalescent Specimen Taken Convalescent Value

Results:

- Significant Rise in IgM
- No Significant Rise in IgM
- Indeterminate
- Pending
- Not Done
- Unknown

2. IgG Testing

Acute Specimen Taken Acute Value

Convalescent Specimen Taken Convalescent Value

Results:

- Significant Rise in IgG
- No Significant Rise in IgG
- Indeterminate
- Pending
- Not Done
- Unknown

Other Lab Test

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City State ZIP Code

Physician/Hospital Phone

Was the patient treated with antibiotics for this illness?

- Yes
- No

If Yes, antibiotic:

Start date:

Was the patient hospitalized?

- Yes
- No

If Yes, admission date:

Hospital:

Discharge date:

Did patient die?

- Yes
- No

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Section 3. Risk Factors

Patient's home setting:

- Urban  Suburban  Rural

During the three weeks prior to onset of symptoms, did the patient:

Have exposure to animals either recreationally or occupationally?

- Yes  No  Unknown

If Yes, which animals?

- Dogs/Puppies  Cattle  Swine  Horses  Rats/Mice  Other Wild Animals

\_\_\_\_\_

If Other, describe

Engage in any outdoor activities?

- Yes  No  Unknown

If Yes, which activities?

- Camping  Hiking  Fishing  Picnicking  Swimming  Other

\_\_\_\_\_

If Other, specify

Recreational exposure to surface water (e.g., lakes, rivers, marshes, etc.)?

- Yes  No  Unknown

\_\_\_\_\_

If Yes, where

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

Exposure to flood water, wet soil, vegetation?

- Yes  No  Unknown

\_\_\_\_\_

If Yes, where

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

Travel outside of Indiana?

- Yes  No  Unknown

\_\_\_\_\_

If Yes, where

\_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of departure

Date of return

