



Department of Health and Human Services  
Centers for Disease Control and Prevention  
Atlanta, GA 30333

# Leptospirosis Case Report Form

Form Approved  
OMB 0920-0728  
Exp. 1/31/2017

Visit [www.cdc.gov/leptospirosis](http://www.cdc.gov/leptospirosis) for a fillable PDF version of this Case Report

Patient's Name	<input type="text"/>	Date First Submitted	<input type="text"/>	Clinician's Name	<input type="text"/>
Address	<input type="text"/>	State Case ID	<input type="text"/>	Clinician's Phone	<input type="text"/>
City	<input type="text"/>	Reporting State	<input type="text"/>		

## Demographics

State of Residence	Zip Code	County of Usual Residence	Sex	Pregnant	Birth Date	Age	<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Race	<input type="checkbox"/> Alaska Native or American Indian <input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Not Specified	Ethnicity	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		

## Clinical Presentation

Was the patient symptomatic?  If yes, Date of Onset

Select all clinical manifestations the patient experienced:

<input type="checkbox"/> Fever	<input type="checkbox"/> Conjunctival suffusion	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Pulmonary complications	<input type="checkbox"/> Gastrointestinal involvement
<input type="checkbox"/> Myalgia	<input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Cardiac involvement	<input type="checkbox"/> Rash (petechial or maculopapular)
<input type="checkbox"/> Headache	<input type="checkbox"/> Aseptic meningitis	<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> Renal insufficiency/failure	
<input type="checkbox"/> Other, specify: <input type="text"/>				

## Outcome

Was the patient hospitalized?  If yes, date admitted  Number of days hospitalized

Was antimicrobial treatment given for this infection?  If yes, date started

Which drugs (select all that apply)?  Doxycycline  Penicillin  Other, specify:

Clinical Outcome  Date of Discharge  Date of Death  Illness Duration (days)

## Laboratory Results

Culture	Specimen Type	<input type="text"/>	Collection date	<input type="text"/>	Result	<input type="text"/>
PCR	Specimen Type	<input type="text"/>	Collection date	<input type="text"/>	Result	<input type="text"/>
MAT	Acute (highest titer)	Convalescent (≥ 2 weeks later, highest titer)		<input type="checkbox"/> 4-fold rise in titer <input type="checkbox"/> Single titer ≥ 800		
(≥7 days)	Date	<input type="text"/>	Titer	<input type="text"/>	Date	<input type="text"/>
Other test	<input type="text"/>	<input type="text"/>	Choose ELISA	<input type="text"/>	Titer*	<input type="text"/>
Other test	<input type="text"/>	<input type="text"/>	Choose ELISA	<input type="text"/>	Titer*	<input type="text"/>
*if applicable						
Leptospira serovar <sup>^</sup>	<input type="text"/>		<sup>^</sup> identified by PFGE, MLST, or other molecular typing method			

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 30333; ATTN: PRA (0920-0728).

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

Contact with animals (select all that apply)  Farm livestock  Wildlife  Rodents  Dogs  Other  No known contact  Unknown  
Specify animal:   
Where did animal contact(s) occur (eg, at home)?

Contact with water (select all that apply)  Standing fresh water (eg, lake, pond)  River/stream  Wet soil  Flood water, run-off  Sewage  Other  No known contact  Unknown  
Specify water:   
Where did water contact(s) occur (specify location)?

**If the patient had contact with animals or water, select the type of contact:**

Occupational  Farmer (Land)  Farmer (Animals)  Fish worker  Unknown  
 Other If Other, Specify:

Avocational  Gardening  Pet Ownership  Unknown  
 Other If Other, Specify:

Recreational  Swimming  Boating  Outdoor competition  Camping/hiking  Hunting  Unknown  
 Other If Other, Specify:

Other (Specify):

**In the 30 days prior to illness onset,**

Did the patient stay in housing with evidence of rodents?  Did the patient stay in a rural area?   
Did the patient travel outside of county, state, or country?  Travel destination(s)   
Was there heavy rainfall near the patient's place of residence, work site, activities, or travel?   
Was there flooding near the patient's place of residence, work site, activities, or travel?   
Did the patient have similar exposures as a contact diagnosed with leptospirosis in the 30 day period?

Has the patient ever had leptospirosis?   
Is this patient part of an outbreak?  If yes, describe outbreak

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

Confirmed  Probable

Investigator Name  Phone Number

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.

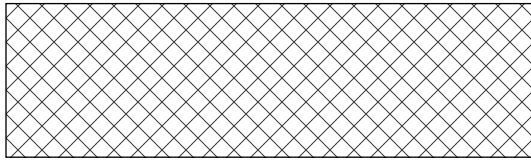


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Date First Submitted  Clinician's Name   
 State Case ID  Clinician's Phone   
 Reporting State  CDC ID   
CDC use only

## Demographics

State of Residence  Zip Code  County of Usual Residence  Sex  Pregnant  Birth Date  Age   days  
 months  
 years

Race  Alaska Native or American Indian  Black/African American  White  Hispanic or Latino  
 Asian  Native Hawaiian or Other Pacific Islander  Not Specified Ethnicity  Not Hispanic or Latino  
 Unknown

## Clinical Presentation

Was the patient symptomatic?  If yes, Date of Onset

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Fever  Conjunctival suffusion  Jaundice  Pulmonary complications  Gastrointestinal involvement  
 Myalgia  Thrombocytopenia  Hepatitis  Cardiac involvement  Rash (petechial or maculopapular)  
 Headache  Aseptic meningitis  Hemorrhage  Renal insufficiency/failure  
 Other, specify:

## Outcome

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Which drugs (select all that apply)?  Doxycycline  Penicillin  Other, specify:

Clinical Outcome  Date of Discharge  Date of Death  Illness Duration (days)

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Culture Specimen Type  Collection date  Result

PCR Specimen Type  Collection date  Result

MAT Acute (highest titer) Convalescent (≥ 2 weeks later, highest titer)  
 (≥7 days) Date  Titer  Date  Titer   4-fold rise in titer  
 Single titer ≥ 800

Other test   Choose ELISA  Titer\*  Result

Other test   Choose ELISA  Titer\*  Result

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*Leptospira* serovar<sup>^</sup>  <sup>^</sup>identified by PFGE, MLST, or other molecular typing method

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Has the patient ever had leptospirosis?

Is this patient part of an outbreak?  If yes, describe outbreak

### Classify case based on the CSTE/CDC case definition (see criteria-page 2)

Confirmed  Probable

Investigator Name  Phone Number

Comments

Send completed pages 3-4 to: CDC/ Bacterial Special Pathogens Branch, 1600 Clifton Road NE, MS-A30, Atlanta, GA 30333, by fax to (404) 929-1590, or by encrypted e-mail to [bspb@cdc.gov](mailto:bspb@cdc.gov).  
Call (404) 639-1711 or e-mail [bspb@cdc.gov](mailto:bspb@cdc.gov) with questions about a case, lab testing, or the form.