LEPTOSPIROSIS CASE REPORT FORM
Florida Division of Public Health

Merlin Number:

Date of Interview: _____/_____/_____

A. Demographic Information

Name:	DOB: ____/____/____ Age:
Address:	Sex: □ Male □ Female
City/State/Zip:	Occupation:
County:	Home Phone: Other Phone:

Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Multiracial
□ Native Hawaiian/Pacific Islander □ White/Caucasian □ Other (please specify): □ Unknown

Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

B. Clinical Information

Name of Physician: _____ Physician Phone: _____
Address: _____ City/State/Zip: _____

Have you experienced any of the following symptoms?

Fever	□ Y □ N	Abdominal Pain	□ Y □ N	Headache	□ Y □ N	Icterus	□ Y □ N
Chills/Shakes	□ Y □ N	Vomiting	□ Y □ N	Meningitis	□ Y □ N	Rash	□ Y □ N
Joint Aches	□ Y □ N	Diarrhea	□ Y □ N	Conjunctivitis	□ Y □ N	Hemorrhage	□ Y □ N
Muscle Aches	□ Y □ N	Discolored Urine	□ Y □ N	Hepatitis	□ Y □ N		

Other symptoms _____ Number of stools in the past 24 hours ____

What was the first symptom(s)? _____ Date of Onset: _____/_____/_____
Duration of symptoms? _____ □ Days □ Weeks □ Months

Did you receive any treatment? □ Y □ N Date of Diagnosis: _____/_____/_____
Treatment (specify products, dosage, and duration): _____
Dates of treatment: _____/_____/_____ to _____/_____/_____

Were you hospitalized? □ Y □ N Name of Hospital/Facility: _____
Dates of hospitalization: _____/_____/_____ to _____/_____/_____

Outcome: □ Recovered □ Died □ Unknown Date of Death (if patient died): _____/_____/_____

C. Diagnostic Criteria

Fits clinical description: □ Y □ N □ Unknown

Test/Specimen Type	Date Specimen Collected	Results	Name of Laboratory
PCR □ Blood □ Urine □ Other _____	_____/_____/_____		
Culture □ Blood □ Urine □ Other _____	_____/_____/_____		
Acute-phase serum Convalescent-phase serum	_____/_____/_____ _____/_____/_____	Fourfold increase □ Y □ N	
ELISA (IgM)	_____/_____/_____		
LEPTO Dipstick (IgM)	_____/_____/_____		

D. Exposure Information

Did you travel out of the state or country in the 20 days prior to onset of symptoms? □ Y □ N
If yes, where? _____

Did you participate in any of the following activities in the 20 days prior to onset of symptoms?

Wading or swimming in natural waters □ Y □ N
If yes, where? _____

Boating/Kayaking/Rafting □ Y □ N
If yes, where? _____

Camping/Hiking □ Y □ N
If yes, where? _____

Outdoor race or competition □ Y □ N
If yes, where? _____

Did you have contact with the following animals or their wastes in the 20 days prior to onset of symptoms?

Livestock □ Y □ N
If yes, specify species: _____ Location of livestock: _____

Rodents □ Y □ N
If yes, what type of exposure (e.g., pet store, personal pet, infestation)? _____

Dogs □ Y □ N
If yes, what type of exposure (e.g., pet store, personal pet, infestation)? _____

Cats □ Y □ N
If yes, what type of exposure (e.g., pet store, personal pet, infestation)? _____

Wildlife □ Y □ N
If yes, specify species: _____

If exposure to livestock or pets, were animals seen by a veterinarian? □ Y □ N
Name: _____ Phone number: _____

E. Additional Information

Submitted by:	Title:	Agency:
Phone:	Fax:	Date: _____/_____/_____

(Leave this section blank for state health department use)
Reviewed by epidemiologist: □ Y □ N Name: Date of review: _____/_____/_____