For Use by DSHS Central Office Only

Approved By: _____ **Date:** _____

MMWR Year: _____

TEXAS Health and Human Services | Texas Department of State Health Services

Brucellosis Case Investigation

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

☐ Confirmed ☐ Probable ☐ Not a Case

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female ☐ Unknown

Street Address: _____ City, State, Zip: _____

Patient Phone: _____ County of Residence: _____

Race: ☐ Asian ☐ American Indian/Alaskan Native

☐ Black or African American ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Clinical Information

Physician: _____ Address: _____

City, State, Zip: _____ Phone: _____ Fax: _____

Was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, provide name and location of hospital: _____

Dates of hospitalization: Admission ____/____/_____ Discharge ____/____/_____

Date of illness onset: ____/____/_____

Was the patient pregnant during illness? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Is the patient deceased? ☐ Yes ☐ No ☐ Unknown

If yes, provide date of death: _____ *(submit documentation)*

Clinical Evidence

Fever	☐ Yes	☐ No	☐ Unknown	Endocarditis	☐ Yes	☐ No	☐ Unknown
Night sweats	☐ Yes	☐ No	☐ Unknown	Orchitis	☐ Yes	☐ No	☐ Unknown
Arthralgia	☐ Yes	☐ No	☐ Unknown	Epididymitis	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown	Hepatomegaly	☐ Yes	☐ No	☐ Unknown
Fatigue	☐ Yes	☐ No	☐ Unknown	Splenomegaly	☐ Yes	☐ No	☐ Unknown
Anorexia	☐ Yes	☐ No	☐ Unknown	Arthritis	☐ Yes	☐ No	☐ Unknown
Myalgia	☐ Yes	☐ No	☐ Unknown	Meningitis	☐ Yes	☐ No	☐ Unknown
Weight loss	☐ Yes	☐ No	☐ Unknown	Spondylitis	☐ Yes	☐ No	☐ Unknown

Other pertinent clinical history:

NBS Patient ID:_____ Patient Name: _____

Laboratory Findings

If culture-positive, did any possible laboratory exposures occur? ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, use the Brucellosis Laboratory Exposure Questionnaire on the DSHS Website to assess risk and make recommendations for testing and PEP.

Serologic Tests	**Date Collected**	**Titer/Value**	**Interpretation**
Agglutination Test (Acute)			☐ Positive ☐ Negative ☐ Not Done
Agglutination Test (Convalescent)			☐ Positive ☐ Negative ☐ Not Done
Other			

Other Tests	**Species Identified**	**Date Collected**	**Source**	**Interpretation**
PCR				☐ Positive ☐ Negative ☐ Not Done
Culture				☐ Positive ☐ Negative ☐ Not Done

Risk Factors

In the last 10 years, did the case:

Live or travel in another region of the United States? ☐ Yes ☐ No ☐ Unknown

If yes, where: _____ Year: _____

Live or travel outside of the United States? ☐ Yes ☐ No ☐ Unknown

If yes, where: _____ Year: _____

Have contact with animals (e.g., dogs, cows, goats, pigs, etc.)? ☐ Yes ☐ No ☐ Unknown

Animal Type	**Year**	**Location**	**Description**

Hunt and/or field dress an animal in the United States or abroad? ☐ Yes ☐ No ☐ Unknown

Animal Type	**Year**	**Location**	**Was PPE used? (Y/N)**	**Additional Details**

Consume unpasteurized dairy products or undercooked meat? ☐ Yes ☐ No ☐ Unknown

Product Description	**Year**	**Where Purchased**	**Additional Details**

NBS Patient ID:_____ Patient Name: _____

Risk Factors (continued)

Have contacts with similar symptoms or were diagnosed with brucellosis? ☐ Yes ☐ No ☐ Unknown

If yes, provide details: _____

Have an occupational exposure (e.g., laboratorian, veterinarian, abattoir worker)? ☐ Yes ☐ No ☐ Unknown

If yes, describe the exposure _____

Was post-exposure prophylaxis administered? ☐ Yes ☐ No ☐ Unknown

In the **30 days** prior to illness onset, did the patient donate blood products, organs, or tissues? ☐ Yes ☐ No ☐ Unknown

Type of Donation	Date(s)	Location	Additional Details

Treatment

Did the patient receive antibiotic treatment? ☐ Yes ☐ No ☐ Unknown

If yes, select all that apply:

☐ Doxycycline ☐ Streptomycin

☐ Rifampin ☐ Unknown

☐ Other (specify): _____

Combined duration of antibiotics for this illness: ☐ <1 month ☐ 1-3 months ☐ >3 months ☐ unknown

Comments or Other Pertinent Epidemiological Data (*Use separate page if necessary)*

Notes

Date First Reported: ____/____/_____ Investigation: Started ____/____/_____ Completed ____/____/_____

Reporting Facility: _____

Name of Investigator: _____ (Please print clearly)

Agency: _____ (Please do not abbreviate)

Phone: _____ E-Mail: _____