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

Tick-borne Relapsing Fever Case Investigation

NBS Patient ID: _____ **PLEASE PRINT LEGIBLY**

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 Symptom Onset: ____/____/_____

Is there a more likely clinical explanation for this patient's symptoms? ☐ Yes ☐ No ☐ Unknown

If yes, provide explanation: _____

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

If yes, provide week of pregnancy at onset: _____ Outcome of pregnancy? _____

Is the patient deceased? ☐ Yes ☐ No ☐ Unknown

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

Clinical Evidence (check all that apply)

Case definition clinical evidence

Fever (if yes, **circle type** below) ☐ Yes ☐ No ☐ Unknown

Measured OR **Subjective**

Date of 1st fever _____
Days duration _____
Highest temp _____
Number of relapses _____

Headache ☐ Yes ☐ No ☐ Unknown
Myalgia ☐ Yes ☐ No ☐ Unknown
Nausea/Vomiting ☐ Yes ☐ No ☐ Unknown
Arthralgia ☐ Yes ☐ No ☐ Unknown

Other signs and symptoms

☐ Abdominal pain
☐ Dry cough
☐ Eye pain
☐ Diarrhea
☐ Photophobia
☐ Neck pain
☐ Confusion
☐ Rash
☐ Jaundice
☐ Hepatomegaly
☐ Splenomegaly
☐ Bell's palsy
☐ Other:

Treatment

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

If yes, indicate state date and antibiotics used for this illness (check all that apply):

Start Date: ____/____/_____

☐ Doxycycline ☐ Ceftriaxone ☐ Erythromycin ☐ Other: _____ ☐ Unknown

Combined duration of antibiotics for this illness: ☐ <10 days ☐ 10-14 days ☐ ≥15 days ☐ Unknown

Did patient respond to treatment? ☐ Yes ☐ No ☐ Unknown

Laboratory Findings

Confirmatory laboratory evidence:
Isolation of *Borrelia hermsii, B. parkerii,* or *B. turicatae* from blood
☐ Positive ☐ Negative ☐ Not Done Date of specimen collection: _____/_____/_____

B. hermsii, B. parkerii, or *B. turicatae* detection through nucleic acid testing, such as PCR, which differentiates soft-tick relapsing fever *Borrelia* spp. from other relapsing fever *Borrelia* spp.
☐ Positive ☐ Negative ☐ Not Done Date of specimen collection: _____/_____/_____

Presumptive laboratory evidence:
Identification of *Borrelia* spirochetes in peripheral blood, bone marrow, or cerebral spinal fluid (CSF)
☐ Positive ☐ Negative ☐ Not Done Date of specimen collection: _____/_____/_____

Serologic evidence of *B. hermsii*, *B. parkeri*, or *B. turicatae* infection by equivocal or positive EIA and positive Western blot
☐ Positive ☐ Negative ☐ Not Done Date of specimen collection: _____/_____/_____

Relapsing fever *Borrelia* detection through nucleic acid testing, such as PCR, which does not differentiate soft-tick relapsing fever *Borrelia* spp. from other relapsing fever *Borrelia* spp.
☐ Positive ☐ Negative ☐ Not Done Date of specimen collection: _____/_____/_____

Epidemiology

During the 3 weeks prior to symptom onset:

Did the patient report cave exploration (i.e. caving or spelunking)? ☐ Yes ☐ No ☐ Unknown
If yes, identify and describe geographic location of the cave(s):

Did the patient report tick bites? ☐ Yes ☐ No ☐ Unknown
If yes, identify and describe geographic location of exposure:

Did the patient spend time in or around a rodent infested dwelling? ☐ Yes ☐ No ☐ Unknown
If yes, identify and describe geographic location of dwelling:

Did patient travel outside their county of residence? ☐ Yes ☐ No ☐ Unknown
If yes, provide travel dates and locations in the table below.

Does the patient know other individuals with the same exposure? ☐ Yes ☐ No ☐ Unknown
If yes, provide name and phone number of contact(s) and whether they are experiencing a similar illness:
Name:_____ Phone:_____ Illness? ☐ Yes ☐ No ☐ Unknown
Name:_____ Phone:_____ Illness? ☐ Yes ☐ No ☐ Unknown

Travel Dates and Locations Prior to Illness Onset

Dates	Area/Street Address	City	State	Country
___/___/____ to ___/___/____				
___/___/____ to ___/___/____				
___/___/____ to ___/___/____				

Comments or Other Pertinent Epidemiological Data:

Date First Reported: ____/_____/_____ Investigation: Started _____/_____/_____ Completed _____/_____/_____
Reporting Facility: _____
Name of Investigator: _____ (Please print clearly)
Agency: _____ (Please do not abbreviate)
Phone: _____ E-Mail: _____