BURKHOLDERIA SPP. INFECTION CASE INVESTIGATION FORM

Instructions

Please complete as much of the form as possible. The instructions below explain each variable.
If you have questions, please contact Bacterial Special Pathogens Branch at (404) 639-1711 or bspb@cdc.gov.

Send the completed form with all personal identifiers removed to CDC either by:

Email: bspb@cdc.gov

Fax: (404) 929-1590

DCIPHER: contact bspb@cdc.gov for more information

Reporting Information	Details
Date Reported	Date case was first reported to jurisdiction (mm/dd/yyyy).
Reporting Jurisdiction	State, territory, or jurisdiction reporting case to CDC.
State Case ID	Unique identifier given by the state health department.
Reporter Name, Phone Number, and Email	Contact information for person reporting case to CDC.
Clinician Name and Phone Number	Primary health care provider name and phone number.
Patient Status	Recurrent melioidosis is defined as a re-presentation with *B. pseudomallei* culture-positive clinical disease occurring <18 months following initial diagnosis and after the time designated for treatment completion (both intravenous and oral phases) for the previous episode, irrespective of whether the patient was adherent to the therapy or initially lost to follow-up.
Pathogen	Specify *Burkholderia* species.
Outbreak?	Denote if this case is part of a cluster or outbreak.

Case Demographic Information	Details
Sex	Genetic sex of patient.
Pregnant	Pregnancy status at onset of current illness.
Age	Age of patient at onset of current illness.
Residence	State, county, and zip code of patient's current residence.
Country of Usual Residence	If patient is not a US resident, denote country where patient usually resides.
Country of Birth	Indicate original country of birth, including US born. If unknown, please enter "Unknown."
Time in US	If not US born, indicate number of years patient has lived in the US.
Race and Ethnicity	Race and ethnicity of patient as noted in the chart or reported by physician or infection control personnel (ICP). Multiple boxes for race may be checked. Do not make assumptions based on name or native language. If race or ethnicity is unknown, please select "Unknown."
Occupation	Indicate occupation at time of disease onset. Specify past occupation(s) if relevant (i.e., occupations with environmental, animal, or travel related exposures).

Case Medical History	Details
Pre-existing Medical Conditions	Select all pre-existing medical conditions. If patient has no underlying medical conditions, select "No pre-existing conditions."
Excessive Alcohol Use	Excessive alcohol use includes binge drinking (4+ drinks on an occasion for a woman or 5+ drinks on an occasion for a man) or heavy drinking (8+ drinks per week for a woman or 15+ drinks per week for a man).

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Case Exposure Information	Details
Travel	Indicate all continents and US gulf coast states the patient has visited or lived in during their lifetime. Provide travel specifics for any travel in the 30 days prior to onset of current illness, if applicable.
Environmental Exposures	Indicate any water, mud, soil, compost, or sewage contact the patient had in the 30 days prior to onset of current illness and the locations where this contact occurred.
Animal Contact	Indicate any animal contact the patient had in the 30 days prior to onset of current illness, the type of animal, and the type of exposure.
Significant Weather	Indicate any significant weather events (e.g., monsoon, typhoon, cyclone, hurricane, flooding) experienced by the patient in the 30 days prior to onset of current illness.
Other Exposures	Specify any additional exposure information not captured elsewhere.

Case Clinical and Treatment Information	Details
Illness Onset	Date of the beginning of this illness (mm/dd/yyyy). Reported date of the onset of symptoms of this illness being reported to the public health system.
Symptoms and Conditions	Select patient-described symptoms or medically-identified conditions associated with this illness.
Hospitalization	Indicate whether the patient was admitted to a hospital for this illness. Enter admission and discharge dates, if applicable.
Treatment	Select the prescribed antimicrobial agents and duration for each. If prescribed other antibiotics, enter the generic name and duration, if known.
Post-Exposure Prophylaxis (PEP)	Indicate if the patient took PEP or the reasons for not taking PEP. If the patient took PEP, indicate if the patient completed the entire course of PEP as prescribed.
Outcome	Indicate the outcome of the patient following this illness. If the patient died of this illness, enter date of death.

Laboratory Testing Information*	Details
Test Type	Indicate the laboratory test performed.
Performing Laboratory	Indicate the laboratory that performed the test.
Specimen Type	Indicate the type of specimen collected.
Specimen Collection Date	Indicate the date the specimen was collected (mm/dd/yyyy).
Results	Indicate if the test was positive, any applicable qualitative results associated with the test, the species identified if applicable, and the test result date (mm/dd/yyyy).
Specimens to CDC	Indicate if the specimen was sent to CDC for testing.
AST Request	Indicate if the jurisdiction would like CDC to perform antimicrobial susceptibility testing on this specimen or isolate.

***NOTE:** Complete a new test block (4 available on the form) for each test performed.

Case Classification and Comments	Details
Case Classification	Indicate the patient's case classification based on the melioidosis case definition. Confirmed and Probable melioidosis cases must be reported to CDC following the notification criteria outlined in the CSTE position statement (22-ID-08).
Comments	List any other pertinent information about the case not provided elsewhere on the form.

BURKHOLDERIA SPP. INFECTION CASE INVESTIGATION FORM

Form Version Apr 2023

REPORTING INFORMATION

Date Reported: _____ Reporting Jurisdiction: _____ State Case ID: _____

Reporter Name: _____ Reporter Phone Number: _____ Reporter Email: _____

Clinician Name: _____ Clinician Phone Number: _____

Case Status:
○ New ○ Recurrent ○ Unknown

Pathogen:
○ *B. mallei* ○ *B. pseudomallei* ○ Other: _____

Part of an outbreak?
○ Yes ○ No ○ Unknown

DEMOGRAPHIC INFORMATION

Sex: ○ Male ○ Female DOB: _____ Age: _____ ○ Years ○ Months ○ Days

Pregnant: ○ Yes ○ No ○ Unknown RESIDENCE: State: _____ County: _____ Zip Code: _____

Country of Usual Residence: _____ Country of Birth: _____ Years in US: _____

Race:
☐ American Indian/Alaskan Native
☐ Asian
☐ White
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Unknown
☐ Other: _____

Ethnicity:
○ Hispanic
○ Non-Hispanic
○ Unknown

Occupation: _____ Other: _____

MEDICAL HISTORY

Does the patient have any of the following pre-existing medical conditions? (select all that apply)

☐ Diabetes ☐ Liver disease ☐ Chronic lung disease ☐ Chronic kidney disease ☐ No pre-existing conditions
☐ Malignancy ☐ Thalassemia ☐ Systemic lupus erythematosus ☐ Chronic granulomatous disease ☐ Unknown
☐ On immunosurpressive drugs: _____ ☐ Other pre-existing condition:

Does the patient excessively use alcohol or have they in the past?
○ Current excessive alcohol use ○ No
○ Former excessive alcohol use ○ Unknown

TRAVEL HISTORY

Has the patient EVER traveled or lived outside of the US in the lifetime (including military service)? ○ Yes ○ No ○ Unknown

If yes, select all continents where patient has visited or lived in their lifetime and most recent year visited:

☐ Asia Year: _____ ☐ Europe Year: _____ ☐ North America *(outside US)* Year: _____
☐ Africa Year: _____ ☐ Middle East Year: _____ ☐ Central America Year: _____
☐ Australia Year: _____ ☐ Caribbean Year: _____ ☐ South America Year: _____

Has the patient served overseas in the military? ○ Yes ○ No ○ Unknown

Has the patient EVER visited or lived in any of the following US states in their lifetime?
☐ Alabama ☐ Florida ☐ Louisiana ☐ Mississippi ☐ Texas ☐ No/None ☐ Unknown Year most recently visited: _____

In the 30 days prior to illness onset, did the patient travel 50 miles or more from their normal residence? ○ Yes ○ No ○ Unknown

If yes, where? _____ Dates of Travel: _____ to: _____

If yes, where? _____ Dates of Travel: _____ to: _____

If yes, where? _____ Dates of Travel: _____ to: _____

ENVIRONMENTAL AND ANIMAL EXPOSURES

In the 30 days prior to illness onset, did the patient have contact with fresh water, mud, soil, compost, or sewage? ○ Yes ○ No ○ Unknown

If yes, select all that apply:
☐ Running water *(e.g., river, stream)* ☐ Still water *(e.g. lake, pond)* ☐ Flood water ☐ Heavy rainfall ☐ Sewage
☐ Rainwater run-off/puddles ☐ Mud or wet soil ☐ Compost ☐ Other soil

Specify locations where contact occurred:

1. _____ 2. _____ 3. _____

In the 30 days prior to illness onset, did the patient own or have contact with any animals? ○ Yes ○ No ○ Unknown

If yes, select all that apply:

☐ Iguana ☐ Fish ☐ Cat ☐ Dog ☐ Goat ☐ Other: _____
☐ Sheep ☐ Horse ☐ Mule ☐ Cow ☐ Pig

Type of exposure:

☐ Handling or petting
☐ Contact with animal fluids
☐ Cleaning enclosure/bedding
☐ Animal present in home/property but never touch
☐ Other

Location of purchase or where animal was acquired: _____

What activities led to the indicated environmental or animal exposure(s)? [select all that apply]

☐ Swimming or bathing
☐ Fresh water fishing
☐ Adventure race, triathalon, or mud run
☐ Biking/motorcycle riding
☐ Pet or livestock ownership
☐ Boating, kayaking, or rafting
☐ Camping or hiking
☐ Playing sports in yard or park
☐ Gardening or yard work
☐ Petting/touching animals at farm/zoo/other location
☐ Drinking water
☐ Hunting
☐ Maintenance or house cleaning
☐ Washing dishes or laundry
☐ Occupational
☐ Other: _____
☐ Unknown

In the 30 days prior to illness onset, has the patient been in any areas experiencing significant weather? ○ Yes ○ No ○ Unknown

If yes, select all that apply:

☐ Hurricane, cyclone, or typhoon
☐ Mudslide
☐ Flooding/heavy rain
☐ Earthquake
☐ Windstorm or tornado
☐ Other: _____

Specify location: _____

Please list any additional exposure information not captured above:

CLINICAL INFORMATION AND PRESENTATION

Date of Illness Onset: _____

Select all symptoms and conditions experienced by the patient during this illness:

☐ Fever
☐ Nodule
☐ Anorexia
☐ Seizure
☐ Periocardial effusion
☐ Muscle aches
☐ Skin abscess
☐ Pneumonia/pleural effusion
☐ Skin or soft tissue infection
☐ Bone or joint infection
☐ Joint pain
☐ Organ abscess
☐ Abdominal discomfort
☐ Genitourinary infection
☐ Septic shock
☐ Fatigue
☐ Chest pain
☐ Headache
☐ CNS infection
☐ Ulcer
☐ Respiratory distress
☐ Disorientation
☐ Weight loss
☐ Sepsis
☐ Encephalomyelitis/meningitis/ extra-meningeal disease
☐ Other symptoms or conditions: _____

TREATMENT AND OUTCOME

Was the patient hospitalized for this illness?

○ Yes
○ No
○ Unknown

1st Admission Date: _____ 1st Discharge Date: _____
2nd Admission Date: _____ 2nd Discharge Date: _____
3rd Admission Date: _____ 3rd Discharge Date: _____

Were antibiotics prescribed or administered to the patient?

○ Yes
○ No
○ Unknown

☐ Ceftazidime Start Date: _____ End date: _____
☐ Meropenem Start Date: _____ End date: _____
☐ Trimethoprim/Sulfamethoxazole Start Date: _____ End date: _____
☐ Amoxicillin/Clavulanate Start Date: _____ End date: _____
☐ Other: Start Date: _____ End date: _____

Did patient receive post-exposure prophylaxis (PEP)?

○ Yes
○ No
○ Unknown

If patient did not receive PEP, why not?

☐ Not indicated ☐ Allergic ☐ Other: _____
☐ Unaware of exposure ☐ Pregnant
☐ Unavailable ☐ Unknown

If yes, antibiotic taken:

Did the patient complete the course?

○ Yes
○ No
○ Unknown

If patient did not complete course, provide reason:

Clinical outcome:

○ Died
○ Still hospitalized
○ Still sick (outpatient)
○ Recovered
○ Long-term disability
○ Unknown

Date of Death: _____

LABORATORY TESTING INFORMATION

1st Test & Specimen

Test type: ○ PCR ○ IHC ○ Other ELISA IgM ○ Viteck or other automated clinical laboratory system ○ IHA ○ ImmunoDot/DotBlot IgM ○ Culture ○ Other:

Performing lab: _____ _____

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Tissue ○ Urine ○ Other: _____ **Specify tissue type:** _____ **Specimen collection date:** _____

Qualitative result: ○ Positive ○ Borderline ○ Negative ○ Indeterminate ○ Other: _____ **Quantitative result** *(e.g., titer)*: _____

Organism name: _____ **Lab result date:** _____

Send to CDC? ○ Yes ○ No, isolate destroyed ○ No, specimen not available **AST requested?** ○ Yes ○ No ○ Not applicable

2nd Test & Specimen

Test type: ○ PCR ○ IHC ○ Other ELISA IgM ○ Viteck or other automated clinical laboratory system ○ IHA ○ ImmunoDot/DotBlot IgM ○ Culture ○ Other:

Performing lab: _____ _____

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Tissue ○ Urine ○ Other: _____ **Specify tissue type:** _____ **Specimen collection date:** _____

Qualitative result: ○ Positive ○ Borderline ○ Negative ○ Indeterminate ○ Other: _____ **Quantitative result** (*e.g., titer*): _____

Organism name: _____ **Lab result date:** _____

Send to CDC? ○ Yes ○ No, isolate destroyed ○ No, specimen not available **AST requested?** ○ Yes ○ No ○ Not applicable

3rd Test & Specimen

Test type: ○ PCR ○ IHC ○ Other ELISA IgM ○ Viteck or other automated clinical laboratory system ○ IHA ○ ImmunoDot/DotBlot IgM ○ Culture ○ Other:

Performing lab: _____ _____

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Tissue ○ Urine ○ Other: _____ **Specify tissue type:** _____ **Specimen collection date:** _____

Qualitative result: ○ Positive ○ Borderline ○ Negative ○ Indeterminate ○ Other: _____ **Quantitative result** (*e.g., titer*): _____

Organism name: _____ **Lab result date:** _____

Send to CDC? ○ Yes ○ No, isolate destroyed ○ No, specimen not available **AST requested?** ○ Yes ○ No ○ Not applicable

4th Test & Specimen

Test type: ○ PCR ○ IHC ○ Other ELISA IgM ○ Viteck or other automated clinical laboratory system ○ IHA ○ ImmunoDot/DotBlot IgM ○ Culture ○ Other:

Performing lab: _____ _____

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Tissue ○ Urine ○ Other: _____ **Specify tissue type:** _____ **Specimen collection date:** _____

Qualitative result: ○ Positive ○ Borderline ○ Negative ○ Indeterminate ○ Other: _____ **Quantitative result** (*e.g., titer*): _____

Organism name: _____ **Lab result date:** _____

Send to CDC? ○ Yes ○ No, isolate destroyed ○ No, specimen not available **AST requested?** ○ Yes ○ No ○ Not applicable

CASE CLASSIFICATION

○ Confirmed ○ Probable ○ Suspect ○ Not a case ○ Unknown

ADDITIONAL COMMENTS

DOB: date of birth, PCR: polymerase chain reaction, IHA: indirect hemagglutination, IHC: immunohistochemistry, AST: antimicrobial susceptibility testing

RESET