NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

Special Bacterial Reference Laboratory: +27 11 555 0331/0306
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SUSPECTED LEPTOSPIROSIS CASE HISTORY FORM

Filled in by: _____ Contact number: _____
Date: __/__/____ Information collected from: _____

PATIENT INFORMATION

Name: _____ Sex: M ☐ F ☐ Birth date: __/__/____ Or Age: _____ Years
Occupation of patient, describe?
Address: _____

PATIENT COURSE

Consultation date: __/__/____ Physician _____ Tel Nos: _____
Is patient symptomatic? ☐YES ☐NO Is patient pregnant? ☐NO ☐YES _____ weeks
Date first symptoms: __/__/____ Duration illness _____ days
Is patient hospitalized? ☐YES ☐NO Hospital _____ (name)
Admission date: __/__/____ ☐In isolation ☐ICU ☐Ward: _____ (name)

CLINICAL FEATURES *(Tick appropriate box (yes, no; UNK: unknown)*

Symptoms/signs	YES	NO		YES	NO		YES	NO		YES	NO
Fever _____ °C	☐	☐	Myalgia	☐	☐	Jaundice	☐	☐	Seizures	☐	☐
Chills	☐	☐	Lower back pain	☐	☐	Hepatitis	☐	☐	Meningitis	☐	☐
Headache	☐	☐	Joint pain	☐	☐	Swollen ankles/feet	☐	☐	Encephalitis	☐	☐
Nausea	☐	☐	Conjunctivitis	☐	☐	Swollen hands	☐	☐	Renal failure	☐	☐
Vomiting	☐	☐	Cough	☐	☐	Chest pain	☐	☐	Cardiac findings	☐	☐
Loss of appetite	☐	☐	Petechial rash	☐	☐	Shortness breath	☐	☐	Lung function loss	☐	☐
Diarrhoea	☐	☐	Maculopapular rash	☐	☐	Coughing up blood	☐	☐	Internal bleeding	☐	☐

Other, specify: _____

PATHOLOGICAL FINDINGS (Please attach test results)

Tests	Results	Results	Results	Units
Date	__/__/____	__/__/____	__/__/____	
WBC count				10^9/L
Diff N/L				%
Platelets count				10^9/L
Haemoglobin				g/dL
Coagulation				
AST				IU/L
ALT				IU/L
Malaria				

PATIENT TREATMENT AND OUTCOME

Treatment	Discharge	Death
__/__/____	__/__/____	__/__/____

☐Doxycycline
☐Penicillin
☐Other, specify: _____

Clinical Outcome:
☐ Uneventful recovery
☐ Recovery with sequelae
☐ Death
☐ Prolonged with complications

PATIENT EXPOSURE HISTORY *(Tick appropriate boxes)*

	YES	NO	
Has the patient ever had leptospirosis?	☐	☐	If yes, specify period when? _____
Does patient stay in housing with evidence of rodents?	☐	☐	If yes, specify where? _____
Was there flooding near patient's place of residence?	☐	☐	If yes, specify period when? _____
Did patient travel outside area of residence?	☐	☐	If yes, specify where? _____

Does patient practice any of following activities?
☐Farming ☐Gardening ☐Fishing ☐Swimming ☐Camping ☐Hiking ☐Hunting ☐Pet ownership
☐Other (specify): _____

In the 30 days prior to illness onset, has patient had specific contact with any of following animals?
☐Rodents ☐Farm animals ☐Wild animals ☐Dogs ☐Other ☐Unknown

Specify the animal or similar exposure: _____

SEND COMPLETED FORM WITH SPECIMEN TO:
Special Bacterial Pathogens Reference Lab,
National Institute for Communicable Diseases, National Health Laboratory Service,
1 Modderfontein Road, Sandringham 2192, South Africa

FAX OR EMAIL COMPLETED FORM TO:
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