

Q FEVER Australian Paediatric Surveillance Unit Please contact the APSU (02) 9845 3005 or SCHN-APSU@health.nsw.gov.au if you have any questions about this form	<i>APSU Office Use Only</i>
<i>Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided. DK=Don't Know; NA = Not Applicable.</i>	Study ID #: _____ Version 1.2_21/04/2023

Q FEVER CASE DEFINITION:

1. Confirmed acute Q Fever as determined by:

- Laboratory detection of *Coxiella burnetii* by PCR testing of unclotted blood or serum

OR

- Laboratory detection of a \geq four-fold increase in IgG antibody titres to phase II *C.burnetii* antigen in serum collected 2-3 weeks after onset compared with serum collected at onset.

2. Probable acute Q Fever as determined by:

- Laboratory detection of IgM antibody to phase II *C.burnetii* antigen in serum

OR

- Clinical presentation compatible with acute Q Fever disease (e.g. fever, sweats, chills/rigors, fatigue/lethargy, joint/muscle pain)

3. Chronic Q Fever as determined by:

- Clinical presentation consistent with chronic Q fever disease (e.g. endocarditis, osteomyelitis, Hepatitis, encephalitis or other)

AND

- Laboratory detection by indirect immunofluorescence assay (IFA) of elevated titres of IgG antibody to Phase I *C.burnetii* antigen, with or without detection of IgA antibody in serum

OR

- Laboratory detection of *C.burnetii* by PCR in blood or tissue at infection site (e.g bone, joint)

LABORATORY CRITERIA:

Tests completed	Specimen collection date	Results (for each serology test completed, list method (e.g. EIA/CFT/IFA), target antibodies & titres, if available)
<input type="checkbox"/> PCR/nucleic acid testing (NAT)		<input type="checkbox"/> <i>C. burnetii</i> detected <input type="checkbox"/> Not detected
<input type="checkbox"/> Serology 1 (acute sample)		Method used: _____, phase II IgG Positive? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , specify titres _____ IU/ml
<input type="checkbox"/> Serology 2 (convalescent sample)		Method used: _____, phase II IgG Positive? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , specify titres _____ IU/ml
<input type="checkbox"/> Serology (probable case)		Method used: _____, IgM Positive? <input type="checkbox"/> Yes <input type="checkbox"/> No

REPORTING CLINICIAN'S DETAILS:

1. APSU Dr Code/Name: / _____

2. Date case report form completed: ____ / ____ / ____ (dd/mm/yyyy)

PATIENT DETAILS:

3. First 2 letters of first name:

4. First 2 letters of surname:

5. Date of Birth: ____ / ____ / ____ (dd/mm/yyyy)

6. Sex: Male Female
7. Postcode of family:
8. Child's ethnicity: Indigenous Non-Indigenous DK
If Indigenous: Aboriginal Torres Strait Islander

If this patient is primarily cared for by another physician who you believe will report the case, please complete the details above this line and return to the APSU. Please keep the patient's name and other details in your records.

If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.
 The primary clinician caring for this child/young person is: **Name:** _____ **Hospital:** _____

CLINICAL DETAILS:

9. Date of onset of symptoms _____ / _____ / _____ (dd/mm/yyyy)

10. Date child first seen by you _____ / _____ / _____ (dd/mm/yyyy)

11. Symptoms:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Nausea | <input type="checkbox"/> Cough | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Myocarditis |
| <input type="checkbox"/> Chills/rigors | <input type="checkbox"/> Diarrhoea | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Pericarditis |
| <input type="checkbox"/> Fatigue/lethargy | <input type="checkbox"/> Headache | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Endocarditis |
| <input type="checkbox"/> Joint/muscle pain | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Pneumonia | |

Please specify other symptoms: _____

12. Was the child hospitalised? Yes No DK

If yes, days in hospital: _____

13. Was the child treated? (please specify): _____ DK

14. Does the child have any underlying medical conditions? Yes No DK

If Yes, indicate whether any of the following were present:

- Immunosuppressed (specify): _____
- Congenital heart disease
- Other, please specify: _____

15. Has the child ever received a Q fever vaccine? Yes No DK

If yes, date given? _____ / _____ / _____ (dd/mm/yyyy)

EXPOSURE HISTORY:

16. Exposure period: date onset of symptoms _____ / _____ / _____

17. Where did the exposure happen? _____

Animal Exposures

18. Direct contact with animals: Yes No DK

If yes, please tick all types that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cattle | <input type="checkbox"/> Feral goats | <input type="checkbox"/> Kangaroos | <input type="checkbox"/> Dogs |
| <input type="checkbox"/> Sheep | <input type="checkbox"/> Domestic pigs | <input type="checkbox"/> Small marsupials e.g. bandicoots | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Domestic goats | <input type="checkbox"/> Feral pigs | <input type="checkbox"/> Cats | |

19. Direct contact with animal tissues or fluid (e.g. blood, bone, viscera, skin/hides, urine)? Yes No DK

20. Assisted or observed an animal birth? Yes No DK

If yes, direct contact with birthing materials (e.g. placenta, fluids or newborns)?

Yes No DK

21. Hunting or shooting? Yes No DK

22. Shearing, wool processing or wool classing? Yes No DK
23. Contact with pelts or hides? Yes No DK
24. Contact with straw or animal bedding? Yes No DK
25. Contact with animal manure/animal fertiliser? Yes No DK
26. Attended a saleyard or animal show? Yes No DK
27. Observing veterinary practices? Yes No DK
28. Consumed unpasturised milk or milk products? Yes No DK

Environmental Exposures

29. Did the child travel in the month prior to symptom onset? Yes No *If yes*, where did they travel to? _____
30. Lives on a farm/station or rural property? Yes No DK
31. Visited a farm/station or rural property? Yes No DK
32. Visited a facility that processes animal products (e.g. abattoir, factory, etc.)? Yes No DK
33. Lives near an abattoir/animal grazing area or saleyards? Yes No DK
34. Exposure to trucks transporting livestock? Yes No DK
35. Direct contact with clothes worn by someone who works with animals (e.g. laundered)? Yes No DK
36. Direct contact with or bitten by ticks? Yes No DK
37. Exposure to wildlife faeces (e.g. kangaroos) faeces? Yes No DK

OUTCOME:

38. Please indicate if the child: Is still ill
 Recovered
 Died, please advise date of death: ___/___/____ (dd/mm/yyyy)
39. Duration of illness (days): _____
40. Family member with a similar illness? Yes No DK
If yes, relationship to child and date of onset: _____

Thank you for your help with this research project.

*Please return this case report form to the APSU via email to SCHN-APSU@health.nsw.gov.au
or fax to 02 9845 3082*

or mail to Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145

The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Faculty of Medicine and Health, The University of Sydney.

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This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.