Q FEVER **Australian Paediatric Surveillance Unit** Please contact the APSU by emailing SCHN-APSU@health.nsw.gov.au if you have any questions about this form	*APSU Office Use Only*	
	Study ID #:	
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.	*Version 1.3 10.12.2025*	

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 ≥ 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)*
☐ PCR/nucleic acid testing (NAT)		☐ *C. burnetii* detected ☐ Not detected
☐ Serology 1 (acute sample)		Method used:_____, phase II IgG Positive? ☐ Yes ☐ No ***If yes***, specify titres _____IU/ml
☐ Serology 2 (convalescent sample)		Method used:_____, phase II IgG Positive? ☐ Yes ☐ No ***If yes***, specify titres _____IU/ml
☐ Serology (probable case)		Method used:_____, IgM Positive? ☐ Yes ☐ No

REPORTING CLINICIAN'S DETAILS:

1. APSU Dr Code/Name: ☐☐☐☐/_____

Provide your best organisational email address : _____

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:

☐ Fever	☐ Nausea	☐ Cough	☐ Eye pain
☐ Sweats	☐ Vomiting	☐ Jaundice	☐ Myocarditis
☐ Chills/rigors	☐ Diarrhoea	☐ Sore throat	☐ Pericarditis
☐ Fatigue/lethargy	☐ Headache	☐ Shortness of breath	☐ Endocarditis
☐ Joint/muscle pain	☐ Weight loss	☐ Chest pain	☐ Other *(please specify below)*
☐ Abdominal pain	☐ Loss of appetite	☐ 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:

☐ Cattle	☐ Feral goats	☐ Kangaroos	☐ Dogs
☐ Sheep	☐ Domestic pigs	☐ Small marsupials *e.g. bandicoots*	☐ Other, *please specify*: _____
☐ Domestic goats	☐ Feral pigs	☐ 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)
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This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.