Haemophilus influenzae

COUNTY

Date investigation initiated: ____ /____ /____

FOR STATE USE ONLY #

___/___/___ case report

___/___/___ interstate

☐ confirmed

☐ presumptive

☐ suspect

CASE IDENTIFICATION

Name ____ Phone(s) __________________________
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address ____
Street City County State Zip

_______________________e-mail address____

ALTERNATIVE CONTACT: ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ _____________

Name ____ Phone(s) ____________________________
indicate home (H); work (W); message (M)

Address ____
Street City Zip

SOURCES OF REPORT *(check all that apply)*

☐ Lab ☐ Infection Control Practitioner

☐ Physician ☐ _________________

Name ___________________________

Phone ___________ Date ___/___/___ *(first report)*

Primary M.D. ______________________ *(if different)*

Phone _______________ OK to talk to patient? ☐

DEMOGRAPHICS

SEX

☐ female ☐ male

DATE OF BIRTH ____/____/____ (m d y)

or, if unknown, AGE ______

HISPANIC ☐ yes ☐ no ☐ unknown

RACE

☐ White ☐ American Indian

☐ Black ☐ Asian/Pacific Islander

☐ unknown ☐ refused to answer

☐ other _____________

Worksites/school/day care center___________________________

____

Occupations/grade______________________________________

BASIS OF DIAGNOSIS

CLINICAL DATA

ONSET date ____/____/____ (m d y)

Check all that apply:

bacteremia	☐ yes	☐ no	☐ unk
meningitis	☐ yes	☐ no	☐ unk
pneumonia	☐ yes	☐ no	☐ unk
pericarditis	☐ yes	☐ no	☐ unk
septic arthritis	☐ yes	☐ no	☐ unk
conjunctivitis	☐ yes	☐ no	☐ unk
osteomyelitis	☐ yes	☐ no	☐ unk
☐ _________________________			

Hospitalized: ☐ yes ☐ no ☐ unk

if yes, name of hospital ____________

date of admission ____/____/____ (m d y)

date of discharge ____/____/____ (m d y)

Transferred from another hospital:

☐ yes ☐ no ☐ unk

transfer hospital name _____________

Outcome: ☐ survived ☐ died ☐ unk

if died, date of death ____/____/____ (m d y)

LABORATORY DATA

	Culture pos	Culture neg	Gram stain pos	Gram stain neg
blood	☐	☐	☐	☐
CSF	☐	☐	☐	☐

Date of collection of first positive specimen ____/____/____ (m d y)

Culture confirmed: ☐ yes ☐ no

if yes, Lab _________________

serotype _________ ☐ not typable ☐ unknown

Isolate sent to public health lab? ☐ yes ☐ no

PHL specimen # _______________

RESULTS OF CSF EXAM (if available)

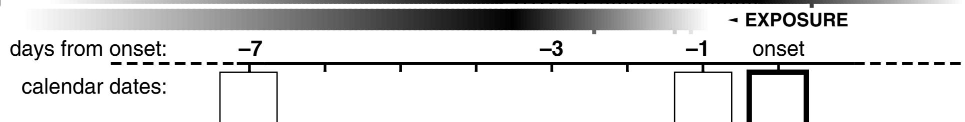
WBC count _________ sugar _________

RBC count _________ protein _________

% neutrophils _________

INFECTION TIMELINE

Enter onset date in box. Count back to figure probable exposure periods.



Persons are probably most infectious in the days before onset. Because asymptomatic carriage is so common, the exposure period is difficult to define. Infections are usually communicable until 48 h after antibiotic therapy aimed specifically at nasopharyngeal carriage has been started.

PATIENT'S NAME ▸

RISK FACTORS FOR DISEASE

Was the patient a contact of a confirmed or presumptive case in the 60 days before onset? ☐ yes ☐ no

if yes, was prophylaxis recommended? ☐ yes ☐ no

Was patient under 60-day surveillance? ☐ yes ☐ no

Did case have any respiratory disease in the 2 weeks before onset? ☐ yes ☐ no

Is patient immunocompromised? ☐ yes ☐ no

if yes, specify ___________________________

Did patient have a cochlear implant? ☐ yes ☐ no

If yes, date of implant ____/____/____ (m d y)

Is case a smoker? ☐ yes ☐ no

if yes, cigarettes per day _______ (number)

years of smoking _______ (number)

If case is a child, does primary caretaker or person who spends most time with case smoke? ☐ yes ☐ no

Excluding case:

How many people in household smoke? _______ (number)

How many household smokers smoke at least:

one cigarette a day _______ (number)

one pack a day _______ (number)

CONTACT MANAGEMENT AND FOLLOW UP

Was the **case** treated for nasopharyngeal carriage? ☐ yes ☐ no

If the case is a child < 5, is there a history of previous Hib invasive disease? ☐ yes ☐ no

if yes, onset date ____/____/____ type of clinical disease ___________________

Was previous case culture confirmed? ☐ yes ☐ no

Prior to onset, had the patient been immunized with Hib vaccine? ☐ yes ☐ no ☐ unknown

DOSE	TYPE	DATE	GIVEN BY
1	_________	____/____/____	__________________________
2	_________	____/____/____	__________________________
3	_________	____/____/____	__________________________
4	_________	____/____/____	__________________________

If a child <5 and not vaccinated, why not?

- ☐ age less than 2 months
- ☐ medical exemption
- ☐ religious objection
- ☐ didn't know about disease
- ☐ didn't know about vaccine

Comments

Does the patient have household contacts <4 years old? ☐ yes ☐ no

if yes, were ***all*** household members prophylaxed? ☐ yes ☐ no date prophylaxed____/____/____

Did the patient have daycare, health care, or other prolonged contact with children <2 years old? ☐ yes ☐ no

if yes, was prophylaxis recommended to any contacts? ☐ yes ☐ no date prophylaxed____/____/____

HOUSEHOLD ROSTER/OTHER CONTACTS *If* they include children under 4, make a roster of household and other close contacts.

☐ **no other contacts identified**

Name	Relation to Case	Age	Date contacted	HiB vaccination status (if <5) yes no unk	Date of vaccine	Date prophylaxis offered	Education provided yes no unk	Comments
______	______	______	___/___/___	☐ ☐ ☐	____/____/____	___/___/___	☐ ☐ ☐	________
______	______	______	___/___/___	☐ ☐ ☐	____/____/____	___/___/___	☐ ☐ ☐	________
______	______	______	___/___/___	☐ ☐ ☐	____/____/____	___/___/___	☐ ☐ ☐	________
______	______	______	___/___/___	☐ ☐ ☐	____/____/____	___/___/___	☐ ☐ ☐	________
______	______	______	___/___/___	☐ ☐ ☐	____/____/____	___/___/___	☐ ☐ ☐	________
______	______	______	___/___/___	☐ ☐ ☐	____/____/____	___/___/___	☐ ☐ ☐	________
______	______	______	___/___/___	☐ ☐ ☐	____/____/____	___/___/___	☐ ☐ ☐	________

Comments

ADMINISTRATION

Remember to copy patient's name to the top of this page.

Case report sent to OHS on ____/____/____

Completed by _________________________________ Date _____________ Phone _______________ Investigation sent to OHS on ____/____/____