CASE REPORT FORM Haemophilus Influenzae Type b Disease

Haemophilus Influenzae Type b Disease EpiSurv No.________________

Reporting Authority

Name of Public Health Officer responsible for case ____________________

Notifier Identification

Reporting source* ○ General Practitioner ○ Hospital-based Practitioner ○ Laboratory ○ Self-notification ○ Outbreak Investigation ○ Other

Name of reporting source ____________ **Organisation** ____________

Date reported* ____________ **Contact phone** ____________

Usual GP ____________ **Practice** ____________ **GP phone** ____________

GP/Practice address Number ______ Street ____________ Suburb ____________
Town/City ____________ Post Code ______ ☐ GeoCode____

Case Identification

Name of case* Surname ____________ Given Name(s) ____________

NHI number* ____________ **Email** ____________

Current address* Number ______ Street ____________ Suburb ____________
Town/City ____________ Post Code ______ ☐ GeoCode____

Phone (home) ____________ **Phone (work)** ____________ **Phone (other)** ____________

Case Demography

Location TA* ____________ **DHB*** ____________

Date of birth* ____________ **OR Age** ______ ○ Days ○ Months ○ Years

Sex* ○ Male ○ Female ○ Indeterminate ○ Unknown

Occupation* ____________

Occupation location ○ Place of Work ○ School ○ Pre-school

Name ____________

Address Number ______ Street ____________ Suburb ____________
Town/City ____________ Post Code ______ ☐ GeoCode____

Alternative location ○ Place of Work ○ School ○ Pre-school

Name ____________

Address Number ______ Street ____________ Suburb ____________
Town/City ____________ Post Code ______ ☐ GeoCode____

Ethnic group case belongs to* (tick all that apply)

☐ NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori

☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan

☐ Other (such as Dutch, Japanese, Tokelauan) *(specify) ____________ ____________

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Basis of Diagnosis

CLINICAL CRITERIA

Fits Clinical Description* ◯ Yes ◯ No ◯ Unknown

Clinical features

Meningitis* ◯ Yes ◯ No ◯ Unknown **Septicaemia*** ◯ Yes ◯ No ◯ Unknown

Epiglottitis* ◯ Yes ◯ No ◯ Unknown **Pneumonia*** ◯ Yes ◯ No ◯ Unknown

Other invasive illness* (specify) ____________

LABORATORY CRITERIA

Isolation of *H. influenzae type b* from CSF* ◯ Yes ◯ No ◯ Not Done ◯ Awaiting Results

Isolation of *H. influenzae type b* from blood* ◯ Yes ◯ No ◯ Not Done ◯ Awaiting Results

Isolation of *H. influenzae type b* from other site* ◯ Yes ◯ No ◯ Not Done ◯ Awaiting Results

(specify site)* ____________

Detection of *H. influenzae type b* nucleic acid* ◯ Yes ◯ No ◯ Not Done ◯ Awaiting Results

(specify site)* ____________

Gram negative bacilli of characteristic appearance* ◯ Yes ◯ No ◯ Not Done ◯ Awaiting Results

(specify site)* ____________

Detection of *H. influenzae type b* antigen* ◯ Yes ◯ No ◯ Not Done ◯ Awaiting Results

(specify site)* ____________

CLASSIFICATION* ◯ Under investigation ◯ Probable ◯ Confirmed ◯ Not a case

ADDITIONAL LABORATORY DETAILS

Other Lab details:* ____________

Clinical Course and Outcome

Date of onset* ____________ ☐ Approximate ☐ Unknown

Hospitalised* ◯ Yes ◯ No ◯ Unknown

Date hospitalised* ____________ ☐ Unknown

Hospital* ____________

Died* ◯ Yes ◯ No ◯ Unknown

Date died* ____________ ☐ Unknown

Was this disease the primary cause of death?* ◯ Yes ◯ No ◯ Unknown

If no, specify the primary cause of death* ____________

Outbreak Details

Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*

☐ Yes **If yes, specify Outbreak No.*** ____________

Risk Factors

Contact with a presumptive case of *H. influenzae type b* disease in 60 days before onset?* ◯ Yes ◯ No ◯ Unknown

If yes, was prophylaxis offered?* ◯ Yes ◯ No ◯ Unknown

If yes, was prophylaxis taken?* ◯ Yes ◯ No ◯ Unknown

Name of presumptive case?* ____________

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Risk Factors continued

Attendance at school, pre-school or childcare* ◯ Yes ◯ No ◯ Unknown

Other risk factor for *H. influenzae type b* disease?* ____________________

Protective Factors

At any time prior to onset, had the case been immunised with *H. influenzae type b* disease vaccine (DTaP/HiB or Hib-HepB)?* ◯ Yes ◯ No ◯ Unknown

If yes, specify vaccine details*

First administered dose:* ◯ DTaP/Hib ◯ Hib-HepB ◯ Unknown

Date given* ____________ Or age when first dose given ______ ◯ Weeks ◯ Months ◯ Years

Source of information:* ◯ Patient/caregiver recall ◯ Documented

Second administered dose:* ◯ DTaP/Hib ◯ Hib-HepB ◯ Not given ◯ Unknown

Date given* ____________ Or age when second dose given ______ ◯ Weeks ◯ Months ◯ Years

Source of information:* ◯ Patient/caregiver recall ◯ Documented

Third administered dose:* ◯ DTaP/Hib ◯ Hib-HepB ◯ Hib ◯ Not given ◯ Unknown

Date given* ____________ Or age when third dose given ______ ◯ Weeks ◯ Months ◯ Years

Source of information:* ◯ Patient/caregiver recall ◯ Documented

Fourth administered dose:* ◯ DTaP/Hib ◯ Hib-HepB ◯ Hib ◯ Not given ◯ Unknown

Date given* ____________ Or age when fourth dose given ______ ◯ Weeks ◯ Months ◯ Years

Source of information:* ◯ Patient/caregiver recall ◯ Documented

Management

CONTACT MANAGEMENT

Type of contact	Number identified	Number counselled	Number offered antibiotics	Number offered vaccination
Household contacts (with pre-schoolers)				
Childcare / pre-school contacts				
Other contacts (specify) ____________				

Comments