

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* <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory			
<input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> 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 _____	
<input type="checkbox"/> GeoCode _____			
Case Identification			
Name of case* Surname _____ Given Name(s) _____			
NHI number* _____		Email _____	
Current address* Number _____ Street _____ Suburb _____			
Town/City _____		Post Code _____	
<input type="checkbox"/> GeoCode _____			
Phone (home) _____		Phone (work) _____	
		Phone (other) _____	
Case Demography			
Location TA* _____		DHB* _____	
Date of birth* _____ OR Age _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years			
Sex* <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown			
Occupation* _____			
Occupation location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address Number _____ Street _____ Suburb _____			
Town/City _____		Post Code _____	
<input type="checkbox"/> GeoCode _____			
Alternative location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address Number _____ Street _____ Suburb _____			
Town/City _____		Post Code _____	
<input type="checkbox"/> GeoCode _____			
Ethnic group case belongs to* (tick all that apply)			
<input type="checkbox"/> NZ European	<input type="checkbox"/> Maori	<input type="checkbox"/> Samoan	<input type="checkbox"/> Cook Island Maori
<input type="checkbox"/> Niuean	<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian	<input type="checkbox"/> Tongan
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan)	*(specify) _____		

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 CRITERIAIsolation of *H. influenzae type b* from CSF* Yes No Not Done Awaiting ResultsIsolation of *H. influenzae type b* from blood* Yes No Not Done Awaiting ResultsIsolation of *H. influenzae type b* from other site* 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)* _____

***STATUS** 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 FactorsContact 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?* _____

Attendance at school, pre-school or childcare*

 Yes No UnknownOther 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:*	<input type="radio"/> DTaP/Hib	<input type="radio"/> Hib-HepB	<input type="radio"/> Unknown
Date given* _____	Or age when first dose given _____	<input type="radio"/> Weeks	<input type="radio"/> Months <input type="radio"/> Years
Source of information:*	<input type="radio"/> Patient/caregiver recall	<input type="radio"/> Documented	
Second administered dose:*	<input type="radio"/> DTaP/Hib	<input type="radio"/> Hib-HepB	<input type="radio"/> Not given <input type="radio"/> Unknown
Date given* _____	Or age when second dose given _____	<input type="radio"/> Weeks	<input type="radio"/> Months <input type="radio"/> Years
Source of information:*	<input type="radio"/> Patient/caregiver recall	<input type="radio"/> Documented	
Third administered dose:*	<input type="radio"/> DTaP/Hib	<input type="radio"/> Hib-HepB	<input type="radio"/> Hib <input type="radio"/> Not given <input type="radio"/> Unknown
Date given* _____	Or age when third dose given _____	<input type="radio"/> Weeks	<input type="radio"/> Months <input type="radio"/> Years
Source of information:*	<input type="radio"/> Patient/caregiver recall	<input type="radio"/> Documented	
Fourth administered dose:*	<input type="radio"/> DTaP/Hib	<input type="radio"/> Hib-HepB	<input type="radio"/> Hib <input type="radio"/> Not given <input type="radio"/> Unknown
Date given* _____	Or age when fourth dose given _____	<input type="radio"/> Weeks	<input type="radio"/> Months <input type="radio"/> Years
Source of information:*	<input type="radio"/> Patient/caregiver recall	<input type="radio"/> 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