

CASE REPORT FORM

Rheumatic Fever

Rheumatic Fever _____		EpiSurv No. _____	
Disease Name			
<input type="radio"/> Rheumatic fever - initial attack		<input type="radio"/> Rheumatic fever - recurrent attack	
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"/> Self-notification		<input type="radio"/> Outbreak Investigation	
<input type="radio"/> Laboratory		<input type="radio"/> Other	
Name of reporting source _____		Organisation _____	
Date reported* _____		Contact phone _____	
Usual GP _____		Practice _____	
GP/Practice address Number _____		Street _____	
Town/City _____		Suburb _____	
Post Code _____		<input type="checkbox"/> GeoCode _____	
GP phone _____			
Case Identification			
Name of case* Surname _____		Given Name(s) _____	
NHI number* _____		Email _____	
Current address* Number _____		Street _____	
Town/City _____		Suburb _____	
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 _____	
Town/City _____		Suburb _____	
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 _____	
Town/City _____		Suburb _____	
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

Meets Jones criteria for rheumatic fever* Yes No Unknown

MAJOR MANIFESTATIONS

Carditis* Yes No Unknown **Polyarthritits*** Yes No Unknown

Subcutaneous nodules* Yes No Unknown **Erythema marginatum*** Yes No Unknown

MINOR MANIFESTATIONS

Arthralgia* Yes No Unknown **Fever*** Yes No Unknown

Elevated ESR* Yes No Unknown **Positive C-reactive protein*** Yes No Unknown

Prolonged PR interval* Yes No Unknown

SUPPORTING LABORATORY CRITERIA FOR STREPTOCOCCAL INFECTION

Evidence of preceding group A Streptococcal infection* Yes No Unknown

- *If yes, specify method(s):
- Elevated or rising streptococcal antibody titre
 - Positive throat culture for group A Streptococcus
 - Positive rapid streptococcal antigen test

OTHER CLINICAL MANIFESTATIONS

Chorea* Yes No Unknown **Indolent carditis*** Yes No Unknown

STATUS* Under investigation Probable Confirmed Not a case

PREVIOUS HISTORY OF RHEUMATIC FEVER (for recurrences only)

Number of previous attacks* _____

First attack - date* _____ Date Unknown **Hospital where diagnosed*** _____

Most recent previous

attack - date* _____ Date Unknown **Hospital where diagnosed*** _____

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 cases of the same disease?*

Yes **If yes, specify Outbreak No.*** _____

Protective Factors - Recurrences only

Case on rheumatic fever register* Yes No Unknown

If yes, name of rheumatic fever register* _____

Case receiving antibiotic prophylaxis* Yes No Unknown

Management**CASE MANAGEMENT**

If case not on rheumatic fever register, was case placed on register? Yes No Unknown

If yes, name of rheumatic fever register _____

If case was receiving antibiotic prophylaxis

Was the case taking prophylaxis regularly irregularly uncertain

Type of prophylaxis benzathine penicillin penicillin V erythromycin

Other antibiotic (specify) _____

Unknown

If case not on antibiotic prophylaxis have arrangements been made for delivery of prophylaxis?* Yes No Unknown

Name of person administering prophylaxis

Occupation group PHN Hospital based Nurse Other Unknown

Case under specialist care Yes No Unknown

Name of specialist _____

Case's dentist advised of condition Yes No Unknown

Name of dentist _____

Comments*