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 OfficerName _____

Notifier Identification

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

Name of reporting source ReportName _____ **Organisation** ReportOrganisation _____

Date reported* ReportDate _____ **Contact phone** ReportPhone _____

Usual GP UsualGP _____ **Practice** GPPracticeName _____ **GP phone** GPPhone _____

GP/Practice address GPAddress Number _____ Street _____ Suburb _____ Town/City _____ Post Code _____ ☐ GeoCode _____

Case Identification

Name of case* Surname Surname _____ Given Name(s) GivenName _____

NHI number* NHINumber _____ **Email** Email _____

Current address* CaseAddress Number _____ Street _____ Suburb _____ Town/City _____ Post Code _____ ☐ GeoCode _____

Phone (home) PhoneHome _____ **Phone (work)** PhoneWork _____ **Phone (other)** PhoneOther _____

Case Demography

Location **TA*** TA _____ **DHB*** DHB _____

Date of birth* DateOfBirth _____ **OR** **Age** Age _____ ○ Days ○ Months ○ Years AgeUnits

Sex* Sex ○ Male ○ Female ○ Indeterminate ○ Unknown

Occupation* Occupation _____

Occupation location PlaceOfWork1Type ○ Place of Work ○ School ○ Pre-school

Name PlaceOfWork1 _____

Address PlaceOfWork1Address Number _____ Street _____ Suburb _____ Town/City _____ Post Code _____ ☐ GeoCode _____

Alternative location PlaceOfWork2Type ○ Place of Work ○ School ○ Pre-school

Name _____

Address PlaceOfWork2Address Number _____ Street _____ Suburb _____ Town/City _____ Post Code _____ ☐ GeoCode _____

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

☐ NZ European EthNZEuropean ☐ Maori EthMaori ☐ Samoan EthSamoan ☐ Cook Island Maori EthCookIslandMaori

☐ Niuean EthNiuean ☐ Chinese EthChinese ☐ Indian EthIndian ☐ Tongan EthTongan

☐ Other (such as Dutch, Japanese) EthOther *(specify) EthSpecify1 _____ EthSpecify2 _____

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Basis of Diagnosis

CLINICAL CRITERIA

Fits Clinical Description* FitClinDes ○ Yes ○ No ○ Unknown

Clinical features

Meningitis* Meningitis ○ Yes ○ No ○ Unknown **Septicaemia*** Septicaemia ○ Yes ○ No ○ Unknown

Epiglottitis* Epiglottitis ○ Yes ○ No ○ Unknown **Pneumonia*** Pneumonia ○ Yes ○ No ○ Unknown

Other invasive illness* (specify) OthInvas _____

LABORATORY CRITERIA

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

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

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

(specify site)* OthSite _____

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

(specify site)* NAATSite _____

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

(specify site)* GramNegSite _____

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

(specify site)* AntigenSite _____

CLASSIFICATION* Status ○ Under investigation ○ Probable ○ Confirmed ○ Not a case

ADDITIONAL LABORATORY DETAILS

Other Lab details:* AddLab _____

Clinical Course and Outcome

Date of onset* OnsetDt _____ ☐ Approximate OnsetDtApprox ☐ Unknown OnsetDtUnknown

Hospitalised* Hosp ○ Yes ○ No ○ Unknown

Date hospitalised* HospDt _____ ☐ Unknown HospDtUnknown

Hospital* HospName _____

Died* Died ○ Yes ○ No ○ Unknown

Date died* DiedDt _____ ☐ Unknown DiedDtUnknown

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

If no, specify the primary cause of death* DiedOther _____

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 Outbrk **If yes, specify Outbreak No.*** OutbrkNo _____

Risk Factors

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

If yes, was prophylaxis offered?* ProphOffer ○ Yes ○ No ○ Unknown

If yes, was prophylaxis taken?* ProphTake ○ Yes ○ No ○ Unknown

Name of presumptive case?* ContName _____

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Risk Factors continued

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

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

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)?* Immunised ○ Yes ○ No ○ Unknown

If yes, specify vaccine details*

First administered dose:* FirstDose ○ DTaP/Hib ○ Hib-HepB ○ Unknown

Date given*DtFirstDose ___ Or age when 1st dose given AgeFirstDose _____ YMWFirstDose ○ W ○ M ○ Y

Source of information:* SceFirstDose ○ Patient/caregiver recall ○ Documented

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

Date given*DtSecndDose ___ Or age when 2nd dose given AgeSecndDose ____ YMWSecndDose ○ W ○ M ○ Y

Source of information:* SceSecndDose ○ Patient/caregiver recall ○ Documented

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

Date given* DtThirdDose _____ Or age when 3rd dose given AgeThirdDose _____ YMWThirdDose ○ W ○ M ○ Y

Source of information:* SceThirdDose ○ Patient/caregiver recall ○ Documented

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

Date given* DtFourthDose _____ Or age when 4th dose given AgeFourthDose ____ YMWFourthDose ○ W ○ M ○ Y

Source of information:* SceFourthDose ○ 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)		NoHHold	NoHHoldCou	NoHHoldAbx	NoHHoldVac
Childcare / pre-school contacts		NoCCare	NoCCareCou	NoCCareAbx	NoCCareVac
Other contacts (specify)	OtherContact	NoOther	NoOtherCou	NoOtherAbx	NoOtherVac

Comments

Comments