

Haemophilus influenzae

PATIENT DEMOGRAPHICS

Name (last, first): _____	Birth date: / / _____ Age: _____
Address: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
City/State/Zip: _____	Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
Phone (home): _____ Phone (work) : _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk
Occupation/grade: _____ Employer/School: _____	(Mark all that apply)
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____	

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigator : _____	WVEDSS ID: _____
Investigator phone: _____	Case Classification: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unk
Investigation Start Date: / / _____	

REPORTING SOURCE

Date of report: / / _____	Report Source: <input type="checkbox"/> Laboratory <input type="checkbox"/> Hospital <input type="checkbox"/> Physician <input type="checkbox"/> Public Health Agency <input type="checkbox"/> Other
Report Source Name: _____	Address: _____ Phone: _____
Earliest date reported to county: / / _____	Earliest date reported to state: / / _____
Reporter Name: _____	Address: _____ Phone: _____

CLINICAL

Physician Name: _____	Physician Facility : _____
Physician Address: _____	Phone: _____

Hospital Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospitalized for this illness?	If yes: Hospital name: _____
	Admit date: / / _____ Discharge date: / / _____

Condition	Illness onset date: / / _____	Diagnosis date: / / _____	Illness end date: / / _____
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Types of infection caused by organism:

- | | | | |
|------------------------------------------------|----------------------------------------------------------|------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Abscess (not skin) | <input type="checkbox"/> Bacteremia without focus | <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Chorioamnionitis |
| <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Empyema | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Endometritis |
| <input type="checkbox"/> Epiglottitis | <input type="checkbox"/> Hemolytic uremic syndrome (HUS) | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Necrotizing fasciitis |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Otitis media | <input type="checkbox"/> Pericarditis | <input type="checkbox"/> Peritonitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Puerperal sepsis | <input type="checkbox"/> Septic abortion | <input type="checkbox"/> Septic arthritis |
| <input type="checkbox"/> Other (specify) _____ | | | <input type="checkbox"/> Unknown |

Date first positive culture obtained: / / _____

Sterile sites from which organism was isolated: Blood Bone Cerebral Spinal Fluid Internal body site Joint Muscle
 Pericardial Fluid Peritoneal Fluid Pleural Fluid Other normally sterile site (specify) _____

Nonsterile sites from which organism isolated: Amniotic fluid Middle ear Placenta Sinus Wound Other (specify) _____

Did patient have any underlying medical conditions? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U If yes, specify:
<input type="checkbox"/> AIDS <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Asthma <input type="checkbox"/> Atherosclerotic Cardiovascular Disease <input type="checkbox"/> Burns <input type="checkbox"/> Cerebral vascular accident (CVA)/Stroke <input type="checkbox"/> Cirrhosis/liver failure <input type="checkbox"/> Cochlear implant <input type="checkbox"/> Complement deficiency <input type="checkbox"/> CSF leak (2 deg trauma/surgery) <input type="checkbox"/> Current smoker <input type="checkbox"/> Deaf/profound hearing loss <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Heart failure/CHF <input type="checkbox"/> HIV <input type="checkbox"/> Hodgkin's disease <input type="checkbox"/> Immunoglobulin deficiency <input type="checkbox"/> Immunosuppressive therapy (steroids, chemo) <input type="checkbox"/> IVDU <input type="checkbox"/> Leukemia <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Obesity <input type="checkbox"/> Renal failure/dialysis <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Splenectomy/Asplenia <input type="checkbox"/> Systemic lupus erythematosus (SLE) <input type="checkbox"/> Unknown <input type="checkbox"/> Other prior illness (specify) _____ <input type="checkbox"/> Other malignancy (specify) _____ <input type="checkbox"/> Organ transplant (specify) _____

Did patient die from this illness? Y N U If yes, date of death: / / _____

Condition (cont.)

What was the serotype?

 a b c d e f non-b not tested not typable Unknown Other (specify) _____Was patient < 15 years of age at the time of first positive culture? Y N U**EPIDEMIOLOGIC** Y N U If <6 years of age, is the patient in daycare? If yes, name of day care facility: _____ Y N U Was the patient a resident of a nursing home or other chronic care facility at time of first positive culture?

If yes, name of chronic care facility? _____

 Y N U Is this case part of an outbreak? If yes, name of outbreak? _____

Where was the disease acquired?

 Indigenous, within jurisdiction Out of country Out of jurisdiction, from another jurisdiction Out of state Unknown

Confirmation method:

 Active surveillance Case/Outbreak management Clinical diagnosis (not lab confirmed) Epidemiologically linked Lab confirmed Lab report Local/State specified Medical record review No information given Occupational disease surveillance Provider certified Other (specify): _____Was patient pregnant or post-partum at time of first culture? Y N UIf yes, outcome of fetus: Survived, no apparent illness Survived, clinical infection Live birth, neonatal death Abortion or stillbirth Induced abortion Unknown

If patient < 1 month of age: Gestational age (in weeks) _____ Birth weight (in grams) _____

PUBLIC HEALTH ACTIONS/NOTES Lost to follow-up

