Local Use Only

Haemophilus influenzae Surveillance Worksheet (Abbreviated Worksheet Option)

Appendix 4

NAME (Last, First)				Hospital Record No.
Address (Street and No.)	City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/LabPhone	Address			Phone

DETACH HERE and transmit only lower portion if sent to CDC

1. State (residence of patient) (1-2)

2. County (residence of patient) (3-12)

5. Hospitalized (25) (If yes, date of admission)
1 ☐ Yes
2 ☐ No
Month ☐☐ Day ☐☐ Year ☐☐

3. State ID (13-18) ☐☐☐☐☐☐

4. CDC ID (19-24) ☐☐☐☐☐☐

6. Date of Birth (32-37)
Month ☐☐ Day ☐☐ Year ☐☐

7a). Age (38-39) ☐☐

b) Is age in day/mo/yr? (40)
1 ☐ Days
2 ☐ Months
3 ☐ Years

c) If <6 years of age is patient in daycare? (41)
1 ☐ Yes
2 ☐ No
3 ☐ Unknown
Daycare is defined as a supervised group of 2 or more unrelated children for >4 hours/week

8. Sex (42)
1 ☐ Male
2 ☐ Female

9a. Race (43)
☐
N = Native Amer./Alaskan Native
A = Asian/Pacific Islander
B = African American
W = White
O = Other
U = Unknown

9b. Ethnic Origin (44)
1 ☐ Hispanic
2 ☐ Non-Hispanic

10. Outcome (45)
1 ☐ Survived
2 ☐ Died
3 ☐ Unknown

11. Physician's Name:
_____
_____

12. Type Of Infection Caused By Organism: (check all that apply)

1 ☐ Primary Bacteremia (46)	1 ☐ Cellulitis (50)	1 ☐ Septic Arthritis (54)
1 ☐ Meningitis (47)	1 ☐ Epiglottitis (51)	1 ☐ Conjunctivitis (55)
1 ☐ Otitis Media (48)	1 ☐ Peritonitis (52)	1 ☐ Other (specify) (56)
1 ☐ Pneumonia (49)	1 ☐ Pericarditis (53)	_____ (57-58)

13. Bacterial Species Isolated From Any Normally Sterile Site* (59)
1 ☐ *Neisseria meningitidis*
2 ☐ *Haemophillus influenzae*
3 ☐ *Group B Streptococcus*
4 ☐ *Listeria monocytogenes*
5 ☐ *Streptococcus pneumoniae** (pneumococcus)
8 ☐ Other bacterial species* (specify: Include mycobacteria, fungi)
_____ (60-61)
* (Report *ONLY* CSF isolates for Pneumococcus or Other Bacterial Species)

14. Type Of Infection Caused By Organism: (check all that apply)

1 ☐ Blood (62)	1 ☐ Pleural Fluid (64)	1 ☐ Pericardial fluid (66)	1 ☐ Placenta (68)
1 ☐ CSF (63)	1 ☐ Peritoneal Fluid (65)	1 ☐ Joint (67)	1 ☐ Other Normally Sterile Site (69)

(specify) _____ (70-71)

15. Date First Positive Culture Obtained:
(date specimen drawn)
Month ☐☐ Day ☐☐ Year ☐☐ (72-77)

- IMPORTANT - PLEASE COMPLETE FOR THE FOLLOWING ORGANISMS:

HAEMOPHILUS INFLUENZAE

16a. Did Patient Receive *Haemophilus b* Vaccine (78) 1 ☐ Yes 2 ☐ No 3 ☐ Unknown If YES, please complete the list below

Dose	Date Given (Month Day Year)	Vaccine Name / Manufacturer	Lot Number
1	(79-84) ☐☐ ☐☐ ☐☐	(85) _____ / _____	(86-95) _____
2	(96-101) ☐☐ ☐☐ ☐☐	(102) _____ / _____	(103-112) _____
3	(113-118) ☐☐ ☐☐ ☐☐	(119) _____ / _____	(120-129) _____
4	(130-135) ☐☐ ☐☐ ☐☐	(136) _____ / _____	(137-146) _____

16b. What Was The Serotype (147)
1 ☐ Type b
2 ☐ Not Typable
8 ☐ Other (specify) _____ (148-149)
9 ☐ Not tested or unknown

16c. If *H. Influenzae* Was Isolated From Blood Or CSF, Was It Resistant To:

Ampicillin	(150)	1 ☐ Yes	2 ☐ No	9 ☐ Not tested or unknown
Cloramphenicol	(151)	1 ☐ Yes	2 ☐ No	9 ☐ Not tested or unknown
Rifampin	(152)	1 ☐ Yes	2 ☐ No	9 ☐ Not tested or unknown

CS106190