Local Use Only

Haemophilus influenzae Surveillance Worksheet (Expanded Worksheet Option)

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

DEMOGRAPHIC INFORMATION

1. Patient Date of Birth ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

2. Reported Age: ☐☐☐ ☐ YEARS ☐ DAYS ☐ HOURS ☐ MONTHS ☐ WEEKS ☐ UNKNOWN

3. Sex ☐ MALE ☐ FEMALE ☐ UNKNOWN

4. Ethnicity ☐ HISPANIC ☐ NOT HISPANIC ☐ UNKNOWN

5. Race: ☐ American Indian or Alaska Native ☐ White ☐ Asian ☐ Other ________ ☐ Black or African-American ☐ Unknown ☐ Native Hawaiian or Other Pacific Islander

6. Identification Information as of ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

Type ______________ Assigning Authority ________

ID Value ____________________

INVESTIGATION

INVESTIGATION SUMMARY

7. Jurisdiction: ______________________

8. Program Area **(state assigned):** ______________

9. State class ID number: ______________

10. Investigation start date ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

11. Investigation status ☐ Open ☐ Closed

12. Share record with guests of this jursidiction and program area? ☐ Yes ☐ No

INVESTIGATOR

13. Last Name: ______________________

14. First Name: ______________________

15. E-mail: ______________________

16. Investigation status ☐☐☐ ☐☐☐ ☐☐☐☐

17. Date assigned to investigation ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

18. Type of insurance

☐ MEDICARE ☐ INDIAN HEALTH SERVICE (IHS) ☐ NO HEALTHCARE COVERAGE

☐ MILITARY/ VA ☐ PRIVATE/ HMO/PPO/MANAGED CARE PLAN ☐ UNKNOWN

☐ MEDICAID/ STATE ASSISTANCE PROGRAM ☐ OTHER **(SPECIFY)** ______________________

19a. WEIGHT

________**lbs** ________**oz OR** ________ **kg** ☐ unknown

19b. HEIGHT

________**Ft** ________**in OR** ________ **cm** ☐ unknown

REPORTING SOURCE

20. Date of report ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

21. Source name: ______________________

22. City: ______________________

23. State: ____________ Zip +4 ____________

24. County: ______________________

EARLIEST DATE REPORTED TO:

25. County: ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

26. State: ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

REPORTER

27. Last name: ______________________

28. First name: ______________________

29. Person ID: ______________________

30. E-mail: ______________________

31. Telephone: ☐☐☐ ☐☐☐ ☐☐☐☐

Extension: ☐☐☐☐

CLINICAL

PHYSICIAN

32. Last name: ______________________ **33. First name:** ______________________

34. E-mail: ______________________ **35. Telephone:** ☐☐☐ ☐☐☐ ☐☐☐☐ **Extension:** ☐☐☐☐

HOSPITAL

36. Was the patient hospitalized for this illness?

☐ Yes ☐ No ☐ UNKNOWN

37. Hospital name: ____________________

38. Hospital ID: ____________________

39. Hospital ID Type: ____________________

40. Admission Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

41. Discharge Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

42.Total duration of stay within hospital: ☐☐☐ Days

43a. Hospital/lab iD where culture identified: ☐☐☐☐☐

43b. Hospital iD where patient treated: ☐☐☐☐☐

44a. Was patient transferred from another hospital?

☐ Yes ☐ No ☐ Unknown

44b. If Yes, hospital iD ☐☐☐☐☐

45. Illness Onset Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

46. Illness End Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

47. Types of infection caused by organism (CHECK ALL THAT APPLY)

- ☐ Bacteremia without focus
- ☐ Abscess (not skin)
- ☐ Empyema
- ☐ Meningitis
- ☐ Peritonitis
- ☐ Endocarditis
- ☐ Otitis media
- ☐ Pericarditis
- ☐ Endometritis
- ☐ Pneumonia
- ☐ Septic abortion
- ☐ STSS
- ☐ Cellulitis
- ☐ Chorioamnionitis
- ☐ Necrotizing fasciitis
- ☐ Epiglotitis
- ☐ Septic arthritis
- ☐ Puerperal sepsis
- ☐ Hemolytic uremic syndrome (HUS)
- ☐ Osteomyelitis
- ☐ Other infection ____________

48a. Bacterial species isolated from any normally sterile site (CHECK ALL THAT APPLY)

- ☐ *Neisseria meningitidis*
- ☐ Abscess (not skin)
- ☐ *Haemophilus influenzae*
- ☐ Group A streptococcus
- ☐ Group B streptococcus
- ☐ *Streptococcus pneumoniae*

48b. Other bacterial species isolated from any normally sterile site

____

____

____

49. Sterile sites from which organism isolated: (CHECK ALL THAT APPLY)

- ☐ Blood
- ☐ Peritoneal fluid
- ☐ Bone
- ☐ CSF
- ☐ Pericardial fluid
- ☐ Muscle
- ☐ Pleural fluid
- ☐ Joint

Specify

- ☐ Internal body site ____________________
- ☐ Other normally sterile site ____________________

50. Date first positive culture obtained: (date specimen drawn)

☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

51. Other nonsterile sites from which organism isolated: (CHECK ALL THAT APPLY)

- ☐ Placenta
- ☐ Middle ear
- ☐ Amniotic fluid
- ☐ Sinus
- ☐ Wound
- ☐ Other nonsterile site ____________

52. Underlying causes or prior illness: (CHECK ALL THAT APPLY)

- ☐ Current smoker
- ☐ Multiple myleoma
- ☐ Sickle cell anemia
- ☐ Splenectomy / asplenia
- ☐ Immunoglobulin deficiency
- ☐ Immunosupressive therapy (Steroids, Chemotherapy, Radiation)
- ☐ Leukemia
- ☐ Hodgkin disease
- ☐ Asthma
- ☐ Emphysema / COPD
- ☐ Systemic lupus erythematosus (SLE)
- ☐ Diabetes mellitus
- ☐ Nephrotic syndrome
- ☐ Renal failure/Dialysis
- ☐ HIV infection
- ☐ AIDS or CD4 count <200
- ☐ Cochlear implant
- ☐ Deaf / profound hearing loss
- ☐ Cirrhosis / Liver failure
- ☐ Alcohol Abuse
- ☐ Atherosclerotic Cardiovascular Disease (ASCVD) / (CAD)
- ☐ Heart failure / CHF
- ☐ Obesity
- ☐ CSF leak
- ☐ IVDU
- ☐ Cerebral vascular accident (CVA) / Stroke
- ☐ Complement deficiency

Specify

- ☐ Other malignancy ____________________
- ☐ Organ transplant ____________________
- ☐ Other prior illness ____________________

53. Was patient pregnant / post partum at time of first positive culture? ☐ Yes ☐ No ☐ Unknown

If yes, outcome of fetus

- ☐ Survived, no apparent illness
- ☐ Survived, clinical infection
- ☐ Live birth / neonatal death
- ☐ Abortion / stillbirth
- ☐ Induced abortion
- ☐ Unknown

54. Is the patient <1 month of age? ☐ Yes ☐ No ☐ Unknown If yes, time of birth: _____:_____

Gestational age: ☐☐(wks) Birth weight: ☐☐☐☐(gms)

55. Did the patient die from this illness? ☐ Yes ☐ No

56. What was the serotype?

☐ a ☐ d ☐ Not Typable
☐ b ☐ e ☐ Not Tested or Unknown
☐ c ☐ f ☐ Other ___________________

57. Was the patient <15 years of age at the time of the first positive culture ☐ Yes ☐ No ☐ Unknown

58. Birth Country:

____

59. Type of insurance: (CHECK ALL THAT APPLY)

☐ Medicare
☐ Military/VA
☐ Medicaid/state assistance program
☐ Indian Health Service (IHS)
☐ Private/HMO/PPO/managed care plan
☐ No health care coverage
☐ Unknown
☐ Other Insurance_________________________________

60. Is there a known previous contact with Hib disease within the preceding two months? ☐ Yes ☐ No ☐ Unknown

If yes specify type of contact: ____

61. Significant past medical history: ____

____

____

If pre-term birth (<37 weeks). Specify weeks: ________________

Serum availability

Is acute serum available? ☐ Yes ☐ No ☐ Unknown
Date: ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

Is convalescant serum available? ☐ Yes ☐ No ☐ Unknown
Date: ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

62. If <15 years of age and serotype “b” or “unk”, did patient receive *Haemophilus influenzae* b vaccine? ☐ Yes ☐ No ☐ Unknown

Dose	Date Given (MONTH / DAY / YEAR)	Vaccine Name/Manufacturer	Lot Number
1	☐☐ ☐☐ ☐☐☐☐	____________________	____________
2	☐☐ ☐☐ ☐☐☐☐	____________________	____________
3	☐☐ ☐☐ ☐☐☐☐	____________________	____________
4	☐☐ ☐☐ ☐☐☐☐	____________________	____________

Epidemiologic

63. Does this patient: (CHECK ALL THAT APPLY)

Attend a day care* facility ☐ Yes ☐ No ☐ Unknown **Facility name** ______________________________

*DAY CARE IS DEFINED AS A SUPERVISED GROUP OF 2 OR MORE UNRELATED CHILDREN FOR >4 HOURS PER WEEK.

Reside in a long term care facility? ☐ Yes ☐ No ☐ Unknown **Facility name** ______________________________

64. Is this case part of an outbreak? ☐ Yes ☐ No ☐ Unknown **Outbreak name** ______________________________

Where was this disease acquired? ____

Imported Country: ______________________ Imported City: ______________________

Imported State: ______________________ Imported County: ______________________

CONFIRMATION METHOD

65. Case status:

☐ Confirmed ☐ Not a case
☐ Probable ☐ Unknown
☐ Suspect

66. Does this patient have recurrent disease with the same pathogen?

☐ Yes ☐ No ☐ Unknown

If yes, previous (1st) state I.D. ☐☐☐☐☐☐☐

67. CRF Status:

☐ Complete
☐ Incomplete
☐ Edited & Correct
☐ Chart unavailable after 3 requests

General Comments: ____

____

____