

## INVASIVE HAEMOPHILUS INFLUENZAE DISEASE CASE REPORT

### PATIENT DEMOGRAPHICS

Patient name—last	first	middle initial	Date of birth ____/____/____	Age (enter age and check one) ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (number, street)			City	State	ZIP code
					County

**ETHNICITY** (check one)     Hispanic or Latino     Not Hispanic or Latino     Unknown

**RACE** (check all that apply)

<input type="checkbox"/> Unknown	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> African-American or Black	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Guamanian
<input type="checkbox"/> White	<input type="checkbox"/> Chinese	<input type="checkbox"/> Samoan
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Pacific Islander: _____
<input type="checkbox"/> Hmong	<input type="checkbox"/> Japanese	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Thai	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Asian: _____
<input type="checkbox"/> Laotian		

Occupation (check all that apply)

Food service     Health care     Day care     School     Correctional facility     Other: \_\_\_\_\_

Country of birth \_\_\_\_\_ Country of residence \_\_\_\_\_

### COMMON LHD TRACKING DATA

CMRID number	IZB Case ID number	Web CMR ID number
Date reported to county ____/____/____	Date investigation started ____/____/____	Person/clinician reporting case
		Reporter telephone (      )
Case investigator completing form	Investigator telephone (      )	Investigator's LHD or jurisdiction

### CLINICAL SYNDROME

(check all that apply)

Meningitis     Bacteremia     Epiglottitis     Pneumonia     Other, describe: \_\_\_\_\_

Date of onset of symptoms: \_\_\_\_/\_\_\_\_/\_\_\_\_    Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Does case meet clinical criteria for further investigation?     Yes     No     Unknown

**CASE MEETS CDC/CSSTE CLINICAL CRITERIA? (FOR STATE USE ONLY)**     Yes     No     Unknown

### COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days hospitalized _____	Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of death ____/____/____	Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Describe other complications \_\_\_\_\_

### TREATMENT

1. Were antibiotics given <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Antibiotic 1 code _____	Date started ____/____/____	Antibiotic codes:    1 = Cefotaxime sodium    6 = Rifampin 2 = Ceftriaxone sodium    7 = Other 3 = Ampicillin                    8 = None 4 = Chloramphenicol            9 = Unknown 5 = Ampicillin and chloramphenicol
2. Were antibiotics given <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Antibiotic 2 code _____	Date started ____/____/____	

### LABORATORY TESTS

Any lab tests done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CASE LAB CONFIRMED (FOR LHD USE) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CASE LAB CONFIRMED (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Culture <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen date ____/____/____	Source of specimen <input type="checkbox"/> Blood <input type="checkbox"/> Joint <input type="checkbox"/> CSF <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Placenta <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Pericardial fluid
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Culture result <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U	LAB RESULT CODES P=Positive    I=Indeterminate    X=Not done N=Negative    E=Pending        U=Unknown
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Was isolate serotyped?     Yes     No     Unknown

Isolate serotype     Type B     Not typeable     Other type: \_\_\_\_\_     Unknown

Isolate forwarded to MDL for testing?     Yes     No     Unknown

Date sent: \_\_\_\_/\_\_\_\_/\_\_\_\_    MDL serotype: \_\_\_\_\_

Isolate forwarded to CDC for testing?     Yes     No     Unknown

Date sent: \_\_\_\_/\_\_\_\_/\_\_\_\_    CDC serotype: \_\_\_\_\_

CSF bacterial antigen screen     Yes     No     Unknown

CSF bacterial antigen screen results     P     N     U

**VACCINATION/MEDICAL HISTORY**

Is case ≤ 15 years of age?  Yes  No  Unknown (If no, skip to question regarding pregnancy.)

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Received one or more doses of HIB-containing vaccine  Yes  No  Unknown

Number of doses prior to illness onset \_\_\_\_\_

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Vaccination dates—Dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 2: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 3: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 4: \_\_\_\_/\_\_\_\_/\_\_\_\_

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Reason not vaccinated

1  Personal Beliefs Exemption (PBE) 4  Lab confirmation of previous disease 7  Delay in starting series or between doses  
 2  Permanent Medical Exemption (PME) 5  MD diagnosis of previous disease 8  Other  
 3  Temporary Medical Exemption 6  Under age for vaccination 9  Unknown

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Pregnant  Yes  No  Unknown Immunocompromised  Yes  No  Unknown

**TRANSMISSION AND CONTACT INVESTIGATION**

Spread setting (check all that apply)

1  Day care 4  Hospital ward 7  Home 10  College 13  Church  
 2  School 5  Hospital ER 8  Work 11  Military 14  International travel  
 3  Doctor's office 6  Outpatient hospital clinic 9  Unknown 12  Correctional Facility 15  Other

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Number of contacts for whom antibiotic was recommended \_\_\_\_\_ Number of ill contacts \_\_\_\_\_

**CASE CLASSIFICATION (FOR LHD USE)**  Confirmed  Probable  Suspect  Not a case  Unknown

**CASE CLASSIFICATION (FOR STATE USE ONLY)**  Confirmed  Probable  Suspect  Not a case  Unknown

**HAEMOPHILUS INFLUENZAE INVASIVE DISEASE CASE CLASSIFICATION**

Clinical Description: Invasive disease caused by Haemophilus influenzae may produce any of several clinical syndromes, including meningitis, bacteremia, epiglottitis, or pneumonia.

Laboratory Criteria for Diagnosis: Isolation of Haemophilus influenzae from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid)

Case Classification:  
 Probable: a clinically compatible case with detection of Haemophilus influenzae type b antigen in CSF  
 Confirmed: a clinically compatible case that is laboratory confirmed