West Virginia Bureau for Public Health
Department of Health & Human Resources
Your Health Your Safety Our Purpose

Haemophilus influenzae

PATIENT DEMOGRAPHICS

Name (last, first): ________________________________
Address: ________________________________
City/State/Zip: ________________________________
Phone (home): ____________ Phone (work) : ____________
Occupation/grade:____________ Employer/School:____________
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
Name: ____________ *Phone:* ____________

Birth date: __ / __ / ____ Age: _____
Gender: ☐Male ☐Female ☐Unk
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): ____________
Investigator : ____________
Investigator phone: ____________
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: ____________
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unk

REPORTING SOURCE

Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐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
☐ ☐ ☐ Hospitalized for this illness?
If yes: Hospital name: ____________
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Condition Illness onset date: __ / __ / ____ Diagnosis date: __ / __ / ____ Illness end date: __ / __ / ____

Types of infection caused by organism:
☐ Abscess (not skin) ☐ Bacteremia without focus ☐ Cellulitis ☐ Chorioamnionitis
☐ Conjunctivitis ☐ Empyema ☐ Endocarditis ☐ Endometritis
☐ Epiglottitis ☐ Hemolytic uremic syndrome (HUS) ☐ Meningitis ☐ Necrotizing fasciitis
☐ Osteomyelitis ☐ Otitis media ☐ Pericarditis ☐ Peritonitis
☐ Pneumonia ☐ Puerperal sepsis ☐ Septic abortion ☐ Septic arthritis
☐ Other (specify) ____________ ☐ 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? ☐ **Y** ☐ **N** ☐ **U** If yes, specify:
☐ AIDS ☐ Alcohol abuse ☐ Asthma
☐ Atherosclerotic Cardiovascular Disease ☐ Burns ☐ Cerebral vascular accident (CVA)/Stroke
☐ Cirrhosis/liver failure ☐ Cochlear implant ☐ Complement deficiency
☐ CSF leak (2 deg trauma/surgery) ☐ Current smoker ☐ Deaf/profound hearing loss
☐ Diabetes mellitus ☐ Emphysema/COPD ☐ Heart failure/CHF
☐ HIV ☐ Hodgkin's disease ☐ Immunoglobulin deficiency
☐ Immunosuppressive therapy (steroids, chemo) ☐ IVDU ☐ Leukemia
☐ Multiple myeloma ☐ Nephrotic syndrome ☐ Obesity
☐ Renal failure/dialysis ☐ Sickle cell anemia ☐ Splenectomy/Asplenia
☐ Systemic lupus erythematosus (SLE) ☐ Unknown ☐ Other prior illness (specify)____________
☐ Other malignancy (specify) ____________ ☐ 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** ☐ **U**

If 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

Contact Tracing Sheet

Name/Contact Information (including guardian information for minors)	Household Contact (Y/N)	Age	Relationship to case?	Exposure date (mm/dd/yyyy)	Exposure setting	Exposure Mode	PEP given? (Y/N)	Date PEP given (mm/dd/yyyy)	PEP given by whom?

* PEP = Post-exposure prophylaxis

Number of contacts in any setting recommended PEP: _____

Y=Yes N=No U=Unknown