Haemophilus influenzae Surveillance Worksheet (Expanded Worksheet Option) Local Use Only

	Expanded II of	Ronoot Option,			
NAME (Last, First)			Hosp	ital Record No.	
Address (Street and No.)	City	County	Zip	Phone	
Reporting Physician/Nurse/Hospital/Clinic/LabPhone	Address			Phone	

DETACH HERE and transmit on	ly lower portion if sent to CDC				
DEMOGRAPHI	CINFORMATION				
1. Patient Date of Birth DAY 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 Type Assigning Authority ID Value ID Value				
INVEST	- FIGATION				
INVESTIGATION SUMMARY	INVESTIGATOR				
7. Jurisdiction:	13. Last Name:				
8. Program Area (state assigned):	14. First Name:				
9. State class ID number:	15. E-mail:				
10. Investigation start date MONTH DAY YEAR	16. Investigation status				
11. Investigation status Open Closed	17. Date assigned to investigation DAY DAY YEAR				
12. Share record with guests of this jursidiction and program area?	WONTE DAT TEAD				
18. Type of insurance					
MEDICARE INDIAN HEAL	TH SERVICE (IHS) NO HEALTHCARE COVERAGE				
MILITARY/ VA PRIVATE/ HM	O/PPO/MANAGED CARE PLAN UNKNOWN				
MEDICAID/ STATE ASSISTANCE PROGRAM OTHER (SPEC	IFY)				
19a. WEIGHT	19b. HEIGHT				
lbsoz ORkg unknown	Ftin ORcmunknown				
REPORTIN	NG SOURCE				
20. Date of report	REPORTER				
MONTH DAY YEAR	27. Last name:				
21. Source name:	28. First name:				
23. State: Zip +4	29. Person ID:				
24. County:	31. Telephone:				
EARLIEST DATE REPORTED TO:					
25. County: 26. State:	Extension:				
MONTH DAY YEAR MONTH DAY YEAR					
CLINICAL					
PHYSICIAN					
32. Last name: 33. First name:					
34. E-mail: 35. Telephone:					

HOSPITAL	43a. Hospital/lab iD where culture	43b. Hospital iD where patient	
36. Was the patient hospitalized for this illness?	identified:	treated:	
Yes No UNKNOWN			
37. Hospital name:	44a. Was patient transferred from	44b. If Yes, hospital iD	
38. Hospital ID:	another hospital?	145. II 165, Hoopital 15	
39. Hospital ID Type:			
40. Admission Date: 41. Discharge Date:	Yes No Unknown		
	45. Illness Onset Date:	46. Illness End Date:	
MONTH DAY YEAR MONTH DAY YEAR			
42.Total duration of stay within hospital: Days	MONTH DAY YEAR	MONTH DAY YEAR	
47. Types of infection caused by organism (CHECK ALL THAT APPLY)	48a. Bacterial species isolated from (CHECK ALL THAT APPLY)	m any normally sterile site	
Bacteremia Abscess (not skin) Empyema	Neisseria meningitidis	Abscess (not skin)	
Meningitis Peritonitis Endocarditis	Haemophilus influenzae	Group A streptococcus	
Otitis media Pericarditis Endometritis	Group B streptococcus	Streptococcus pneumoniae	
Pneumonia Septic abortion STSS	48b. Other bacterial species isolated from any normally sterile site		
Cellulitis Chorioamnionitis Necrotizing fasciitis			
Epiglotitis Septic arthritis Puerperal sepsis			
Hemolytic uremic Syndrome (HUS) Osteomyelitis Other infection			
49. Sterile sites from which organism isolated: (CHECK ALL 50. Date first positive culture obtained: (date specimen dra		ned: (date specimen drawn)	
THAT APPLY)			
Blood Peritoneal fluid Bone	MONTH DAY YEAR		
CSF Pericardial fluid Muscle	51. Other nonsterile sites from which organism isolated: (CHECK ALL THAT APPLY)		
		THAT APPLY)	
Pleural fluid	Placenta Middle ear	THAT APPLY)	
Pleural fluid	☐ Placenta ☐ Middle ear ☐ Amniotic fluid ☐ Sinus	THAT APPLY)	
Specify	Amniotic fluid Sinus	THAT APPLY)	
Specify Internal body site	Amniotic fluid Sinus		
Specify Internal body site Other normally sterile site	Amniotic fluid Sinus		
Specify Internal body site Other normally sterile site 52. Underlying causes or prior illness: (CHECK ALL THAT APPLY)	Amniotic fluid Sinus Wound Other nonsteri	le site	
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Specify Internal body site Other normally sterile site 52. Underlying causes or prior illness: (CHECK ALL THAT APPLY) Current smoker Hodgkin disease Multiple myleoma Sickle cell anemia Emphysema / COPD	Amniotic fluid Sinus Wound Other nonsteri HIV infection AIDS or CD4 count <200 Cochlear implant	Heart failure / CHF Obesity CSF leak	
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56. What was the serotype?		59. Type of insurance: (CHECK ALL T	HAT APPLY)		
☐ a ☐ d	☐ Not Typable	☐ Medicare			
□ b □ e	☐ Not Tested or Unknown	☐ Military/VA			
□ c □ f	Other	☐ Medicaid/state assistance progra	ım		
E7 Was the matter of the first		☐ Indian Health Service (IHS)			
57. Was the patient <15 years of a		☐ Private/HMO/PPO/managed care	e plan		
of the first positive culture	Yes No Unknown	☐ No health care coverage			
58. Birth Country:		Unknown			
Co. 2		Other Insurance			
60. Is there a known previous con	tact with Hib disease within the pre	eceding two months? Yes	No Unknown		
If yes specify type of contact:					
61 Cignificant past madical history	***				
61. Significant past medical histor	ry:				
If pre-term birth (<37 weeks). Spe	cify weeks:				
Serum availability					
Is acute serum available? Yes	No Unknown	Is convalescant serum available?	Yes No Unknown		
	INO CIRCIOWII				
Date:	DAY YEAR	Date: L	MONTH DAY YEAR		
62. II < 15 years of age and seroty	e b or unk, did patient receive	maemophilus innuenzae b vaccine?	Yes No Unknown		
Date Given	Vaccine	Name/Manufacturer	Lot Number		
MONTH DAY YEAR		Name/Wandactarer	Lot Number		
1					
3					
4					
	. Enide	miologic			
63. Does this patient: (CHECK ALL T		mologio			
Co. Bocs tine patient: (oneox ALE)					
Attend a day care* facility	Yes No Unknown Fa	icility name			
*DAY CARE IS DEFINED AS A SUPERVIS	SED GROUP OF 2 OR MORE UNRELATED CHILI	DREN FOR >4 HOURS PER WEEK.			
Reside in a long term care fac	ility? Yes No Unk	nown Facility name			
64. Is this case part of an outbrea	k? Yes No Unknow	wn Outbreak name			
Where was this disease acquire	ed?				
Imported Country: Imported City:					
	Imported County:				
CONFIRMATION METHOD					
65. Case status:	66. Does this patient have recurrer	nt disease with the same pathogen?	67. CRF Status:		
☐ Confirmed ☐ Not a case			☐ Complete ☐ Chart		
Probable Unknown	Yes No Unkn	own	unavailable		
Suspect	If yes, previous (1st) state I.D.		Edited & Correct requests		
Guspect			Laitea & Correct		
General Comments:					