Haemophilus influenzae Surveillance Worksheet

NAME _____ (last) _____ (first) **ADDRESS (Street and No.)** _____ **Phone** _____ **Hospital Record No.** _____

This information will not be sent to CDC

REPORTING SOURCE TYPE
☐ physician ☐ PH clinic
☐ nurse ☐ laboratory
☐ hospital ☐ other clinic
☐ other source type _____

NAME _____
ADDRESS _____
ZIP CODE _____
PHONE (__ __ __) __ __ __ __ __ __ __

SUBJECT ADDRESS CITY _____
SUBJECT ADDRESS STATE _____
SUBJECT ADDRESS COUNTY _____
SUBJECT ADDRESS ZIP CODE __ __ __ __ __
LOCAL SUBJECT ID _____

CASE INFORMATION

Date of Birth __ __ __ __ __ __ __ __ (month day year)
Sex M=male F=female ☐
Ethnic Group H=Hispanic or Latino O=Other _____ N=Not Hispanic/Latino U=Unknown ☐

Race ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Not asked ☐ Refused to answer ☐Other ☐ Unknown

Country of Birth _____ **Other Birth Place** _____ **Country of Usual Residence** _____

Age at Case Investigation _____ **Age Unit*** _____ **Reporting County** _____ **Reporting State** _____

Date Reported __ __ __ __ __ __ __ __ (month day year)
Date First Reported to PHD __ __ __ __ __ __ __ __ (month day year)
National Reporting Jurisdiction ____

Ealiest Date Reported to County __ __ __ __ __ __ __ __ (mm/dd/yyy)
Earliest Date Reported to State __ __ __ __ __ __ __ __ (mm/dd/yyy)

Case Class Status ☐ Suspected ☐ Probable ☐ Confirmed ☐ Unknown ☐ Not a case
Case Investigation Start Date __ __ __ __ __ __ __ __ (month day year)

CASE INVESTIGATION STATUS CODE ☐ approved ☐ closed ☐deleted ☐in progress ☐notified ☐ rejected ☐ other_____ ☐ ready for review ☐ reviewed ☐suspended ☐unknown

ABCs State ID _____
Bacterial Species Isolated _____

CLINICAL INFORMATION

Illness Onset Date __ __ __ __ __ __ __ __ (month day year)
Illness End Date __ __ __ __ __ __ __ __ (month day year)
Illness Duration ____
Duration Units* _____

Illness Onset Age ☐☐☐
Illness Onset Age Units* ☐☐☐
Date of Diagnosis __ __ __ __ __ __ __ __ (month day year)
Pregnancy Status Y=yes N=no U=unknown ☐

Hospitalized? Y=yes N=no U=unknown ☐
Hospital Admission Date __ __ __ __ __ __ __ __ (month day year)
Hospital Discharge Date __ __ __ __ __ __ __ __ (month day year)

Duration of Hospital Stay 0 – 998 999=unknown ____ (days)
Epi-linked to a laboratory-confirmed case? Y=yes N=no U=unknown ☐

Did patient have any underlying causes or prior illnesses? Y=yes N=no U=unknown ☐ **If "yes" select below:**

Underlying Conditions	Y	N	U		Y	N	U		Y	N	U		Y	N	U
AIDS				Congestive heart failure				Immunoglobulin deficiency				Parkinson's disease			
Alcohol abuse				Connective tissue disorder				Immunosuppressive therapy				Peptic ulcer			
Asthma				Coronary arteriosclerosis				Intravenous drug user				Peripheral neuropathy			
Blood Cancer				Corticosteroids				Kidney disease				Peripheral vascular disease			
Bone marrow transplant				CSF leak				Leukemia				Premature birth			
Broken skin				Current chronic dialysis				Missing spleen				Renal failure/dialysis			
Cancer				Current smoker				Multiple myeloma				Seizure disorder			
Cancer treatment				Deaf/profound hearing loss				Multiple sclerosis				Sickle cell trait			
Cerebrovascular accident				Dementia				Myocardial infarction				Solid organ malignancy			
Chronic hepatitis C				Diabetes mellitus				Nephrotic syndrome				Solid organ transplant			
Chronic respiratory disease				Emphysema/COPD				Neuromuscular disorder				Splenectomy/asplenia			
Cirrhosis/liver failure				Former smoker				None				Systemic lupus erythematosus			
Cochlear prosthesis				Hodgkin's disease				Obesity				Trouble swallowing			
Complement deficiency				HIV infection				Paralysis				Unknown			

[Y=yes; N=no; U=unknown]

Other (specify) _____

TYPES OF INFECTION CAUSED BY ORGANISM

☐	Abortion with sepsis	☐	Cellulitis	☐	Epiglottitis	☐	Osteomyelitis	☐	Pneumonia
☐	Abcess (not skin)	☐	Chorioamnionitis	☐	Hemolytic Uremic Syndrome	☐	Other (specify) _____	☐	Puerperal septicemia
☐	Asymptomatic bacteremia	☐	Empyema	☐	Infective arthritis	☐	Otitis media	☐	Septic shock
☐	Bacteremia without focus	☐	Endocarditis	☐	Meningitis	☐	Pericarditis	☐	Staphylococcal Toxic Shock
☐	Bacterial septicemia	☐	Endometritis	☐	Necrotizing fasciitis	☐	Peritonitis	☐	Unknown

UNITS a=year d=day h=hour min=minute mo=month s=second wk=week UNK=unknown

Does this patient attend a day care facility? ☐ Y=yes N=no U=unknown **Facility Name** _____

Does this patient reside in a long-term care facility? ☐ Y=yes N=no U=unknown **Facility Name** _____

Did patient have known previous contact(s) with a Hib disease within the preceding 2 months? Y=yes N=no U=unknown ☐

If "yes" above, select type:

TYPE OF PREVIOUS CONTACT							
☐	Classmate	☐	Father	☐	Nursing home	☐	Sibling
☐	Co-worker	☐	Mother	☐	Other family member	☐	Unknown
☐	Daycare	☐	None	☐	Other (specify) _____		

Did patient have known previous contact(s) with a non-b or nontypeable case of *H. influenzae* disease within the preceding 2 months? Y=yes N=no U=unknown ☐

If "yes" above, select type:

TYPE OF PREVIOUS CONTACT							
☐	Classmate	☐	Father	☐	Nursing home	☐	Sibling
☐	Co-worker	☐	Mother	☐	Other family member	☐	Unknown
☐	Daycare	☐	None	☐	Other (specify) _____		

Weight at Diagnosis ☐☐☐ **Weight Units** gram ☐ kilogram ☐ ounce ☐ pound ☐

Height at Diagnosis ☐☐ **Height Units** ☐ centimeter inch ☐

Recurrent disease with pathogen? Y=yes N=no U=unknown ☐

State ID of 1st occurrence for this pathogen? _____

Pregnancy status at time of first positive culture: ☐ Not pregnant nor postpartum ☐ Currently Pregnant ☐ Postpartum ☐ Unknown

If pregnant or postpartum, what was the outcome of the fetus? (select below)

FETAL OUTCOME							
☐	Abortion/still birth	☐	Live birth/neonatal death	☐	Survived, clinical infection	☐	Unknown
☐	Induced abortion	☐	Still pregnant	☐	Survived, no apparent illness		

If patient <1 month of age: Gestational age (weeks) ☐☐ **Birth weight** ☐☐☐

Premature at birth [for children <2 years of age]? Y=yes N=no U=unknown ☐

Birth Weight Units Gram ☐ Kilogram ☐ Ounce ☐ Pound ☐

RESIDENCE LOCATION AT TIME OF INITIAL CULTURE

☐Home ☐Non-medical ward ☐Incarcerated
☐College dorm ☐Homeless ☐Long-term acute care
☐Long-term care ☐Other _____ ☐Unknown

Subject died? Y=yes N=no U=unknown ☐

Deceased Date __ __ __ __ __ __ __ __ (mm/dd/yyyy)

TYPE OF INSURANCE

☐ Incarcerated ☐ Indian Health Service ☐ Managed Care ☐ Managed Care (unspecified) ☐ MEDICAID
☐ MEDICARE ☐ Military/VA ☐ Private Health ☐ Other (specify) _____ ☐ Uninsured ☐ Unknown

IMPORTATION AND EXPOSURE INFORMATION

CASE DISEASE IMPORTED CODE

☐	Indigenous	☐	In state, out of jurisdiction	☐	Unknown
☐	International	☐	Out of state	☐	Yes, imported, but not able to determine source state/country

Imported Country _____ **Imported State** _____ **Imported County** _____ **Imported City** _____

Country of Exposure _____ **State or Province of Exposure** _____

County of Exposure _____ **City of Exposure** _____

Outbreak related? Y=yes N=no U=unknown ☐ **Outbreak Name** _____ **Transmission Mode** _____

LABORATORY INFORMATION

VPD Lab Message Reference Laboratory	VPD Lab Message Patient Identifier	VPD Lab Message Specimen Identifier
_____	_____	_____

Was there laboratory testing done to confirm the diagnosis? Y=Yes N=No U=Unknown ☐

Was case laboratory confirmed? Y=yes N=no U=unknown ☐

Was a specimen sent to CDC for testing? Y=yes N=no U=unknown ☐

Test Type	Test Result	Date Specimen Collected (mm dd yyyy)	Test Result Quantitative	Result Units	Test Method	Test Manufacturer	Date Specimen Sent to CDC (mm dd yyyy)	Specimen Type	Serotype	Serotype Method	Lab Accession Number	Performing Laboratory Name	Performing Laboratory Type

LABORATORY TESTING CODES

Lab Test Type

1=antigen
2=susceptibility
3=culture
4=genotyping
5=Gram stain
6=immunohistochemistry
7=latex agglutination
8=other (specify)
9=unknown
10=PCR
11=serotyping
12=species confirmation
13=genome sequencing

Specimen Source

1=amniotic fluid	13=liver	25=pleural fluid
2=BAL	14=lung	26=purpuric lesions
3=blood	15=lymph node	27=respiratory secretions
4=bone	16=middle ear	28=serum
5=brain	17=muscle/fascia/tendon	29=sinus
6=CSF	18=NP swab	30=spleen
7=heart	19=oropharyngeal swab	31=sputum
8=other	20=ovary	32=stool
9=unknown	21=pancreas	33=tracheal aspirate
10=internal body site	22=pericardial fluid	34=urine
11=joint	23=peritoneal fluid	35=vascular tissue
12=kidney	24=placenta	36=vitreous
	37=wound	

Serotype Method

1=other 2=PCR 3=Quellung
4=whole genome sequencing 5=unknown

Serotype

1=A	3=C	5=E	7=non-typeable	9=unknown
2=B	4=D	6=F	8=other (specify)	10=not tested

Test Result Interpretation

P=positive N=negative I=indeterminate E=pending
S=significant rise in titer NS=no significant rise in titer
Q=equivocal X=not done O=other U=unknown
V=vaccine type strain W=wild type strain

Performing Laboratory Type

1=CDC lab 2=commercial lab 3=hospital lab 4=other clinical lab
5=public health lab 6=VPD testing lab 8=other (specify) 9=unknown

Lab Test Method

A=Antigen Card B=BD Directigen BCT=Blood culture
BC=BCID Blood culture panel MA=MALDI Biotyper
ME=meningitis/encephalitis panel O=Other (specify)
W=Wellcogen Rapid Antigen U=Unknown

Was any susceptibility data available? Y=yes N=no U=unknown ☐

Antimicrobial Susceptibility Test Type	Test Method	Susceptibility Interpretation	Test Manufacturer	Performing Laboratory Name	Performing Laboratory Type

SUSCEPTIBILITY TEST METHOD CODES

A=AGAR Agar dilution method
B=BROTH Broth dilution method
C=DISK DISK dilution (Kirby Bauer)
G=whole genome sequencing
S=STRIP Gradient strip (E-test)
I=Automated testing instrument

SUSCEPTIBILITY RESULT CODES

R=RESISTANT **S**=SUSCEPTIBLE **U**=UNKNOWN
I=INTERMEDIATE **N**=NOT DONE

VACCINATION HISTORY INFORMATION

Vaccinated (has the case-patient ever received a vaccine against this disease)? Y=yes N=no U=unknown ☐

Number of vaccine doses against this disease received prior to illness onset? 0–6 99=unknown ☐☐ (doses)

Date of last vaccine dose against this disease prior to illness onset? __ __ __ __ __ __ __ __ (mm/dd/yyyy)

Was the case-patient vaccinated as recommended by the ACIP? Y=yes N=no U=unknown ☐

Vaccine Type	Vaccination Date (month day year)	Vaccine Manuf	Vaccine Lot Number	National Drug Code	Vaccine Expiration Date (month day year)	Vaccine Event Information Source	Vaccination Record Identifier	Age†	Age Units₸	Vaccine Dose Number

VACCINE TYPE CODES

46=Hib(PRP-D) 120=DTaP-Hib-IPV
47=Hib(HbOC) OTH=other (specify)
48=Hib(PRP-T) 999=unknown
49=Hib(PRP-OMP) PHC1560=type not specified

VACCINE MANUFACTURER CODES

PMC=Sanofi Pasteur OTH=other (specify)
WAL=Wyeth UNK=unknown
SKB=GlaxoSmithKline
MA=Massachusetts PH Biologic
NAV=North American Vaccine

VACCINE EVENT INFORMATION SOURCE CODES

1=Birth certificate 8=Other
2=IIS 9=Unknown
3=Medical record 10=Patient or parent's written record
4=New immunization record 11=Primary care provider
5=Other provider 12=Public agency
6=Other registry 13=School record
7=Patient or parent's recall 14=Source unspecified

†Age at vaccination

₸Age Units
a=year
d=day
mo=month
wk=week
OTH=other
UNK=unknown

Reason Not Vaccinated Per ACIP

1 = religious exemption
2 = medical contraindication
3 = philosophical objection
4 = lab evidence of previous disease
5 = MD diagnosis of previous disease
6 = too young
7 = parent/patient refusal
8 = other _____
9 = unknown
10 = parent/patient forgot to vaccinate
11 = vaccine record incomplete/unavailable
12 = parent/patient report of previous disease
13 = parent/patient unaware of recommendation
14 = missed opportunity
15 = foreign visitor ☐☐
16 = immigrant

Vaccine History Comments

CASE NOTIFICATION

CONDITION CODE 10590 **Immediate National Notifiable Condition** Y=yes N=no U=unknown ☐ **Legacy Case ID** _____

State Case ID _____ **Local Record ID** _____ **Jurisdiction Code** ___ **Binational Reporting Criteria** __ __ __ __ __ __ __

Date First Verbal Notification to CDC __ __ __ __ __ __ __ __ (month day year)

Date Notification First Electonically Submitted __ __ __ __ __ __ __ __ (month day year)

Date of Electronic Case (this version) Notification to CDC __ __ __ __ __ __ __ __ (month day year)

MMWR Week ___ **MMWR Year** _____

Notification Result Status F = Final C = Record is a correction X = Results cannot be obtained ☐

Person Reporting to CDC Name _____ (first)
_____ (last)

Person Reporting to CDC Email _____ @ _____
Person Reporting to CDC Phone Number (__ __ __) __ __ __ __ __ __ __

Current Occupation _____

Current Occupation Standardized _____

Current Industry _____

Current Industry Standardized _____

Comments

CLINICAL CASE DEFINITION[§]
PROBABLE
● Meningitis WITH detection of *Haemophilus influenzae* type b antigen in cerebrospinal fluid [CSF]
CONFIRMED
● Isolation of *Haemophilus influenzae* from a normally sterile body site (e.g., cerebrospinal fluid [CSF], blood, joint fluid, pleural fluid, pericardial fluid) **OR** ● Detection of *Haemophilus influenzae*-specific nucleic acid in a specimen obtained from a normally sterile body site (e.g., cerebrospinal fluid [CSF], blood, joint fluid, pleural fluid, pericardial fluid), using a validated polymerase chain reaction (PCR) assay

[§]https://wwwn.cdc.gov/nndss/conditions/haemophilus-influenzae-invasive-disease/case-definition/2015/