Arizona Department of Health Services

Send or Fax to:
ADHS Infectious Disease Epidemiology
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Phoenix, Arizona 85007-3237
(602) 364-3199 Fax

HAEMOPHILUS INFLUENZAE (INVASIVE)

PATIENT INFORMATION

MEDSIS Case No: _____

County: _____

☐ Confirmed ☐ Probable
☐ Suspect ☐ Ruled Out
☐ Lost to Follow Up

REPORT SOURCE

Initial report date: _____

Reporter: _____

Reporter org.: _____

Reporter phone: _____

Provider name _____

Provider org.: _____

Provider phone: _____

Name (last, first) _____

Street address _____

City _____ State _____ Zip _____

Mailing address _____

Phone _____ Alt. Phone _____

Occupation/school grade/ college year:_____

Employer/school/other: _____

Alt. contact _____ Phone _____

☐Parent/guardian ☐Spouse ☐Other _____

Birthdate ____ / ____ / ____ or age _____ Sex: ☐Male ☐Female ☐Unknown/Other

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown
Race: ☐White ☐African American ☐Native Hawaiian/Pac Islander
☐Asian ☐Amer Indian / AK Native ☐Other _____

CLINICAL INFORMATION

Onset date: ___ / ___ / ____ **Diagnosis date**: ___ / ___ / ____ If < 1 month old: Gestational Age ____ weeks | Birthweight _____

Type of infection caused **(check all that apply)**

☐Bacteremia without focus (if nothing else noted)
☐Meningitis
☐Otitis media
☐Pneumonia
☐Cellulitis
☐Epiglottitis
☐Hemolytic uremic syndome (HUS)
☐Abcess (not skin)
☐Peritonitis
☐Pericarditis
☐Septic abortion
☐Chorioamnionitis
☐Septic Arthritis
☐Osteomyletitis
☐Empyema
☐Endocarditis
☐Endometritis
☐Toxic Shock Syndrome (STSS)
☐Necrotizing fasciitis
☐Puerperal sepsis
☐Other: _____
_____
_____

Hospitalization

Y	N	UN	NA		
☐	☐	☐	☐	Hospitalized	☐ED only

Hospital: _____

Admit date: ___ / ___ / ____ Discharge date: ___ / ___ / ____

Y	N	UN	NA	
☐	☐	☐	☐	Transferred from another hospital?

If yes, hospital name: _____

_____

Admit date: ___/___/____ Transfer date: ___/___/____

Underlying Conditions **(check all that apply)**

☐Sickle Cell
☐Asplenia / Splenectomy
☐Obesity
☐Therapy suppressing the immune system
☐Organ transplant
☐Other notable condition(s): _____
_____
☐Other immunosuppressed condition(s):
_____
☐Peritonitis

Patient Outcome

Y	N	UN	NA		
☐	☐	☐	☐	Died	Death date: ___/___/____

Pregnancy Status

Y	N	UN	NA		
☐	☐	☐	☐	Pregnant	Due date: ___/___/____

Fetal Outcome: _____

Y= 'Yes' N='No' UN='Unknown' NA='Not Applicable' Pos='Positive' Neg='Negative'

LABORATORY INFORMATION

Laboratory—Clinical Specimen

State Lab ID: _____

Hospital Lab ID: _____

Specimen sent to ASL? ☐Y ☐N

Specimen Type(s)
☐Blood ☐CSF ☐Pleural Fluid ☐Peritoneal Fluid
☐Pericardial Fluid ☐Joint (Synovial) Fluid ☐Placenta

☐ Other: _____

Date First Positive Culture Obtained: ____ / ____ / _____

Laboratory Results:

Pos	Neg	UN	
☐	☐	☐	Culture Collect date: ___ / ___ / _____
☐	☐	☐	*Latex agglutination (Antigen testing, CSF only)* Collect date: ___ / ___/ _____
☐	☐	☐	*Other lab results:* Specify: _____ _____ Collect date: ___ / ___/ _____

Serotype information:
☐A ☐B ☐C ☐D ☐E ☐F ☐Not typable
☐Other:_____
☐Sent to CDC ☐Unknown

EPIDEMIOLOGICAL INFORMATION

Group Settings

Was the case a resident of a nursing home or long term care facility at the time of the first positive culture? ☐Y ☐N ☐UN

Name of facility: _____

_____

Does the case attend or work at a child care facility or nursery school? ☐Y ☐N ☐UN

Name of facility: _____

_____

Other Health Indicators/ Conditions of Interest

Y	N	UN		Y	N	UN	
☐	☐	☐	Current Smoker	☐	☐	☐	Diabetes mellitus
☐	☐	☐	Alcohol Abuse	☐	☐	☐	Renal failure/ dialysis
☐	☐	☐	Asthma	☐	☐	☐	Multiple myleoma

Vaccination Status ***(if case <15 years of age and serotype B or unknown)***

Case received Hib vaccine prior to illness ☐Y ☐N ☐UN

Total number of doses received prior to illness: _____

Dose 1:

Vaccine Type (if known):

Vaccination Date: ___ / ___ / _____

Lot # (if known): _____

Dose 2:

Vaccine Type (if known):

Vaccination Date: ___ / ___ / _____

Lot # (if known): _____

Dose 3:

Vaccine Type (if known): _____

Vaccination Date: ___ / ___ / _____

Lot # (if known): _____

Dose 4:

Vaccine Type (if known):

Vaccination Date: ___ / ___ / _____

Lot # (if known): _____

Haemophilus influenzae

Name (Last, First):_____

FOR PUBLIC HEALTH DEPARTMENT USE ONLY

ACTIONS TAKEN (type B only):	**ACTIONS TAKEN (all types):**
☐Case isolated during infectious period ☐Droplet precautions (if hospitalized) ☐Household members identified and notified ☐Education on illness provided ☐Determine if an at risk child resides in the household ☐Appropriate prophylaxis recommended for all household members ☐Appropriate prophylaxis received by all household members ☐School/ Child care facility or other group facility notified (if applicable)	☐Specimens sent to state laboratory for serotyping ☐Any contacts symptomatic prior to case? ☐Any contacts symptomatic after case? ☐Epi-linked to another case? Case ID: _____ Case Name: _____ Case Date of Birth: ___ / ___ / _____ ☐Outbreak? Outbreak name: _____

Haemophilus Influenzae Case Definition

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

Laboratory Criteria for Diagnosis: Isolation of H. influenzae from a normally sterile site

Case Classifications

Confirmed: A clinically compatible illness that is culture-confirmed.

Probable: A clinically compatible illness with detection of H. influenzae type b antigen in cerebrospinal fluid.

NOTES

INVESTIGATOR(S): _____ **DATE:** ___/___/___ **DATE CLOSED:** ___/___/___

Y= 'Yes' N='No' UN='Unknown' NA='Not Applicable' Pos='Positive' Neg='Negative'