



Haemophilus Influenzae

County _____

LHJ Use ID _____

Reported to DOH Date ____/____/____

LHJ Classification Confirmed
 Probable

By: Lab Clinical
 Epi Link: _____

Outbreak-related

LHJ Cluster# _____

LHJ Cluster Name: _____

DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____ Investigation start date ____/____/____

Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

OK to talk to case? Yes No DK Date of interview ____/____/____

PATIENT INFORMATION

Name (last, first) _____

Address _____ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact Parent/guardian Spouse Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender F M Other Unk

Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk

Race (check all that apply)

Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk

CLINICAL INFORMATION

Onset date: ____/____/____ Derived Diagnosis date: ____/____/____ Illness duration: ____ days

Signs and Symptoms

Y N DK NA

- Fever Highest measured temp: ____ °F
Type: Oral Rectal Other: ____ Unk
- Conjunctivitis
- Eyes sensitive to light (photophobia)
- Other symptoms consistent with illness: _____

Vaccination

Y N DK NA

Ever received Hib containing vaccine
Number of doses Hib vaccine prior to illness: _____

Dose 1 Type: _____ Date received: ____/____/____
Dose 2 Type: _____ Date received: ____/____/____
Dose 3 Type: _____ Date received: ____/____/____
Dose 4 Type: _____ Date received: ____/____/____

Clinical Finding

Y N DK NA

- Bacteremia
- Meningitis
- Pneumonia
X-ray result: P N I O NT
- Epiglottitis
- Otitis media (otitis media alone does not meet the case definition for H. influenzae)
- Cellulitis
- Pericarditis or pericardial effusion
- Osteomyelitis
- Septic arthritis
- Coma
- Admitted to intensive care unit
- Mechanical ventilation or intubation required during hospitalization

P = Positive
N = Negative
I = Indeterminate
O = Other
NT = Not Tested

Y N DK NA

Vaccine up to date for Hib

Vaccine series not up to date reason:

- Religious exemption
- Medical contraindication
- Philosophical exemption
- Previous infection confirmed by laboratory
- Previous infection confirmed by physician
- Parental refusal
- Other: _____
- Unk

Laboratory

Collection date ____/____/____

Source _____

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

P N I O NT

H. influenzae culture from a normally sterile site [Confirmed]

Site: _____
Serotype: _____

H. influenzae DNA by validated PCR from normally sterile site [Confirmed]

H. influenzae type b antigen (CSF) [Probable]

Beta lactamase resistance testing of isolate

Hospitalization

Y N DK NA

Hospitalized at least overnight for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

Died from illness Death date ____/____/____

Autopsy Place of death _____

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:

Calendar dates:

o
n
s
e
t

Contagious period*

As long as organisms are present (may be prolonged)

* If treated, 24-48 hours after onset of effective antibiotic therapy

EXPOSURE (Refer to dates above)

Y N DK NA

Travel out of the state, out of the country, or outside of usual routine
Out of: County State Country
Destinations/Dates: _____

Y N DK NA

Contact with lab confirmed case
 Household Casual Sexual
 Needle use Other: _____

Y N DK NA

Does the case know anyone else with similar symptoms or illness

Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

No risk factors or exposures could be identified

Patient could not be interviewed

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

Treated for nasopharyngeal carriage

PUBLIC HEALTH ISSUES

Y N DK NA

Attends child care or preschool
 Do any household members or close contacts work at or attend childcare or preschool

PUBLIC HEALTH ACTIONS

Prophylaxis of appropriate contacts recommended
recommended prophylaxis: _____
receiving prophylaxis: _____
completing prophylaxis: _____

NOTES

Investigator _____ Phone/email: _____

Investigation complete date ___/___/___

Local health jurisdiction _____

Record complete date ___/___/___