Haemophilus influenzae B (HIB)

Agency:
Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: ________ Date of Birth: __/__/__ Estimated? ☐ Age: ____
First and middle name: ________
Gender: ☐ Female ☐ Male ☐ Other ____
Maiden name: ________ Suffix: ____
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: __/__/__
Address line: ________
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Zip: ____ City: ________
State: ____ County: ________
Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ Asian
Phone: ( )- - Type: ____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Parent/Guardian name: ________
Facility name: ________
Parent/Guardian phone: ( )- - Type: ____

EVENT

Diagnosis date: __/__/__ Onset date: __/__/__
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Date of Death __/__/__ ☐ Unknown
Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name: ________
Exposure setting: ________
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom: ________
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: ____ Country: ____

Healthcare provider information

Last name: ________
First name: ________
Provider title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP
Facility name: ________
Address line 1: ________
Address line 2: ________
Zip code: ____ City: ____
State: ____ County: ____
Phone : ( )- - Type: ____

LABORATORY FINDINGS

Laboratory: ________
Specimen source: ________
Result: ☐ Positive ☐ Negative ☐ No growth
Date received: __/__/__
Test type: ☐ Gram stain ☐ PCR ☐ Latex agglutination ☐ Culture ☐ Immuno-histochemistry
Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y
Result type: ☐ Preliminary ☐ Final
Collection date: __/__/__
Accession #:
Result date: __/__/__
Organism: ***Neisseria meningitidis***

Laboratory: ________
Specimen source: ________
Result: ☐ Positive ☐ Negative ☐ No growth
Date received: __/__/__
Test type: ☐ Gram stain ☐ PCR ☐ Latex agglutination ☐ Culture ☐ Immuno-histochemistry
Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y
Result type: ☐ Preliminary ☐ Final
Collection date: __/__/__

Accession #: Result date: / / Organism: ***Neisseria meningitidis***

Laboratory: ____________________
Specimen source: ____________________
Result: ☐ Positive ☐ Negative ☐ No growth

Date received: / /
Test type: ☐ Gram stain ☐ Gram stain ☐ PCR ☐ Culture ☐ Latex agglutination ☐ Immuno-histochemistry
Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y

Result type: ☐ Preliminary ☐ Final
Collection date: / /

Accession #: Result date: / / Organism: ***Neisseria meningitidis***

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: ____________________ Job title: ____________________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________________
Date worked from: / / Address: ____________________
Date worked to: / / Zip code: ____________________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: __________ State: ______ County: __________
Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: ____________________ Job title: ____________________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________________
Date worked from: / / Address: ____________________
Date worked to: / / Zip code: ____________________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: __________ State: ______ County: __________
Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Attending a College or University: ☐ Yes ☐ No ☐ Unknown **College/University name**:
Student status: ☐ Active ☐Inactive ☐ Unknown **Year in College**: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate student
Housing: ☐ Apartment ☐ Dormitory ☐ Family home with family ☐ Family home with students ☐ Other- see notes

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ____________________ Admission date: / / Discharge date: / /
Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): __________
Days hospitalized: Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Purpura fulminans present: ☐ Yes ☐ No ☐ Unk
Antibiotic resistance testing performed : ☐ Resistant to ampicillin ☐ Resistant to rifampin ☐ Resistant to chloramphericol ☐ Resistant to sulfa

Infection type: ☐ Bacteremia ☐ Peritonitis ☐ Meningitis ☐ Pneumonia ☐ Pericarditis ☐ Epiglottitis

Other infection type (specify):
Spinal tap performed: ☐ Yes ☐ No ☐ Unk Date / /

Normal ☐ Yes ☐ No ☐ Unk **Results:** Protein Glucose White Blood Count

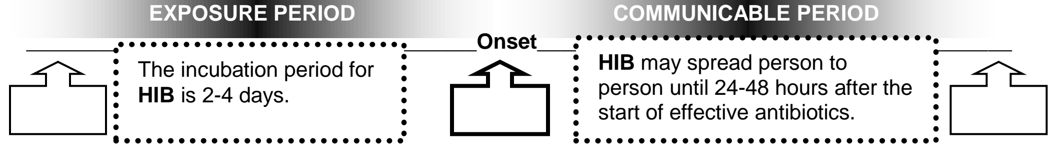
TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic: ______	Antibiotic: ______	Antibiotic: ______
Date started: __/__/__	Date started: __/__/__	Date started: __/__/__
Dose: ______	Dose: ______	Dose: ______
Unit: ☐ mg ☐ ml ☐ IU # of days: ____	Unit: ☐ mg ☐ ml ☐ IU # of days: ____	Unit: ☐ mg ☐ ml ☐ IU # of days: ____
# of times a day: ____ Route: ____	# of times a day: ____ Route: ____	# of times a day: ____ Route: ____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Vaccinated for HIB: ☐ Yes ☐ No ☐ Unk

Vaccinated for Meningococcal: ☐ Yes ☐ No ☐ Unk

Date vaccinated: __/__/__	Date vaccinated: __/__/__	Date vaccinated: __/__/__
Lot #: ______	Lot #: ______	Lot #: ______
Vaccine type: ______	Vaccine type: ______	Vaccine type: ______
Manufacturer: ______	Manufacturer: ______	Manufacturer: ______

Number of vaccinations: ______ Number of vaccinations: ______

CONTACTS

Number of people living in case's household: _____

Number of people living in case's home age 3 or less: _____

Close contacts of the case: ☐ Yes ☐ No ☐ Unknown

Close contacts of the case

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

PROPHYLAXIS

Vaccinated for HIB: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: __/__/__

Lot #: ______

Vaccine type: ______

Manufacturer: ______

Antibiotics prescribed: ☐ Yes ☐ No ☐ Unknown

Antibiotic: ______

Date started: __/__/__

Dose: ______

Unit: ☐ mg ☐ ml ☐ IU

# of times a day: Route:

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

PROPHYLAXIS

Vaccinated for HIB: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /

Lot #:

Vaccine type:

Manufacturer:

Antibiotics prescribed: ☐ Yes ☐ No ☐ Unknown

Antibiotic:

Date started: / /

Dose:

Unit: ☐ mg ☐ ml ☐ IU

# of times a day: Route:

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

PROPHYLAXIS

Vaccinated for HIB: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /

Lot #:

Vaccine type:

Manufacturer:

Antibiotics prescribed: ☐ Yes ☐ No ☐ Unknown

Antibiotic:

Date started: / /

Dose:

Unit: ☐ mg ☐ ml ☐ IU

# of times a day: Route:

NOTES: