# *Haemophilus influenzae* Surveillance Worksheet

**Local Use Only** GENERIC MMG **(Expanded Worksheet Option)** Hfu MMG (RIBD_V1.0_MMG_PTR_20190124_2) *Appendix 4-2*

| | | | | |
|---|---|---|---|---|
| NAME (Last, First) | | | Hospital Record No. | |
| Address (Street and No.) | City PID-11.3 | County PID-11.9 | Zip PID-11.5 | Phone |
| Reporting Physician/Nurse/Hospital/Clinic/Lab 48766-0 | Address | | Phone | |

DETACH HERE and transmit only lower portion if sent to CDC

## DEMOGRAPHIC INFORMATION

**1. Patient Date of Birth** ☐☐ ☐☐ ☐☐☐☐ PID-7
MONTH DAY YEAR

**2. Reported Age:** ☐☐☐ 77998-3
☐ YEARS ☐ DAYS
☐ HOURS ☐ MONTHS
☐ WEEKS ☐ UNKNOWN
OBX-6 for 77998-3

**3. Sex** PID-8 ☐ MALE ☐ FEMALE ☐ UNKNOWN

**4. Ethnicity** PID-22 ☐ HISPANIC ☐ NOT HISPANIC ☐ UNKNOWN

**5. Race:** PID-10
☐ American Indian or Alaska Native ☐ White
☐ Asian ☐ Other 32624-9 _____
☐ Black or African-American ☐ Unknown
☐ Native Hawaiian or Other Pacific Islander

**6. Identification Information as of** ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR
Type _____ Assigning Authority _____
ID Value _____

## INVESTIGATION

### INVESTIGATION SUMMARY

**7. Jurisdiction:** 77969-4 _____

**8. Program Area** (state assigned): _____

**9. State case ID number:** 77993-4

**10. Investigation start date** 77979-3 ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

**11. Investigation status** INV109 ☐ Open ☐ Closed

**12. Share record with guests of this jurisdiction and program area?** ☐ Yes ☐ No

### INVESTIGATOR

**13. Last Name:** _____

**14. First Name:** _____

**15. E-mail:** _____

**16. Investigation status** ☐ ☐☐☐ ☐☐☐ ☐☐☐

**17. Date assigned to investigation** ☐☐ ☐☐ ☐☐☐☐
MONTH DAY EAR

**18. Type of insurance** 76437-3
☐ MEDICARE ☐ INDIAN HEALTH SERVICE (IHS) ☐ NO HEALTHCARE COVERAGE
☐ MILITARY/ VA ☐ PRIVATE/ HMO/PPO/MANAGED CARE PLAN ☐ UNKNOWN
☐ MEDICAID/ STATE ASSISTANCE PROGRAM ☐ OTHER (SPECIFY) _____

**19a. WEIGHT** 3141-9
_____lbs_____oz **OR** _____kg ☐ unknown
OBX-6 for 3141-9

**19b. HEIGHT** 3137-7
_____Ft_____in **OR**_____cm ☐ unknown
OBX-6 for 3137-7

## REPORTING SOURCE

**20. Date of report** 77995-9 ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

**21. Source name:** _____

**22. City:** _____

**23. State:** 77966-0 _____ Zip +4 52831-5 _____

**24. County:** 77967-8 _____

**EARLIEST DATE REPORTED TO:**

**25. County:** 77972-8 ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

**26. State:** 77973-6 ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

### REPORTER

**27. Last name:** 74549-7 _____

**28. First name:** _____

**29. Person ID:** _____

**30. E-mail:** 74547-1 _____

**31. Telephone:** ☐ ☐☐☐ ☐☐☐ ☐☐☐ 74548-9

**Extension:** ☐☐☐☐

## CLINICAL

### PHYSICIAN

**32. Last name:** _____ **33. First name:** _____

**34. E-mail:** _____ **35. Telephone:** ☐ ☐☐☐ ☐☐☐ ☐☐☐ **Extension:** ☐☐☐☐

## HOSPITAL

**36. Was the patient hospitalized for this illness?** 77974-4

☐ Yes ☐ No ☐ UNKNOWN

**37. Hospital name:** _____

**38. Hospital ID:** _____

**39. Hospital ID Type:** _____

**40. Admission Date:** 8656-1 ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

**41. Discharge Date:** 8649-6 ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

**42. Total duration of stay within hospital:** ☐☐☐ Days 78033-8

**43a. Hospital/lab ID where culture identified:** ☐ ☐☐☐☐

**43b. Hospital ID where patient treated:** ☐ ☐☐☐☐

**44a. Was patient transferred from another hospital?**

☐ Yes ☐ No ☐ Unknown

**44b. If Yes, hospital ID**

☐ ☐☐☐☐

**45. Illness Onset Date:** 11368-8 ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

**46. Illness End Date:** 77976-9 ☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

**47. Types of infection caused by organism (CHECK ALL THAT APPLY)** INV298

- ☐ Bacteremia without focus
- ☐ Abscess (not skin)
- ☐ Empyema
- ☐ Meningitis
- ☐ Peritonitis
- ☐ Endocarditis
- ☐ Otitis media
- ☐ Pericarditis
- ☐ Endometritis
- ☐ Pneumonia
- ☐ Septic abortion
- ☐ STSS
- ☐ Cellulitis
- ☐ Chorioamnionitis
- ☐ Necrotizing fasciitis
- ☐ Epiglottitis
- ☐ Septic arthritis
- ☐ Puerperal sepsis
- ☐ Hemolytic uremic syndrome (HUS)
- ☐ Osteomyelitis
- ☐ Other infection

**48a. Bacterial species isolated from any normally sterile site** LAB278 **(CHECK ALL THAT APPLY)**

- ☐ *Neisseria meningitidis*
- ☐ Abscess (not skin)
- ☐ *Haemophilus influenzae*
- ☐ Group A streptococcus
- ☐ Group B streptococcus
- ☐ *Streptococcus pneumoniae*

**48b. Other bacterial species isolated from any normally sterile site** LAB278

_____

_____

**49. Sterile sites from which organism isolated: (CHECK ALL THAT APPLY)** 66746-9

- ☐ Blood
- ☐ Peritoneal fluid
- ☐ Bone
- ☐ CSF
- ☐ Pericardial fluid
- ☐ Muscle
- ☐ Pleural fluid
- ☐ Joint

**Specify:**

- ☐ Internal body site _____
- ☐ Other normally sterile site _____

**50. Date first positive culture obtained: (date specimen drawn)**

☐☐ ☐☐ ☐☐☐☐ MONTH DAY YEAR

**51. Other nonsterile sites from which organism isolated: (CHECK ALL THAT APPLY)** 66746-9

- ☐ Placenta
- ☐ Middle ear
- ☐ Amniotic fluid
- ☐ Sinus
- ☐ Wound
- ☐ Other nonsterile site _____

**52. Underlying causes or prior illness: (CHECK ALL THAT APPLY)** INV236

- ☐ Current smoker
- ☐ Hodgkin's disease
- ☐ HIV infection
- ☐ Heart failure/CHF
- ☐ Multiple myeloma
- ☐ Asthma
- ☐ AIDS or CD4 count <200
- ☐ Obesity
- ☐ Sickle cell anemia
- ☐ Emphysema / COPD
- ☐ Cochlear implant
- ☐ CSF leak
- ☐ Splenectomy / asplenia
- ☐ Systemic lupus erythematosus (SLE)
- ☐ Deaf / profound hearing loss
- ☐ IVDU
- ☐ Immunoglobulin deficiency
- ☐ Diabetes mellitus
- ☐ Cirrhosis / Liver failure
- ☐ Cerebral vascular accident (CVA) / Stroke
- ☐ Immunosuppressive therapy (Steroids, Chemotherapy, Radiation)
- ☐ Nephrotic syndrome
- ☐ Alcohol Abuse
- ☐ Complement deficiency
- ☐ Leukemia
- ☐ Renal failure/Dialysis
- ☐ Atherosclerotic Cardiovascular Disease (ASCVD)/(CAD)

**Specify:**

- ☐ Other malignancy _____
- ☐ Organ transplant _____
- ☐ Other prior illness _____

**53. Was patient pregnant / postpartum at time of first positive culture?** INV661 ☐ Yes ☐ No ☐ Unknown

If yes, outcome of fetus 63893-2

- ☐ Survived, no apparent illness
- ☐ Live birth / neonatal death
- ☐ Induced abortion
- ☐ Survived, clinical infection
- ☐ Abortion / stillbirth
- ☐ Unknown

**54. Is the patient <1 month of age?** ☐ Yes ☐ No ☐ Unknown If yes, time of birth: _____ : _____

18185-9 Gestational age: ☐☐ (wks) 56056-5 Birth weight: ☐☐☐☐ (gms) OBX-6 for 56056-5

**55. Did the patient die from this illness?** 77978-5

☐ Yes ☐ No

**56. What was the serotype?** INV706

☐ a ☐ d ☐ Not Typeable
☐ b ☐ e ☐ Not Tested or Unknown
☐ c ☐ f ☐ Other _____

**57. Was the patient <15 years of age at the time of the first positive culture?** ☐ Yes ☐ No ☐ Unknown

**58. Birth Country:** 78746-5

_____

**59. Type of insurance:** (CHECK ALL THAT APPLY) 76437-3

☐ Medicare
☐ Military/VA
☐ Medicaid/state assistance program
☐ Indian Health Service (IHS)
☐ Private/HMO/PPO/managed care plan
☐ No health care coverage
☐ Unknown
☐ Other Insurance _____

**60. Is there a known previous contact with Hib disease within the preceding two months?** ☐ Yes ☐ No ☐ Unknown INV1041

**If yes specify type of contact:** INV1042 _____

**61. Significant past medical history:** _____

**If pre-term birth (<37 weeks).** 76517-2 **Specify weeks:** _____

**Serum availability:**

Is acute serum available? ☐ Yes ☐ No ☐ Unknown
Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

Is convalescent serum available? ☐ Yes ☐ No ☐ Unknown
Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

**62. If <15 years of age and serotype "b" or "unk", did patient receive *Haemophilus influenzae* b vaccin** VAC126 ☐ Yes ☐ No ☐

| Dose 30973-2 | Date Given 30952-6 (MONTH DAY YEAR) | Vaccine Name/Manufacturer 30957-5 | Lot Number 30959-1 |
|---|---|---|---|
| 1 | ☐☐ ☐☐ ☐☐☐☐ | | |
| 2 | ☐☐ ☐☐ ☐☐☐☐ | | |
| 3 | ☐☐ ☐☐ ☐☐☐☐ | | |
| 4 | ☐☐ ☐☐ ☐☐☐☐ | | |

## Epidemiologic

**63. Does this patient:** (CHECK ALL THAT APPLY)

**Attend a day care* facility** INV615 ☐ Yes ☐ No ☐ Unknown **Facility name** _____

*DAY CARE IS DEFINED AS A SUPERVISED GROUP OF 2 OR MORE UNRELATED CHILDREN FOR >4 HOURS PER WEEK.

**Reside in a long-term care facility?** INV636 ☐ Yes ☐ No ☐ Unknown **Facility name** _____

**64. Is this case part of an outbreak?** 77980-1 ☐ Yes ☐ No ☐ Unknown **Outbreak name** 77981-9 _____

Where was this disease acquired?

Imported Country: INV153 _____ Imported City: INV155 _____

Imported State: INV154 _____ Imported County: INV156 _____

**CONFIRMATION METHOD**

**65. Case status:** 77990-0

☐ Confirmed ☐ Not a case
☐ Probable ☐ Unknown
☐ Suspect

**66. Does this patient have recurrent disease with the same pathogen?** INV975

☐ Yes ☐ No ☐ Unknown

**If yes, previous (1st) state I.D.** INV976 ☐☐☐☐☐☐☐

**67. CRF Status:** INV656

☐ Complete
☐ Incomplete
☐ Edited & Correct
☐ Chart unavailable after 3 requests

**General Comments:** 77999-1