North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

HAEMOPHILUS INFLUENZAE, INVASIVE DISEASE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 23

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS

Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Meningitis ☐Y ☐N ☐U
Arthritis ☐Y ☐N ☐U
Extent:
☐ One joint
☐ Multiple joints
Note location: _____
Type:
☐ Septic
☐ Other, specify: _____
Osteomyelitis ☐Y ☐N ☐U
Cellulitis ☐Y ☐N ☐U
Conjunctivitis ☐Y ☐N ☐U
Otitis media ☐Y ☐N ☐U
Epiglottitis ☐Y ☐N ☐U
Pneumonia ☐Y ☐N ☐U
Pericarditis ☐Y ☐N ☐U
Peritonitis ☐Y ☐N ☐U
Bacteremia ☐Y ☐N ☐U
Date of positive blood culture (mm/dd/yyyy): _____
Septicemia/sepsis ☐Y ☐N ☐U
Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
1. Hospital name: _____
City, State: _____
Hospital contact name: _____
Phone: _____
Admit date _____/_____/_____
Discharge date _____/_____/_____

If applicable:
2. Hospital name: _____
City, State: _____
Hospital contact name: _____
Phone: _____
Admit date _____/_____/_____
Discharge date _____/_____/_____
Discharge/Final diagnosis: _____

Patient in child care? ☐Y ☐N ☐U
Patient a child care worker or volunteer in child care? ☐Y ☐N ☐U
Patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U
Is patient a student? ☐Y ☐N ☐U
Type of school:
Is patient a school WORKER / VOLUNTEER in NC school setting? ☐Y ☐N ☐U

VACCINE

Has the patient ever received Haemophilis Influenza (Hib) vaccine? ☐Y ☐N ☐U
Number of Hib doses prior to illness? _____
Dose 1
Vaccine date: _____
Vaccine type: _____
Manufacturer: _____
Lot Number: _____

Dose 2
Vaccine date: _____
Vaccine type: _____
Manufacturer: _____
Lot Number: _____
Dose 3
Vaccine date: _____
Vaccine type: _____
Manufacturer: _____
Lot Number: _____
Dose 4
Vaccine date: _____
Vaccine type: _____
Manufacturer: _____
Lot Number: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)*
						SSN

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐ Y ☐ N ☐ U

Specify _____

_____

CLINICAL FINDINGS

Did the patient have a chest X ray? ☐ **Y** ☐ **N** ☐ **U**

Was the X ray abnormal? ☐ Y ☐ N ☐ U

Specify _____

Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐ Y ☐ N ☐ U

Specify _____

CLINICAL OUTCOMES

Survived? ☐ Y ☐ N ☐ U

Died? ☐ Y ☐ N ☐ U

Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy):_____

TRAVEL/IMMIGRATION

The patient is:

☐ Resident of NC

☐ Resident of another state or US territory

☐ None of the above

Did patient have a travel history during the 7 days prior to onset of symptoms until 48 hours after start of antibiotics? ☐ Y ☐ N ☐ U

List travel dates and destinations _____

_____

_____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U

List persons and contact information:

_____

_____

_____

Additional travel/residency information:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 7 days prior to onset of symptoms until 48 hours after start of antibiotics did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐ Y ☐ N ☐ U

Name of facility:_____

Dates of contact: _____

In what setting was the patient most likely exposed?

☐ Restaurant
☐ Home
☐ Work
☐ Child Care
☐ School
☐ University/College
☐ Camp
☐ Doctor's office/ Outpatient clinic
☐ Hospital In-patient
☐ Hospital Emergency Department
☐ Laboratory
☐ Long-term care facility /Rest Home
☐ Military
☐ Prison/Jail/Detention Center
☐ Place of Worship
☐ Outdoors, including woods or wilderness
☐ Athletics
☐ Farm
☐ Pool or spa
☐ Pond, lake, river or other body of water
☐ Hotel / motel
☐ Social gathering, other than listed above
☐ Travel conveyance (airplane, ship, etc.)
☐ International
☐ Community
☐ Other (specify)
_____
☐ Unknown

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

7 days prior to onset of symptoms until 48 hours after start of antibiotics, was patient exposed to human saliva/oral secretions (e.g., shared water bottle, cigarettes, eating utensils, kissing)**?** ☐ Y ☐ N ☐ U

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

Specify _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): __/__/____

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed?

Were health care providers consulted? ☐ Y ☐ N ☐ U

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Sources:

☐ Hospital ☐ Clinic/Health Care provider

☐ Other_____

Please specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County_____

☐ Outside NC, but within US

City _____

State _____

County_____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes:

Haemophilus influenzae, invasive disease (*H. influenzae*)

1997 CDC Case Definition

Clinical description

Invasive disease caused by *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 (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid).

Case classification

- *Probable*: a clinically compatible case with detection of *H. influenzae* type b antigen in CSF
- *Confirmed*: a clinically compatible case that is laboratory confirmed

Comment

Positive antigen test results from urine or serum samples are unreliable for diagnosis of *H. influenzae* disease.