State of California—Health and Human Services Agency

Mail to: California Department of Public Health
Immunization Branch
850 Marina Bay Parkway
Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
Or Fax to: (510) 620-3949

INVASIVE *HAEMOPHILUS INFLUENZAE* DISEASE CASE REPORT

PATIENT DEMOGRAPHICS

Patient name—last	first	middle initial	Date of birth	Age *(enter age and check one)*	Gender
			____ /____ /_____	_____ ☐ Days ☐ Weeks ☐ Months ☐ Years	☐ Male ☐ Female

Address—number, street	City	State	ZIP code	County

Telephone number	Email:
Home ( ) Work ( )	

ETHNICITY (*check one*)
☐ Hispanic/Latino
☐ Non-Hispanic/ Non-Latino
☐ Unknown

RACE *(check all that apply)*
☐ Black/African-American
☐ Native American/Alaskan Native
☐ White
☐ Unknown
☐ Other: _____

☐ Asian: *Please specify:*
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino
☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian
☐ Thai ☐ Vietnamese ☐ Other Asian: _____

☐ Pacific Islander: *Please specify:*
☐ Native Hawaiian
☐ Guamanian
☐ Samoan
☐ Other Pacific Islander: _____

Country of birth	Country of residence

COMMON LHD TRACKING DATA

CMRID Number	IZB Case ID Number	WebCMR ID Number

Date reported to county	Date investigation started	Person/clinician reporting case	Reporter telephone
____ /____ /_____	____ /____ /_____		( )

Case investigator completing form	Investigator telephone	Investigator's jurisdiction
	( )	

CLINICAL SYNDROME

(check all that apply)
☐ Meningitis ☐ Bacteremia ☐ Epiglottis ☐ Pneumonia ☐ Other, describe: _____

Date of onset of symptoms	Date of diagnosis
____ /____ /_____	____ /____ /_____

Does case meet clinical criteria for further investigation	**CASE MEETS CDC/CSTE CLINICAL CRITERIA? *(FOR STATE USE ONLY)***
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized	Days Hospitalized	Death	Date of death	Other complications
☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No ☐ Unknown	____ /____ /_____	☐ Yes ☐ No ☐ Unknown

Describe other complications

TREATMENT

1. Were antibiotics given?	Antibiotic 1 code	Date started
☐ Yes ☐ No ☐ Unknown		____ /____ /_____
2. Were antibiotics given?	**Antibiotic 2 code**	**Date started**
☐ Yes ☐ No ☐ Unknown		____ /____ /_____

Antibiotic codes:
1 = Cefotaxime sodium
2 = Ceftriaxone sodium
3 = Ampicillin
4 = Chloramphenicol
5 = Ampicillin and chloramphenicol
6 = Rifampin
7 = Other
8 = None
9 = Unknown

LABORATORY TESTS

Any lab tests done?	**CASE LAB CONFIRMED *(FOR LHD USE)***	**CASE LAB CONFIRMED *(FOR STATE USE ONLY)***
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Culture	Specimen date	Source of Specimen
☐ Yes ☐ No ☐ Unknown	____ /____ /_____	☐ Blood ☐ Joint ☐ CSF ☐ Pleural fluid ☐ Peritoneal fluid ☐ Pericardial fluid ☐ Placenta ☐ Other _____ ☐ Unknown

LAB RESULT CODES
P = Positive N = Negative I = Indeterminate E = Pending X = Not Done U = Unknown

Culture result
☐ P ☐ N ☐ I ☐ E ☐ X ☐ U

Was isolate serotyped?	Isolate serotype
☐ Yes ☐ No ☐ Unknown	☐ 1 = Type B ☐ 2 = Not typeable ☐ 3 = Other type _____ ☐ 9 = Unknown

Isolate forwarded to MDL for testing?	Date sent	MDL serotype
☐ Yes ☐ No ☐ Unknown	____ /____ /_____	

Isolate forwarded to CDC for testing?	Date sent	CDC serotype
☐ Yes ☐ No ☐ Unknown	____ /____ /_____	

CSF bacterial antigen screen	CSF bacterial antigen screen result
☐ Yes ☐ No ☐ Unknown	☐ P ☐ N ☐ I ☐ E ☐ X ☐ U

VACCINATION/MEDICAL HISTORY

Is case < to 15 years of age? ☐ Yes ☐ No ☐ Unknown (If no, skip to question regarding pregnancy)

Received one or more doses of HIB-containing vaccine	Number of doses prior to illness onset
☐ Yes ☐ No ☐ Unknown	

Vaccination Dates – Dose 1	Dose 2	Dose 3	Dose 4
____ /____ /_____	____ /____ /_____	____ /____ /_____	____ /____ /_____

Reason not vaccinated (check all that apply)

1 ☐ Personal Beliefs Exemption (PBE)
2 ☐ Permanent Medical Exemption (PME)
3 ☐ Temporary Medical Exemption
4 ☐ Lab confirmation of previous disease
5 ☐ MD diagnosis of previous disease
6 ☐ Under age for vaccination
7 ☐ Delay in starting series or between doses
8 ☐ Other
9 ☐ Unknown

Pregnant	Immunocompromised
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

TRANSMISSION AND CONTACT INVESTIGATION

Spread Setting (check all that apply)

1 ☐ Day care
2 ☐ School
3 ☐ Doctor's office
4 ☐ Hospital Ward
5 ☐ Hospital ER
6 ☐ Outpatient hospital clinic
7 ☐ Home
8 ☐ Work
9 ☐ Unknown
10 ☐ College
11 ☐ Military
12 ☐ Correctional facility
13 ☐ Church
14 ☐ International travel
15 ☐ Other

Number of contacts for whom antibiotic was recommended	Number of ill contacts

CASE CLASSIFICATION *(FOR LHD USE)*	**CASE CLASSIFICATION *(FOR STATE USE ONLY)***
☐ Confirmed ☐ Probable ☐ Not a case ☐ Unknown	☐ Confirmed ☐ Probable ☐ Not a case ☐ Unknown

REMARKS

HAEMOPHILUS INFLUENZAE INVASIVE DISEASE CASE CLASSIFICATION

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.

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