

HOSPITAL 36. Was the patient hospitalized for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNKNOWN 37. Hospital name: _____ 38. Hospital ID: _____ 39. Hospital ID Type: _____ 40. Admission Date: 41. Discharge Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <small>MONTH DAY YEAR MONTH DAY YEAR</small> 42. Total duration of stay within hospital: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Days	43a. Hospital/lab ID where culture identified: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	43b. Hospital ID where patient treated: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
47. Types of infection caused by organism (CHECK ALL THAT APPLY) <input type="checkbox"/> Bacteremia without focus <input type="checkbox"/> Abscess (not skin) <input type="checkbox"/> Empyema <input type="checkbox"/> Meningitis <input type="checkbox"/> Peritonitis <input type="checkbox"/> Endocarditis <input type="checkbox"/> Otitis media <input type="checkbox"/> Pericarditis <input type="checkbox"/> Endometritis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Septic abortion <input type="checkbox"/> STSS <input type="checkbox"/> Cellulitis <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Necrotizing fasciitis <input type="checkbox"/> Epiglottitis <input type="checkbox"/> Septic arthritis <input type="checkbox"/> Puerperal sepsis <input type="checkbox"/> Hemolytic uremic syndrome (HUS) <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Other infection _____	44a. Was patient transferred from another hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 44b. If Yes, hospital ID <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
49. Sterile sites from which organism isolated: (CHECK ALL THAT APPLY) <input type="checkbox"/> Blood <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Bone <input type="checkbox"/> CSF <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Muscle <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Joint Specify <input type="checkbox"/> Internal body site _____ <input type="checkbox"/> Other normally sterile site _____	45. Illness Onset Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <small>MONTH DAY YEAR</small> 46. Illness End Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <small>MONTH DAY YEAR</small>	
52. Underlying causes or prior illness: (CHECK ALL THAT APPLY) <input type="checkbox"/> Current smoker <input type="checkbox"/> Hodgkin disease <input type="checkbox"/> HIV infection <input type="checkbox"/> Heart failure / CHF <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Asthma <input type="checkbox"/> AIDS or CD4 count <200 <input type="checkbox"/> Obesity <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Emphysema / COPD <input type="checkbox"/> Cochlear implant <input type="checkbox"/> CSF leak <input type="checkbox"/> Splenectomy / asplenia <input type="checkbox"/> Systemic lupus erythematosus (SLE) <input type="checkbox"/> Deaf / profound hearing loss <input type="checkbox"/> IVDU <input type="checkbox"/> Immunoglobulin deficiency <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Cirrhosis / Liver failure <input type="checkbox"/> Cerebral vascular accident (CVA) / Stroke <input type="checkbox"/> Immunosuppressive therapy (Steroids, Chemotherapy, Radiation) <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Complement deficiency <input type="checkbox"/> Leukemia <input type="checkbox"/> Renal failure/Dialysis <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD) / (CAD)	50. Date first positive culture obtained: (date specimen drawn) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <small>MONTH DAY YEAR</small> 51. Other nonsterile sites from which organism isolated: (CHECK ALL THAT APPLY) <input type="checkbox"/> Placenta <input type="checkbox"/> Middle ear <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Sinus <input type="checkbox"/> Wound <input type="checkbox"/> Other nonsterile site _____	
53. Was patient pregnant / post partum at time of first positive culture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, outcome of fetus <input type="checkbox"/> Survived, no apparent illness <input type="checkbox"/> Live birth / neonatal death <input type="checkbox"/> Induced abortion <input type="checkbox"/> Survived, clinical infection <input type="checkbox"/> Abortion / stillbirth <input type="checkbox"/> Unknown		
54. Is the patient <1 month of age? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, time of birth: _____:_____:_____ Gestational age: <input type="checkbox"/> <input type="checkbox"/> (wks) Birth weight: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (gms)		55. Did the patient die from this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No

56. What was the serotype?

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

59. Type of insurance: (CHECK ALL THAT APPLY)

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

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

58. Birth Country: _____

60. Is there a known previous contact with Hib disease within the preceding two months? Yes No Unknown
If yes specify type of contact: _____

61. Significant past medical history: _____

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

Serum availability

Is acute serum available? Yes No Unknown Is convalescent serum available? Yes No Unknown

Date: Date:

MONTH DAY YEAR MONTH DAY YEAR

62. If <15 years of age and serotype "b" or "unk", did patient receive *Haemophilus influenzae b* vaccine? Yes No Unknown

Dose	Date Given			Vaccine Name/Manufacturer	Lot Number
	MONTH	DAY	YEAR		
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	_____
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	_____
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	_____
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	_____

Epidemiologic

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

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

64. Is this case part of an outbreak? Yes No Unknown **Outbreak name** _____

Where was this disease acquired? _____

Imported Country: _____ Imported City: _____
 Imported State: _____ Imported County: _____

CONFIRMATION METHOD

65. Case status:

Confirmed Not a case
 Probable Unknown
 Suspect

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

Yes No Unknown

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

67. CRF Status:

Complete Chart unavailable after 3 requests
 Incomplete
 Edited & Correct

General Comments: _____

