**Haemophilus influenzae Surveillance Worksheet**

(Expanded Worksheet Option)

**DEMOGRAPHIC INFORMATION**

1. **Patient Date of Birth**
   - Month
   - Day
   - Year

2. **Reported Age**
   - Years
   - Days
   - Hours
   - Months
   - Weeks
   - Unknown

3. **Sex**
   - Male
   - Female
   - Unknown

4. **Ethnicity**
   - Hispanic
   - Not Hispanic
   - Unknown

5. **Race**
   - American Indian or Alaska Native
   - White
   - Asian
   - Black or African-American
   - Native Hawaiian or Other Pacific Islander
   - Other

6. **Identification Information as of**
   - Month
   - Day
   - Year

**INVESTIGATION SUMMARY**

7. **Jurisdiction**

8. **Program Area**

9. **State class ID number**

10. **Investigation start date**
    - Month
    - Day
    - Year

11. **Investigation status**
    - Open
    - Closed

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

13. **Type of insurance**
    - Medicare
    - Medicaid/State Assistance Program
    - Military/Va
    - Indian Health Service (IHS)
    - Other

14. **Weight**
    - Lbs
    - Oz
    - Unknown

15. **Height**
    - Ft
    - In
    - Cm
    - Unknown

**REPORTING SOURCE**

20. **Date of report**
    - Month
    - Day
    - Year

21. **Source name**

22. **City**

23. **State**

24. **County**

**EARLIEST DATE REPORTED TO**

25. **County**

26. **State**

**CLINICAL**

**Physician**

27. **Last name**

28. **First name**

29. **Person ID**

30. **E-mail**

31. **Telephone**

32. **E-mail**

33. **Telephone**

34. **E-mail**

35. **Telephone**
56. What was the serotype?  
☐ 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


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

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: [ ][][] [ ][][] [ ][]

Is convalescent serum available? ☐ Yes  ☐ No  ☐ Unknown
Date: [ ][][] [ ][] [ ][]

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

<table>
<thead>
<tr>
<th>Dose</th>
<th>Date Given</th>
<th>Vaccine Name/Manufacturer</th>
<th>Lot Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30973-2</td>
<td>30952-6</td>
<td>30957-5</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 77981-9

Where was this disease acquired?  
Imported Country: INV133  
Imported City: INV155  
Imported State: INV154  
Imported County: INV156

CONFIRMATION METHOD

65. Case status: 77990-0  
☐ Confirmed  ☐ Not a case  
☐ Probable  ☐ Unknown  
☐ Suspect

General Comments: 77999-1

66. Does this patient have recurrent disease with the same pathogen?  
☐ Yes  ☐ No  ☐ Unknown

If yes, previous (1st) state I.D. 77975

67. CRF Status:  INV656  
☐ Complete  
☐ Incomplete  
☐ Chart unavailable after 3 requests  
☐ Edited & Correct

General Comments: 77999-1