

# Haemophilus influenzae Disease Surveillance Worksheet (Abbreviated Worksheet Option)

Appendix 4

## Local Use Only

Name (Last, First)		Hospital Record No.		
Address (Street and Number)		City	County	Zip
Reporting Physician/Nurse/Hospital/Clinic/Lab		Address		Phone

DETACH HERE and transmit only lower portion if sent to CDC

<b>State (residence of patient)</b>		<b>County (residence of patient)</b>		<b>Hospitalized (if Yes, date of admission)</b>	
State ID <input type="text"/>		CDC ID <input type="text"/>		<input type="checkbox"/> Y=Yes <input type="checkbox"/> N=No <input type="checkbox"/> U=Unknown	
<b>Date of birth</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		<b>Age</b> <input type="text"/> <input type="text"/> <input type="text"/> 999=Unknown		<b>Is Age in days/wks/mos/yrs?</b> <input type="checkbox"/> 3=Days <input type="checkbox"/> 2=Weeks <input type="checkbox"/> 1=Months	
				<b>If &lt;6 years of age, is patient in daycare?</b> <input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No <input type="checkbox"/> 9=Unknown <small>Daycare is defined as a supervised group of 2 or more unrelated children for &gt;4 hours/week</small>	
<b>Race</b> <input type="checkbox"/> A=Asian/Pacific Islander <input type="checkbox"/> B=African American <input type="checkbox"/> N=Native American/Alaskan Native		<b>Sex</b> <input type="checkbox"/> M=Male <input type="checkbox"/> F=Female <input type="checkbox"/> U=Unknown		<b>Ethnic Origin</b> <input type="checkbox"/> H=Hispanic <input type="checkbox"/> N=Non-Hispanic <input type="checkbox"/> U=Unknown	
				<b>Outcome</b> <input type="checkbox"/> 1=Survived <input type="checkbox"/> 2=Died <input type="checkbox"/> 9=Unknown	
<b>Type of infection caused by organism (check all that apply)</b> 1 <input type="checkbox"/> Primary Bacteremia 2 <input type="checkbox"/> Meningitis 3 <input type="checkbox"/> Otitis Media 4 <input type="checkbox"/> Pneumonia 5 <input type="checkbox"/> Cellulitis 6 <input type="checkbox"/> Epiglottitis 7 <input type="checkbox"/> Peritonitis 8 <input type="checkbox"/> Pericarditis 9 <input type="checkbox"/> Septic Abortion 10 <input type="checkbox"/> Aminonitis 11 <input type="checkbox"/> Septic Arthritis 12 <input type="checkbox"/> Conjunctivitis 13 <input type="checkbox"/> Other				<b>Bacterial species isolated from any normally sterile site</b> 1=Neisseria meningitidis 2=Haemophilus influenzae 3=Group B Streptococcus 4=Listeria monocytogenes 5=Streptococcus pneumoniae (pneumococcus) 6=Other bacterial species	
<b>Specimen from which organism isolated (check all that apply)</b> 1 <input type="checkbox"/> Blood 2 <input type="checkbox"/> CSF 3 <input type="checkbox"/> Pleural fluid 4 <input type="checkbox"/> Peritoneal fluid 5 <input type="checkbox"/> Pericardial fluid 6 <input type="checkbox"/> Joint 7 <input type="checkbox"/> Placenta 8 <input type="checkbox"/> Other normally sterile site				<b>Date first positive culture obtained (date specimen drawn)</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	

## IMPORTANT—PLEASE COMPLETE

Did patient receive *Haemophilus influenzae* b vaccine?

☐ 1=Yes  
☐ 2=No  
☐ 9=Unknown

If Yes, please complete the list below

Dose	Dose Given Month Day Year	Vaccine Name / Manufacturer	Lot Number
1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	/	
2	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	/	
3	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	/	
4	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	/	

What was the serotype?

☐ 1=Type b  
☐ 2=Not typable  
☐ 8=Other  
☐ 9=Unknown

If *H. influenzae* was isolated from blood or CSF, was it resistant to

Ampicillin?

☐ 1=Yes  
☐ 2=No  
☐ 9=Not tested or unknown

Chloramphenicol?

☐ 1=Yes  
☐ 2=No  
☐ 9=Not tested or unknown

Rifampin?

☐ 1=Yes  
☐ 2=No  
☐ 9=Not tested or unknown