

**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.

Durham County Health Department  
Communicable Disease Control  
414 East Main Street  
Durham, NC 27701

Telephone: (919) 560-7600  
Fax: (919) 560-7716

**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



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
/ /						/ /	
/ /						/ /	
/ /						/ /	



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 Haemophilus 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?

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

**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.