



# Haemophilus Influenzae

County \_\_\_\_\_

Case name (last, first) \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age at symptom onset \_\_\_\_\_  Years  Months

Alternate name \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Address type  Home  Mailing  Other  Temporary  Work

Street address \_\_\_\_\_

City/State/Zip/County \_\_\_\_\_

Residence type (incl. Homeless) \_\_\_\_\_ WA resident  Yes  No

## ADMINISTRATIVE

Investigator \_\_\_\_\_ LHI Case ID (optional) \_\_\_\_\_

LHI notification date \_\_\_/\_\_\_/\_\_\_

### Classification

Classification pending  Confirmed  Investigation in progress  Not reportable  Probable  Ruled out  Suspect

### Investigation status

Complete  Complete – not reportable to DOH  Unable to complete Reason \_\_\_\_\_  In progress

Dates: **Investigation start** \_\_\_/\_\_\_/\_\_\_ **Investigation complete** \_\_\_/\_\_\_/\_\_\_ **Record complete** \_\_\_/\_\_\_/\_\_\_ **Case complete** \_\_\_/\_\_\_/\_\_\_

## REPORT SOURCE

**Initial report source** \_\_\_\_\_ LHI \_\_\_\_\_

Reporter organization \_\_\_\_\_

Reporter name \_\_\_\_\_ Reporter phone \_\_\_\_\_

All reporting sources (list all that apply) \_\_\_\_\_

## DEMOGRAPHICS

Sex at birth:  Female  Male  Other  Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

**Ethnicity**  Hispanic, Latino/a, Latinx  Non-Hispanic, Latino/a, Latinx  Patient declined to respond  Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

**Race**  Amer Ind/AK Native (**specify:**  Amer Ind **and/or**  AK Native)  Asian  Black or African American  
 Native HI/Pacific Islander (**specify:**  Native HI **and/or**  Pacific Islander)  White  Patient declined to respond  Unk

Additional race information:

Afghan  Afro-Caribbean  Arab  Asian Indian  Bamar/Burman/Burmese  Bangladeshi  Bhutanese  
 Central American  Cham  Chicano/a or Chicanx  Chinese  Congolese  Cuban  Dominican  Egyptian  
 Eritrean  Ethiopian  Fijian  Filipino  First Nations  Guamanian or Chamorro  Hmong/Mong  
 Indigenous-Latino/a or Indigenous-Latinx  Indonesian  Iranian  Iraqi  Japanese  Jordanian  Karen  
 Kenyan  Khmer/Cambodian  Korean  Kuwaiti  Lao  Lebanese  Malaysian  Marshallese  Mestizo  
 Mexican/Mexican American  Middle Eastern  Mien  Moroccan  Nepalese  North African  Oromo  
 Pakistani  Puerto Rican  Romanian/Rumanian  Russian  Samoan  Saudi Arabian  Somali  
 South African  South American  Syrian  Taiwanese  Thai  Tongan  Ugandan  Ukrainian  
 Vietnamese  Yemeni  Other: \_\_\_\_\_

What is your (your child's) preferred language? Check one:

Amharic  Arabic  Balochi/Baluchi  Burmese  Cantonese  Chinese (unspecified)  Chamorro  Chuukese  
 Dari  English  Farsi/Persian  Fijian  Filipino/Pilipino  French  German  Hindi  Hmong  Japanese  
 Karen  Khmer/Cambodian  Kinyarwanda  Korean  Kosraean  Lao  Mandarin  Marshallese  Mixteco  
 Nepali  Oromo  Panjabi/Punjabi  Pashto  Portuguese  Romanian/Rumanian  Russian  Samoan  
 Sign languages  Somali  Spanish/Castilian  Swahili/Kiswahili  Tagalog  Tamil  Telugu  Thai  Tigrinya  
 Ukrainian  Urdu  Vietnamese  Other language: \_\_\_\_\_  Patient declined to respond  Unknown

Interpreter needed  Yes  No  Unk

**EMPLOYMENT AND SCHOOL**

Employed  Yes  No  Unk Occupation \_\_\_\_\_ Industry \_\_\_\_\_  
 Employer \_\_\_\_\_ Work site \_\_\_\_\_ City \_\_\_\_\_

Student/Day care  Yes  No  Unk  
 Type of school  Preschool/day care  K-12  College  Graduate School  Vocational  Online  Other  
 School name \_\_\_\_\_ School address \_\_\_\_\_  
 City/State/County \_\_\_\_\_ Zip \_\_\_\_\_ Phone number \_\_\_\_\_ Teacher's name \_\_\_\_\_

**COMMUNICATIONS**

Primary HCP name \_\_\_\_\_ Phone \_\_\_\_\_  
 OK to talk to patient (If Later, provide date)  Yes  Later \_\_\_/\_\_\_/\_\_\_  Never  
 Date of interview attempt \_\_\_/\_\_\_/\_\_\_  Complete  Partial  Unable to reach  Patient could not be interviewed  
 Alternate contact:  Parent/Guardian  Spouse/Partner  Friend  Other \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_

Outbreak related  Yes  No LHJ Cluster ID \_\_\_\_\_ Cluster Name \_\_\_\_\_

**CLINICAL INFORMATION**

Complainant ill  Yes  No  Unk Symptom Onset \_\_\_/\_\_\_/\_\_\_  Derived Diagnosis date \_\_\_/\_\_\_/\_\_\_  
 Illness duration \_\_\_\_\_  Days  Weeks  Months  Years Illness is still ongoing  Yes  No  Unk

**Clinical Features**

Type of infection/complication caused by organism (check all that apply)  **Primary bacteremia**  **Meningitis**  Conjunctivitis  
 Septic arthritis  **Pneumonia**  **Otitis media**  Cellulitis  **Epiglottitis**  Peritonitis  Pericarditis  
 Osteomyelitis  Other \_\_\_\_\_

**Y N Unk**  
   **Any fever, subjective or measured** Temp measured?  Yes  No Highest measured temp \_\_\_\_\_°F  
   Photophobia (eyes sensitive to light)  
   Coma  
   Other symptoms consistent with this illness \_\_\_\_\_

**Predisposing Conditions**

**Y N Unk**  
   Immunosuppressive therapy or condition, or disease \_\_\_\_\_

**Vaccination**

**Y N Unk**  
   Ever received Haemophilus influenzae containing vaccine  
 Number of Haemophilus influenzae doses prior to illness \_\_\_\_\_

Vaccine information available  Yes  No

Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_  
 Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_  
 Information source  Washington Immunization Information System (WIIS) WIIS ID number \_\_\_\_\_  
 Medical record  Patient vaccination card  Verbal only/no documentation  Other state IIS

Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_  
 Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_  
 Information source  Washington Immunization Information System (WIIS) WIIS ID number \_\_\_\_\_  
 Medical record  Patient vaccination card  Verbal only/no documentation  Other state IIS

Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_  
 Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_  
 Information source  Washington Immunization Information System (WIIS) WIIS ID number \_\_\_\_\_  
 Medical record  Patient vaccination card  Verbal only/no documentation  Other state IIS

Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_  
 Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_  
 Information source  Washington Immunization Information System (WIIS) WIIS ID number \_\_\_\_\_  
 Medical record  Patient vaccination card  Verbal only/no documentation  Other state IIS

**Y N Unk**

- Haemophilus influenzae vaccination up to date for age per ACIP  
 Vaccine series not up to date reason  
 Religious exemption  Medical contraindication  Philosophical exemption  
 Laboratory confirmation of previous disease  MD diagnosis of previous disease  
 Underage for vaccine  Parental refusal  Other  Unknown

**Hospitalization**

**Y N Unk**

- Hospitalized at least overnight for this illness Facility name \_\_\_\_\_  
 Hospital admission date \_\_\_/\_\_\_/\_\_\_ Discharge \_\_\_/\_\_\_/\_\_\_ HRN \_\_\_\_\_  
 Disposition  Another acute care hospital Facility name \_\_\_\_\_  
 Died in hospital  
 Long term acute care facility Facility name \_\_\_\_\_  
 Long term care facility Facility name \_\_\_\_\_  
 Non-healthcare (home)  Unk  Other \_\_\_\_\_  
   Admitted to ICU Date admitted to ICU \_\_\_/\_\_\_/\_\_\_ Date discharged from ICU \_\_\_/\_\_\_/\_\_\_  
   Mechanical ventilation or intubation required  
   Still hospitalized As of \_\_\_/\_\_\_/\_\_\_

**Y N Unk**

- Died of this illness Death date \_\_\_/\_\_\_/\_\_\_ *Please fill in the death date information on the Person Screen*  
   Autopsy performed  
   Death certificate lists disease as a cause of death or a significant contributing condition  
 Location of death  Outside of hospital (e.g., home or in transit to the hospital)  Emergency department (ED)  
 Inpatient ward  ICU  Other \_\_\_\_\_

**RISK AND RESPONSE (Ask about exposures 1-7 days before symptom onset)**

**Travel**

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

**Risk and Exposure Information**

**Y N Unk**

- Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country \_\_\_\_\_  
   Contact with recent foreign arrival Country \_\_\_\_\_ Date(s) of contact \_\_\_/\_\_\_/\_\_\_  
   Congregate living  
 Barracks  Corrections  Long term care  Dormitory  Boarding school  Camp  Shelter  
 Other \_\_\_\_\_

**Exposure and Transmission Summary**

**Y N Unk**

- Epidemiologically linked to a lab positive case classified as confirmed**
- Likely geographic region of exposure  In Washington – county \_\_\_\_\_  Other state \_\_\_\_\_  
 Not in US - country \_\_\_\_\_  Unk
- International travel related  During entire exposure period  During part of exposure period  No international travel
- Suspected exposure type  Person to person  Healthcare Associated  Unk  Other \_\_\_\_\_  
 Describe \_\_\_\_\_
- Suspected exposure setting  Daycare/Childcare  School (not college)  Doctor's office  Hospital ward  Hospital ER  
 Hospital outpatient facility  Home  Work  College  Military  Correctional facility  Place of worship  
 Laboratory  Long term care facility  Homeless/shelter  International travel  Out of state travel  Transit  
 Social event  Large public gathering  Restaurant  Hotel/motel/hostel  Other \_\_\_\_\_  
 Describe \_\_\_\_\_
- Exposure summary \_\_\_\_\_

Suspected transmission type (check all that apply)  Person to person  Healthcare Associated  Unk

Other \_\_\_\_\_

Describe \_\_\_\_\_

Suspected transmission setting (check all that apply)  Daycare/Childcare  School (not college)  Doctor's office

Hospital ward  Hospital ER  Hospital outpatient facility  Home  Work  College  Military

Correctional facility  Place of worship  Laboratory  Long term care facility  Homeless/shelter

International Travel  Out of state travel  Transit  Social event  Large public gathering  Restaurant

Hotel/motel/hostel  Other \_\_\_\_\_

Describe \_\_\_\_\_

**Public Health Issues**

**Y N Unk**

Evaluate immune status of close contacts  Yes Date initiated \_\_\_/\_\_\_/\_\_\_

Number of close contacts evaluated for immune status \_\_\_\_\_

Number of susceptible contacts identified \_\_\_\_\_

No, close contacts not evaluated

No, case had no close contacts

Unk

*If needed, enter detailed information in the Transmission Tracking Question Package*

**Public Health Interventions/Actions**

**Y N Unk**

Prophylaxis of appropriate contacts recommended Date initiated \_\_\_/\_\_\_/\_\_\_

Number of contacts recommended prophylaxis \_\_\_\_\_

Number of contacts receiving prophylaxis \_\_\_\_\_

Number of contacts completing prophylaxis \_\_\_\_\_

Letter sent Date \_\_\_/\_\_\_/\_\_\_ Batch date \_\_\_/\_\_\_/\_\_\_

**TRANSMISSION TRACKING**

Visited, attended, employed, or volunteered at any public settings while contagious  Yes  No  Unk

Settings and details (check all that apply)

Day care  School  Airport  Hotel/Motel/Hostel  Transit  Health care  Home  Work  College

Military  Correctional facility  Place of worship  International travel  Out of state travel  LTCF

Homeless/shelter  Social event  Large public gathering  Restaurant  Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
	Setting 1	Setting 2	Setting 3	Setting 4
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

*If list of contacts is known, please fill out Contact Tracing Form Question Package*

**TREATMENT**

**Y N Unk**

Did patient receive prophylaxis/treatment

Specify antibiotic \_\_\_\_\_

Number of days actually taken \_\_\_\_\_ Treatment start date \_\_\_/\_\_\_/\_\_\_ Treatment end date \_\_\_/\_\_\_/\_\_\_

**NOTES**

**LAB RESULTS**Lab report information**Lab report reviewed – LHJ** 

WDRS user-entered lab report note \_\_\_\_\_

Submitter \_\_\_\_\_

Performing lab for entire report \_\_\_\_\_

Referring lab \_\_\_\_\_

Specimen**Specimen identifier/accession number** \_\_\_\_\_**Specimen collection date** \_\_\_/\_\_\_/\_\_\_ Specimen received date \_\_\_/\_\_\_/\_\_\_**WDRS specimen type** \_\_\_\_\_

WDRS specimen source site \_\_\_\_\_

WDRS specimen reject reason \_\_\_\_\_

Test performed and result**WDRS test performed** \_\_\_\_\_**WDRS test result, coded** \_\_\_\_\_

WDRS test result, comparator \_\_\_\_\_

**WDRS result, numeric only** (enter only if given, including as necessary **Comparator** and **Unit of measure**) \_\_\_\_\_

WDRS unit of measure \_\_\_\_\_

Test method \_\_\_\_\_

WDRS interpretation code \_\_\_\_\_

Test result – Other, specify \_\_\_\_\_

**WDRS result summary**  Positive  Negative  Indeterminate  Equivocal  Test not performed  PendingTest result status  Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date \_\_\_/\_\_\_/\_\_\_

**Upload document**Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).