Leeds, Grenville & Lanark District HEALTH UNIT

# HAEMOPHILUS INFLUENZAE, INVASIVE REPORTING FORM
## EMAILS WILL NOT BE ACCEPTED FAX: 613-345-5777

| REPORTING SOURCE | | iPHIS CASE NUMBER: | |
|---|---|---|---|
| Name: | Agency: | | |
| Phone #: | Date (y/m/d): | Time: | |

| CLIENT INFORMATION | | | |
|---|---|---|---|
| Last Name: | First Name: | | Gender: |
| Phone #: | DOB (y/m/d): | | |
| Address: | City: | Postal Code: | |
| Name of Parent/Guardian (if applicable): | | Cell/Work #: | |
| Name of Daycare/School/Workplace:<br>Address: | | Occupation:<br>Phone #: | |
| **HEALTH CARE PROVIDER:** | Phone #: | Fax #: | |

**LAB INFORMATION AND TREATMENT**

| Specimen Site | Serotype | Result | Collection date (y/m/d) | Reported date (y/m/d) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| Antibiotic Treatment (dose, route, frequency, duration) | Treatment start date (y/m/d) | Treatment end date (y/m/d) |
|---|---|---|
| | | |

**CASE DETAILS**

| Doctor who made diagnosis: | Phone #: |
|---|---|
| Onset Date (y/m/d): | Date of Diagnosis (y/m/d): |

**Symptoms (fever, vomiting, lethargy, meningeal irritation, bulging fontanelle, stiff neck, cellutis, otitis media) (i.e. Meningitis, bacteraemia, epiglottitis, pneumonia, pericarditis, septic arthritis, empyema)**

List Symptoms:

Possible source of infection:

History of Travel/Location/Dates:

Immunization up-to-date: Yes ☐ No ☐

| 1st Dose (y/m/d) | 2nd Dose (y/m/d) | 3rd Dose (y/m/d) | 4th Dose (y/m/d) |
|---|---|---|---|
| | | | |

| Hospitalized: Yes ☐ No ☐ | Admitted (y/m/d): | Discharged (y/m/d): |
|---|---|---|
| Name of Hospital: | | |
| Complications: | | Outcome: |

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| RISK FACTORS | | |
|---|---|---|
| **For Disease Acquisition:** | | |
| ☐ Not immunized for HIB | ☐ Underlying chronic condition | ☐ Immunocompromised (specify): |
| ☐ Other: | | ☐ Unknown |
| **For Disease Transmission:** | | |
| ☐ Daycare attendee or worker | ☐ Direct contact with immunocompromised patients and/or infants | |

**CONTACTS**

**CLOSE CONTACTS *(for type B only)* – identified according to protocol:** Ensure all household and child care contacts receive prophylactic antibiotics as soon as possible (up to 14 days; see protocol for recommended chemoprophylaxis.) Provide counseling and education re: the risk of disease, the signs and symptoms to watch for, and information on the prophylactic antibiotic, as well as HIB vaccination.

| NAME | AGE | RELATIONSHIP/HCW/DAYCARE | PHONE # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |
| | | | |

**FOLLOW-UP**

| | | |
|---|---|---|
| Daycare/School informed | Yes ☐ | No ☐ |
| Have parents of children at daycare/school been informed | Yes ☐ | No ☐ |
| Have parents of children at daycare/school been given a letter | Yes ☐ | No ☐ |

Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c. H.7.

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| *FOR HEALTH UNIT USE ONLY* | | | | |
|---|---|---|---|---|
| **NOTES (Response/Assessment/Intervention/Plan)** | | | **INVESTIGATOR:** | |
| | | | **iPHIS Client #:** | |
| **DATE** | **TIME** | | **iPHIS Case/Incident #:** | |
| | | Notes taken by:<br>Notes: | | |
| | | Notes taken by:<br>Notes: | | |
| | | Notes taken by:<br>Notes: | | |
| | | Notes taken by:<br>Notes: | | |
| | | Notes taken by:<br>Notes: | | |
| | | Notes taken by:<br>Notes: | | |
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