California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Immunization Branch
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HAEMOPHILUS INFLUENZAE CASE REPORT

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Name	Suffix

Social Security Number (9 digits)	DOB (mm/dd/yyyy)	Age	☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	Apartment / Unit Number

City / Town	State	Zip Code

Census Tract	County of Residence	Country of Residence

Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)

Home Telephone	Cellular Phone / Pager	Work / School Telephone

E-mail Address	Other Electronic Contact Information
Work / School Location	**Work / School Contact**

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	If Yes, Est. Delivery Date (mm/dd/yyyy)
Medical Record Number	Patient's Parent/Guardian Name
Occupation Setting	Other Describe/Specify
Occupation	Other Describe/Specify

Primary Language
☐ English
☐ Spanish
☐ Other: ____________________

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 7)
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

☐ American Indian or Alaska Native

☐ Asian (check all that apply, see list on page 7)
- ☐ Asian Indian ☐ Korean
- ☐ Bangladeshi ☐ Laotian
- ☐ Cambodian ☐ Malaysian
- ☐ Chinese ☐ Pakistani
- ☐ Filipino ☐ Sri Lankan
- ☐ Hmong ☐ Taiwanese
- ☐ Indonesian ☐ Thai
- ☐ Japanese ☐ Vietnamese
- ☐ Other: ____________________

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 7)
- ☐ Native Hawaiian ☐ Samoan
- ☐ Fijian ☐ Tongan
- ☐ Guamanian
- ☐ Other: ____________________

☐ White

☐ Other: ____________________

☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

CLINICAL INFORMATION

Clinical Syndrome

☐ Meningitis	☐ Bacteremia	☐ Epiglottitis	☐ Pneumonia	☐ Otitis media	☐ Cellulitis
☐ Peritonitis	☐ Pericarditis	☐ Septic abortion	☐ Amnionitis	☐ Septic arthritis	☐ Conjunctivitis
☐ Other					

If Other, specify:

Symptom Onset Date (mm/dd/yyyy)	Diagnosis Date (mm/dd/yyyy)	
If Other symptoms, describe:		

NEONATAL CASES

Is the patient < 1 month of age? ☐ Yes ☐ No ☐ Unknown	If Yes, time of birth (military, HH:MM)
Gestational Age (weeks)	Birth Weight (grams)

HOSPITALIZATION

Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unknown	Was patient hospitalized? ☐ Yes ☐ No ☐ Unknown
How many total nights?	During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)? ☐ Yes ☐ No ☐ Unknown

HOSPITALIZATION – DETAILS

Hospital Name	Street Address		
City	State	ZIP Code	Telephone
Admit Date (mm/dd/yyyy)	Discharge Date (mm/dd/yyyy)		
Medical Record Number			
Discharge Diagnosis			
Insurance Provider			

COMPLICATIONS AND OTHER SYMPTOMS

Describe Complications:

Did patient die?

☐ Yes ☐ No ☐ Unknown

VACCINATION HISTORY

Has the patient been immunized for this disease?

☐ Yes ☐ No ☐ Unknown

Dose #1 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Dose #2 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Dose #3 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Dose #4 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	

Reason Not Vaccinated:

☐ Personal Beliefs Exemption (PBE) ☐ Permanent Medical Exemption (PME) ☐ Temporary Medical Exemption ☐ Lab confirmation of previous disease ☐ MD diagnosis of previous disease ☐ Under age for vaccination ☐ Delay in starting series or between doses ☐ Unknown ☐ Other

If other, specify:

COMMENTS

MEDICAL HISTORY

Immunocompromised ☐ Yes ☐ No ☐ Unknown	Does this patient have recurrent disease with the same pathogen? ☐ Yes ☐ No ☐ Unknown
Other pre-existing conditions:	

LABORATORY RESULTS SUMMARY

Case Lab Confirmed ☐ Yes ☐ No ☐ Unknown	
CSF Bacterial Antigen Screen	CSF Bacterial Antigen Screen Results
Was culture performed? ☐ Yes ☐ No ☐ Unknown	

CULTURES PERFORMED – DETAILS

Source of specimen	If Other, specify:
Specimen Collection Date (mm/dd/yyyy)	Result

ISOLATE SEROTYPE

Was isolate serotyped? ☐ Yes ☐ No ☐ Unknown	Isolate Serotype
If Other type, specify:	
Serotype method:	
Isolate forwarded to MDL for testing? ☐ Yes ☐ No ☐ Unknown	Date Sent (mm/dd/yyyy)
MDL Serotype	
Isolate forwarded to CDC for testing? ☐ Yes ☐ No ☐ Unknown	Date Sent (mm/dd/yyyy)
CDC Serotype	
Comments	

EPIDEMIOLOGICAL EXPOSURE HISTORY	
Is there a known previous contact with Hib disease within the preceding 2 months? ☐ Yes ☐ No ☐ Unknown	If Yes, specify type of contact ☐ Yes ☐ No ☐ Unknown
Does this patient attend a daycare facility? ☐ Yes ☐ No ☐ Unknown	If Yes, specify type of contact
Does this patient reside in a long term care facility? ☐ Yes ☐ No ☐ Unknown	If Yes, specify type of contact

SPREAD SETTING	
Setting Type	Name of Setting
First Date of Contact (mm/dd/yyyy)	Last Date of Contact (mm/dd/yyyy)
Number Exposed	Notes

CASE DEFINITION (2015) – HAEMOPHILUS INFLUENZAE

CLINICAL DESCRIPTION

Invasive disease may manifest as pneumonia, bacteremia, meningitis, epiglottitis, septic arthritis, cellulitis, or purulent pericarditis; less common infections include endocarditis and osteomyelitis.

LABORATORY CRITERIA FOR DIAGNOSIS

Isolation of Haemophilus influenzae from a normally sterile body site (e.g., blood or CSF, or less commonly, joint, pleural, or pericardial fluid);

OR

Detection of H. influenzae-specific nucleic acid in a specimen obtained from a normally sterile body site (e.g., blood or CSF), using a validated polymerase chain reaction (PCR) assay

CASE CLASSIFICATION

Probable: Meningitis with detection of Haemophilus influenzae type b antigen in cerebrospinal fluid (CSF).

Confirmed: A clinically compatible case that is laboratory confirmed.

Investigator name (print)	Telephone number
Agency Name	
Date (mm/dd/yyyy)	

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

Bangladeshi	Filipino	Japanese	Maldivian	Sri Lankan
Bhutanese	Hmong	Korean	Nepalese	Taiwanese
Burmese	Indian	Laotian	Okinawan	Thai
Cambodian	Indonesian	Madagascar	Pakistani	Vietnamese
Chinese	Iwo Jiman	Malaysian	Singaporean	

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

Carolinian	Kiribati	Micronesian	Pohnpeain	Tahitian
Chamorro	Kosraean	Native Hawaiian	Polynesian	Tokelauan
Chuukese	Mariana Islander	New Hebrides	Saipanese	Tongan
Fijian	Marshallese	Palauan	Samoan	Yapese
Guamanian	Melanesian	Papua New Guinean	Solomon Islander	