

Communicable Diseases Case Questionnaire

Hepatitis A / E

Date:	/ /
Interviewer:	
Person Interviewed (if not case):	
NDD Number	
NDD Updated?	/ /
Interpreter used? language:	<input type="checkbox"/> No <input type="checkbox"/> Yes
PROBABLE SOURCE	

Laboratory Confirmed Case - IgM

PRIVACY MESSAGE : The information you provide in this questionnaire is for the purpose of trying to prevent further cases of illness. We do this by trying to find out what is likely to have caused your illness and also by providing you with information to reduce the spread of illness to others. The data collected is kept confidential and identifying information will not be disclosed for any other purpose without your consent. You can access your information by contacting the NSW Department of Health.

Information read? SECTION 1: DEMOGRAPHIC DATA

Surname:

Other names:

Street Address:

Suburb/Town: Postcode:

Telephone: H: () W: ()

Date of Birth: / / or Age: Sex: Male / Female

Country of Birth:	Of Aboriginal or Torres Strait Islander Origin?
Language Spoken at Home:	No <input type="checkbox"/>
⇒ Occupation:	Aboriginal <input type="checkbox"/>
	Torres Strait Islander <input type="checkbox"/>
	Both Aboriginal and Torres Strait Islander <input type="checkbox"/>

Name / Address of Employer or School or Child Care Attended:

Telephone: Facsimile:

Date Last Attended Prior To Onset: / / **High Risk occupational group?** no yes

* High risk occupations are food handlers, health care workers, child care workers and children in child care
 ⇒ - Refer to Section 9 if case is Food Handler, CCC worker, Health care worker, Child in CCC/preschool, or Institutionalised

SECTION 2: TREATING DOCTOR / HOSPITAL / LABORATORY

Name of Treating Dr: _____

Hospital (if admitted): _____ UR No: _____

Address: _____

Telephone: _____ Facsimile: _____

Date of Admission: ____ / ____ / ____ Date of Discharge / Death ____ / ____ / ____

Name of Laboratory: _____ Telephone: _____

Consent given by Doctor to interview: no yes Date: ____ / ____ / ____

SECTION 3: ILLNESS (SUMMARY)

Onset date of illness: ____ / ____ / ____

Time of onset: am / pm Total duration of illness: days

Date of blood test 1: ____ / ____ / ____ Result (+ve): IgM IgG Total

Date of blood test 2: ____ / ____ / ____ Result (+ve): IgM IgG Total

Comments:

SYMPTOMS	Yes/ no/ unknown
Fever	
Nausea	
Vomiting	
Abdominal pain	
Jaundice	Onset date:

SYMPTOMS	Yes/ no/ unknown
Dark Urine	Onset date:
Body aches	
Diarrhoea	Onset date: Duration:
Headache	
Other (Specify)	

Has case received Hepatitis A vaccination in the past? no yes unknown

Dose 1: ____ / ____ / ____ date unknown

Dose 2: ____ / ____ / ____ date unknown not given

Dose 3: ____ / ____ / ____ date unknown not given

Name / brand of vaccine: unknown

Did case receive immunoglobulin (Ig) instead of vaccination: no yes ____ / ____ / ____

Source of information **Usual GP/Vax provider details**

Validated source eg ACIR, LGA register, health record (must include date given) _____

Not a validated source eg self or parental recall only _____

History of illness:

SECTION 6: POSSIBLE FOOD OR WATER SOURCES

* Do not complete Section 6 if a source of infection already identified.

For the Incubation Period (7 weeks prior to onset) / / (2 weeks prior to onset) to / /

A. POSSIBLE FOOD / WATER SOURCES

Visited any restaurants / cafes / takeaway food premises during incubation period? no yes

Record the takeaway / restaurants / cafes that the patient visited in the incubation period, and food eaten there and when:

Possible Source	Applies	Details
Ate raw fish?	no <input type="checkbox"/> yes <input type="checkbox"/>	Date: ___/___/___ Type / Brand:..... Where purchased:.....
Ate oysters / mussels?	no <input type="checkbox"/> yes <input type="checkbox"/>	Date: ___/___/___ Type / Brand:..... Where purchased:.....
Ate other shellfish?	no <input type="checkbox"/> yes <input type="checkbox"/>	Date: ___/___/___ Type / Brand:..... Where purchased:.....
Ate fresh / frozen berries?	no <input type="checkbox"/> yes <input type="checkbox"/>	Date: ___/___/___ Type / Brand:..... Where purchased:.....
Ate sun dried tomatoes?	no <input type="checkbox"/> yes <input type="checkbox"/>	Date: ___/___/___ Type: Loose / bagged / Bottled / Other _____ Brand:..... Where purchased:.....
Ate semi dried dried tomatoes?	no <input type="checkbox"/> yes <input type="checkbox"/>	Date: ___/___/___ Type: Loose / bagged / Bottled / Other _____ Brand:..... Where purchased:.....
Ate other dried tomatoes?	no <input type="checkbox"/> yes <input type="checkbox"/>	Date: ___/___/___ Type: Loose / bagged / Bottled / Other _____ Brand:..... Where purchased:.....
Sporting groups or clubs	no <input type="checkbox"/> yes <input type="checkbox"/>	Specify:
Drunk from private water supply	no <input type="checkbox"/> yes <input type="checkbox"/>	Specify type: Location:

	Is water treated? no <input type="checkbox"/> yes <input type="checkbox"/> unknown <input type="checkbox"/>
Participated in Swimming / Water Sports no <input type="checkbox"/> yes <input type="checkbox"/>	Activity:
	Type of water (eg. pool, river, etc):
	Address:
	Date : ____/____/____

SECTION 7: COMMENTS OR CONCLUSIONS

Probable Source of Illness:

Comments:

SECTION 8: EDUCATION

Hygiene and preventing transmission discussed No Yes N/A

Information provided No Yes N/A Date Sent: ____/____/____

Referred to Website

⇒ SECTION 9: HIGH RISK SCENARIO FOLLOW UP AND EXCLUSIONS

For the Incubation Period (7 weeks prior to onset) / / (2 weeks prior to onset) to / /

Tick box that describes case:

Institutional resident Child in CCC CCC worker Health care worker Food handler

Name of related premises:

Date last attended: ____/____/____

Permission to disclose details to premises? no yes

Does the premises prepare food or handle food? no <input type="checkbox"/> yes <input type="checkbox"/>	Case Details:
If a CCC worker / child, does nappy changing / wearing occur? no <input type="checkbox"/> yes <input type="checkbox"/>	Case Details:

Movements of case at work / CCC / institution:

Date:____/____/____ Day:..... Hours:..... Location:.....

Date:____/____/____ Day:..... Hours:..... Location:.....

Date:____/____/____ Day:..... Hours:..... Location:.....

Date:____/____/____ Day:..... Hours:..... Location:.....

Date:____/____/____ Day:..... Hours:..... Location:.....

Exclusion required? no yes

Exclusion discussed with case / parent / guardian. no <input type="checkbox"/> yes <input type="checkbox"/>	<i>It is required that if the cases is in a high risk setting / occupation, they be excluded from attendance / work until diarrhoea has ceased and 7 days after onset of jaundice.</i>
Information provided? no <input type="checkbox"/> yes <input type="checkbox"/>	
Surveillance letter sent to contacts at premises? no <input type="checkbox"/> yes <input type="checkbox"/>	Date sent: ___/___/___
Ig advised for contacts at premises? no <input type="checkbox"/> yes <input type="checkbox"/>	Define contacts (Specify Ig cut off date):

SIGNATURE

Name of interviewer (please print clearly): _____
Interviewer's Signature: _____ Date: ___/___/___

ATTEMPTS TO CONTACT CASE

Date	Time	Comments

INVESTIGATION NOTES

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