

**Communicable Diseases
Case Questionnaire**

Listeriosis Perinatal

PFGE pattern: (If Applicable)

.....

Serotype (if Applicable):

.....

<i>Date:</i>	/ /
<i>Interviewer:</i>	
<i>Person Interviewed (if not case):</i>	
<i>Local Database Number</i>	
<i>Local Database Updated?</i>	/ /
<i>File Ref:</i>	

SPORADIC CASE

CASE PART OF AN OUTBREAK

LOCAL 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 Department of Human Services. A fact sheet is available ("Privacy Legislation & Notification of Infectious Diseases – Information for Patients") if you would like further information.

Information read? **Consent to interview** *no*

yes

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: _____

Language spoken at home: _____

Of Aboriginal or Torres Strait Islander Origin?

No

Aboriginal

Torres Strait Islander

Both Aboriginal and Torres Strait Islander

Interpreter required: *no* *yes*

Occupation:

Which of the following areas best describes where the case lives?

Inner city or urban area.....

Suburban area.....

Town.....

Rural or remote community.....

Rural or remote area farm or property.....

SECTION 2: TREATING DOCTOR / HOSPITAL

Name of Treating :

Doctor or Hospital (if admitted): UR No

Street Address:

Suburb/Town:

Telephone:

Facsimile:

Date of Admission: / /

Date of Mother's Discharge / /

Reason for Admission: Due to Listeriosis
no yes

If admission not for listeriosis- Please state:

Date of Delivery: / /

Expected Date of Delivery: / /

If Baby deceased, cause of death: Due to Listeriosis

Due to other causes - Please state:

Date of Death: / /

Consent given by Dr to interview case: no yes

Date: / /

Go to Section 4.

SECTION 3: ILLNESS (SUMMARY)

Onset date of illness: ____/____/____ Date of Earliest Specimen Collection: ____/____/____

Culture Site: Mother: CSF Blood Other _____

Culture Site: Baby: CSF Blood Gastric aspirate Meconium Other _____

In the 4 weeks before onset of illness did the case have any of the following symptoms:

Symptoms	
Fever	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>
Chills	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>
Skin Rash	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>
Headache	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>
Stiff Neck	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>
Runny Nose	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>

Symptoms	Yes/ no/ unknown
Muscle Aches	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>
Diarrhoea	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>
Vomiting	no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/>
Other - Specify	

Onset of diarrhoea:/...../.....

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Sore Throat	no <input type="checkbox"/>	yes <input type="checkbox"/>	unk <input type="checkbox"/>
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Max stools in 24 hours:

SECTION 4: MEDICAL HISTORY

Does the case have any of the following illnesses or conditions?	Doctor (response)	Case (response)
Diabetes	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Heart disease	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Hypertension/high blood pressure	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Kidney dialysis	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Organ transplant	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Liver disease	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Cancer (type _____)	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Lupus	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Arthritis	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Lung disease (excluding asthma)	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Sickle cell anaemia	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Spleen removed	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Has the case ever had a surgical implant (where _____)	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Other illness or condition that weakens immune system. Specify _____	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes

Comments: _____

In the four weeks before the onset of illness was the case taking any of the following medication?

	Doctor (response)	Case (response)
Prednisone	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Cyclosporine	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Chemotherapy	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Radiation therapy	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Antibiotics (Specify _____)	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Antidiarrhoeal medication (eg Lomotil)	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Antacids (eg Mylanta)	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Medication that decreased stomach acid (eg Zantac)	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
Other (specify _____)	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes

Comments: _____

Has the case had any hospital day visits (where food may have been eaten) in the 2 months prior to onset of illness?

no yes

1. Date ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ Hospital: _____

Has the case had any hospital admissions (where food may have been eaten) in the 2 months prior to onset of illness?

no yes

1. Admission date ___/___/___ Discharge date ___/___/___ Hospital: _____

2. Admission date ___/___/___ Discharge date ___/___/___ Hospital: _____

Comments: _____

SECTION 5: RISK FACTOR DATA

In the 4 weeks before the onset of illness did the case:

Live in a residential institution no yes Details: _____

Have contact with pets no yes Details: _____

Have contact with farm animals no yes Details: _____

If Yes, have contact with "silage" (fermented cattle feed) no yes Details: _____

Travel overseas no yes Where: _____

Dates of travel Departure: __/__/__ Return: __/__/__

Travel within Australia no yes Where: _____

Dates of travel Departure: __/__/__ Return: __/__/__

SECTION 6: POSSIBLE FOOD SOURCES

(INTERVIEWER NOTE: if the patient has consumed any of these foods during a hospital admission / day surgery / outpatient clinic etc, indicate whether food was purchased at the hospital cafeteria or served on the ward)

Did the case eat or drink any of the following during the four weeks before becoming ill?

Fruits and Vegetables	Brand	Where purchased or eaten
Salads from a self serve salad bar	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk	
Prepared salad from a delicatessen	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk	
Prepared salad - other source	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Fruit salad from a self serve salad bar	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Prepared fruit salad from a delicatessen	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Prepared fruit salad - other source	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Bagged lettuce/green salad mix	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Bagged coleslaw mix	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Loose self serve lettuce/green salad mix	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Whole Lettuce	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Canteloupe/rockmelon	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Watermelon	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Strawberries	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Other berries	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Uncooked mushrooms	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Alfalfa/pea sprouts	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	
Bean shoots	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> uk.....	

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- Fresh herbs eaten raw - coriander no yes uk.....
- Parsley no yes uk.....
- Mint no yes uk.....
- Raw vegetable garnish no yes uk.....
- Do you grow any of your produce? no yes uk Specify _____
- Was animal manure or fertiliser containing animal manure used to grow the homegrown produce? no yes uk

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Fresh Fruit and/or Vegetable juices

Brand

Where purchased or eaten

- Fresh fruit juice (state type) no yes uk.....
- Fresh vegetable juice (state stype) no yes uk.....

Deli meats, cheeses and produce

- Barbeque chicken no yes uk.....
- Cold cooked chicken no yes uk.....
- Devon/luncheon meat no yes uk.....
- Ham no yes uk.....
- Salami or other similar uncooked meats no yes uk.....
- Pate no yes uk.....
- Dips no yes uk.....
- Liverwurst no yes uk.....
- Uncooked Hot dogs no yes uk.....
- Brie no yes uk.....
- Camembert no yes uk.....
- Blue-veined no yes uk.....
- Fetta no yes uk.....
- Ricotta no yes uk.....
- Mozarella no yes uk.....
- Cottage Cheese no yes uk.....
- Other soft cheese (specify type) no yes uk.....
- Unpasteurised Milk or cheese no yes uk.....
- Soft-serve Ice-cream no yes uk.....

Seafood (fresh or frozen only)

- Mussels no yes uk.....
- Prawns (state if purchased cooked or raw) no yes uk.....
- Oysters no yes uk.....
- Smoked Salmon no yes uk.....
- Sushi (California rolls etc) no yes uk.....

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Sashimi (raw fish: eg Tuna, Salmon) no yes uk.....

Other smoked fish/seafood no yes uk.....

List any high risk foods not previously listed but mentioned by the case _____

SECTION 7: COMMENTS OR CONCLUSIONS

Before this illness with Listeriosis, did a healthcare worker tell you to avoid certain foods to prevent Listeriosis? no yes

Comments:

Is this case linked to any other notified case? No Not sure Yes

Signature: _____ ref: _____

ATTEMPTS TO CONTACT CASE

Date	Time	Comments

Will food samples be taken for analysis? no yes

Foods will be sampled by (Name of organization or local council) _____

Date sampled	Name of food sampled	Name and address of premises food sampled from

