☐ Sporadic case

☐ **Case part of outbreak - Outbreak ref**_____

Listeria Case Questionnaire

Attempt	Date	Time	Outcome
1	___ / ___ / _____	_____ am / pm	_____
2	___ / ___ / _____	_____ am / pm	_____
3	___ / ___ / _____	_____ am / pm	_____
4	___ / ___ / _____	_____ am / pm	_____

Call Outcomes
OC1 – No Answer
OC2 – Subject not home, call back
OC3 – Appointment to call back
OC4 – Refusal
OC5 - Interviewed

Interviewer: _____
Date of interview: _____/____/____
State ID no.: _____
National ID no.: _____

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?*** ☐

Note: The following preliminary information can be recorded prior to interview if known

Person interviewed (if not case):

Patient details

First Name: _____ Address: _____

Last Name: _____ _____

Telephone: _____ (Home) _____

_____ (Mobile) Post Code: _____

_____ (Work) Occupation: _____

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

Do you identify yourself as indigenous or of a particular ethnic background? ☐ Yes ☐ No

If yes:

☐ Aboriginal ☐ TSI ☐ both Aboriginal & TSI ☐ other: _____

Country of birth: _____ Language spoken at home: _____

Case admitted to hospital? ☐ Yes ☐ No Hospital: _____

Date of admission: _____ / _____ / _____ Date of discharge: _____ / _____ / _____

Hospital UR#: _____ Notification Date: _____ / _____ / _____

Reason for admission: ☐ Listeriosis ☐ Other _____

Treating Doctor: _____ Telephone: _____

Hospital / Medical Practice: _____

Medical & diagnostic information

Typing	Result	Conducted by (lab name):
Serotype (PCR)		
Binary type		

Has the isolate been forwarded for further typing? ☐ Yes ☐ No

PFGE		
Other: _____		

☐ Non-perinatal case

Culture site (case): ☐ CSF ☐ Blood ☐ Other _____ Collection date: ___ / ____/ ___ Day: _____

Nature of illness (case): ☐ Meningitis ☐ Septicaemia ☐ Other _____

Outcome: ☐ Survived
☐ Died Date of death: ___ / ___/ ___ Death due to listeriosis? ☐ Yes ☐ No
☐ Unknown

☐ Perinatal case

Mother

Culture Site	**Specimen collection date**
☐ Blood	____ / ____ / _____
☐ CSF	____ / ____ / _____
☐ Placenta	____ / ____ / _____
☐ Other	____ / ____ / _____

Specify: _____

Foetus / Neonate

Culture Site	**Specimen collection date**
☐ Blood	____ / ____ / _____
☐ CSF	____ / ____ / _____
☐ Gastric aspirate	____ / ____ / _____
☐ Meconium	____ / ____ / _____
☐ Other	____ / ____ / _____

Specify: _____

Outcome of pregnancy	**Weeks Gestation**	**Date**
☐ Still pregnant…….	_____	____ / ____ / _____
☐ Foetal death (miscarriage / stillbirth)…….	_____	____ / ____ / _____
☐ Induced abortion……..	_____	____ / ____ / _____
☐ Delivery (live birth)……..	_____	____ / ____ / _____
☐ Other _____	_____	____ / ____ / _____

Type(s) of illness in mother (tick all that apply)

☐ Bacteremia / sepsis
☐ Meningitis
☐ Febrile gastroenteritis
☐ Amnionitis
☐ Non-specific “flu-like” illness
☐ None
☐ Other: _____
☐ Unknown

Type(s) of illness in foetus / neonate (tick all that apply)

☐ Bacteremia / sepsis
☐ Meningitis
☐ Pneumonia
☐ Granulomatosis infantisepticum
☐ None
☐ Other: _____
☐ Unknown

Mother’s outcome

☐ Survived
☐ Died
date: ____ / ____ / _____
☐ due to Listeria
☐ due to other cause (specify)
_____
☐ Unknown

Foetus / Neonate outcome

☐ Survived
☐ Died
date: ____ / ____ / _____
☐ due to Listeria
☐ due to other cause (specify)
_____
☐ Unknown

NOTE: For perinatal cases ask the remaining questions of the mother

Clinical history

Date of onset of illness: _____ / _____ / _____

In the 4 week period prior to diagnosis of Listeria, did you experience any of the following symptoms?

Symptom	Yes	No	DK/NS	Onset date
Fever ……	☐	☐	☐	_____ / ____ / _____
Chills/shakes……	☐	☐	☐	_____ / ____ / _____
Headache……	☐	☐	☐	_____ / ____ / _____
Stiff neck……..	☐	☐	☐	_____ / ____ / _____
Confusion…….	☐	☐	☐	_____ / ____ / _____
Diarrhoea……..	☐	☐	☐	_____ / ____ / _____
Vomiting ……...	☐	☐	☐	_____ / ____ / _____
Muscle & Body Aches……	☐	☐	☐	_____ / ____ / _____
Other symptoms…….	☐	☐	☐	_____ / ____ / _____
Specify _____				

Do you have any of the following illnesses or conditions?

Illness / condition	Case (response) Yes	No	DK/NS	Doctor (response) Yes	No	DK/NS
Diabetes- insulin dependant……..	☐	☐	☐	☐	☐	☐
Diabetes- non-insulin dependant……..	☐	☐	☐	☐	☐	☐
Heart disease ……..	☐	☐	☐	☐	☐	☐
Renal / kidney disease requiring dialysis……	☐	☐	☐	☐	☐	☐
Other renal disease ……	☐	☐	☐	☐	☐	☐
Rheumatological condition ……	☐	☐	☐	☐	☐	☐
Blood disorder ……..	☐	☐	☐	☐	☐	☐
Organ transplant ……..	☐	☐	☐	☐	☐	☐
Cancer (_____)	☐	☐	☐	☐	☐	☐
Liver disease……	☐	☐	☐	☐	☐	☐
Chronic lung disease (excluding asthma) ….	☐	☐	☐	☐	☐	☐
Other illness or condition ……..	☐	☐	☐	☐	☐	☐
Specify_____						

In the 4 weeks prior to illness, were you taking any of the following treatments?

Treatments	Case (response) Yes	No	DK/NS	Doctor (response) Yes	No	DK/NS
Corticosteroids (e.g. prednisone) ……...	☐	☐	☐	☐	☐	☐
Cyclosporine ……..	☐	☐	☐	☐	☐	☐
Other drugs that affect the immune system	☐	☐	☐	☐	☐	☐
Chemotherapy ……...	☐	☐	☐	☐	☐	☐
Radiation therapy ……..	☐	☐	☐	☐	☐	☐
Antibiotics (_____)...	☐	☐	☐	☐	☐	☐
Antidiarrhoeal medication (e.g. Lomotil, Imodium) ..	☐	☐	☐	☐	☐	☐
Antacids (e.g. Mylanta, Mucaine)……	☐	☐	☐	☐	☐	☐
Medications that reduce stomach acid (e.g. Zantac, Tagamet, Somac, Losec)……...	☐	☐	☐	☐	☐	☐
Other (_____)	☐	☐	☐	☐	☐	☐

Comments: _____

Hospital admission and day visits (for treatment/care)

Did you have any hospital day visits in the 12 weeks prior to illness? ☐ Yes ☐ No

Date of hospital visit	Hospital	Hospital food consumed	Detail of food consumed
____ / ____ / ____	_____	☐ Yes ☐ No	
____ / ____ / ____	_____	☐ Yes ☐ No	
____ / ____ / ____	_____	☐ Yes ☐ No	

Reason for visit (e.g. dialysis, outpatient appointment):

_____

Were you admitted to hospital in the 12 weeks prior to illness? ☐ Yes ☐ No

Admission	Discharge	Hospital	Reason for admission	Ward / section
____ / ____ / ____	____ / ____ / ____	_____	_____	_____
____ / ____ / ____	____ / ____ / ____	_____	_____	_____
____ / ____ / ____	____ / ____ / ____	_____	_____	_____

Foods consumed during hospital admission: _____

_____

_____

_____

High risk hospital foods consumed? ☐ Yes ☐ No ☐ Maybe ☐ don't know/not answered

Environmental risk factors

In the 12 weeks prior to illness, did you travel overseas, to another state or territory or anywhere within the state? ☐ Yes ☐ No	
Travel type:	☐ International ☐ Domestic ☐ Local (please tick)
Specify location(s):	_____
	_____
Name of resort, hotel, etc:	_____
Departure date:_____ / ____ / ____	Airline/coach company: _____ Flight No._____
Return date: _____ / _____ / _____	Airline/coach company: _____Flight No. _____

Foods consumed on plane or bus: _____

_____

Potential Food Sources

In the 4 weeks prior to illness (___ / ____ / ____ to ____ / ____ / ____) did you consume any of the following?

Fruits	Yes	No	DK/ NS	Type / brand / details	Where purchased / eaten
Fruit salad (self-serve salad bar)	☐	☐	☐		
Fruit salad (delicatessen)	☐	☐	☐		
Fruit salad (other source)	☐	☐	☐		
Rockmelon / cantaloupe	☐	☐	☐		
Honeydew melon	☐	☐	☐		
Watermelon	☐	☐	☐		
Strawberries	☐	☐	☐		
Other berries	☐	☐	☐		
Other fruit Specify: _____ _____	☐	☐	☐		
Fresh fruit juice (state type)	☐	☐	☐		

Vegetables / salads	Yes	No	DK/ NS	Type / brand / details	Where purchased / eaten
Whole lettuce (specify bagged/unbagged)	☐	☐	☐		
Bagged processed lettuce (ie. leaves/shredded): specify…..	☐	☐	☐		
Bagged salad other (ie. rocket/spinach): specify….	☐	☐	☐		
Bagged coleslaw mix	☐	☐	☐		
Uncooked mushroom	☐	☐	☐		
Alfalfa / pea sprouts	☐	☐	☐		
Bean sprouts	☐	☐	☐		
Fresh herbs eaten raw	☐	☐	☐		
Organic produce	☐	☐	☐		
Home grown produce	☐	☐	☐		
Raw vegetable juice (state type)	☐	☐	☐		
Other raw vegetables Specify:_____ _____	☐	☐	☐		

Dairy	Yes	No	DK /NS	Type / brand / details	Where purchased / eaten
Brie cheese	☐	☐	☐		
Camembert cheese	☐	☐	☐		
Blue-veined cheese	☐	☐	☐		
Fetta cheese	☐	☐	☐		
Ricotta cheese	☐	☐	☐		
Mozarella cheese	☐	☐	☐		
Cottage cheese	☐	☐	☐		
Other soft cheese (specify	☐	☐	☐		
Shredded/grated hard cheese	☐	☐	☐		
Raw / unpasteurised cheese	☐	☐	☐		
Sour cream	☐	☐	☐		
Ice-cream	☐	☐	☐		
Gelato	☐	☐	☐		
Yogurt	☐	☐	☐		
Raw / unpasteurised milk (cow / goat)	☐	☐	☐		
Flavoured milk	☐	☐	☐		
Other dairy products: specify:_____	☐	☐	☐		

Deli	Yes	No	DK/NS	Loose (deli)	Type./ brand / details	Where purchased / eaten
Barbequed chicken	☐	☐	☐	-		
Cold cooked chicken	☐	☐	☐	-		
Luncheon / sandwich meat	☐	☐	☐	☐		
Ham	☐	☐	☐	☐		
Salami	☐	☐	☐	☐		
Chicken / turkey slices	☐	☐	☐	☐		
Other uncooked meat products	☐	☐	☐	☐		
Pate	☐	☐	☐	☐		
Liverwurst	☐	☐	☐	☐		
Frankfurts / cheerios	☐	☐	☐	☐		
Silverside	☐	☐	☐	☐		
Pre-prepared potato salad (deli)	☐	☐	☐	☐		
Pre-prepared coleslaw (deli)	☐	☐	☐	☐		
Pre-prepared pasta salad (deli)	☐	☐	☐	☐		
Dips: Specify:_____	☐	☐	☐	☐		
Other pre-prepared salads: Specify_____	☐	☐	☐	☐		

Cold/uncooked seafood	Yes	No	DK//NS	Type / brand / details	Where purchased / eaten
Mussels	☐	☐	☐		
Crab	☐	☐	☐		
Prawns (purchased cooked)	☐	☐	☐		
Prawns (purchased raw)	☐	☐	☐		
Oysters	☐	☐	☐		
Smoked salmon	☐	☐	☐		
Other smoked fish / seafood	☐	☐	☐		
Sushi / sashimi	☐	☐	☐		
Other seafood: Specify:_____ _____	☐	☐	☐		

Sandwiches / burgers / rolls / wraps containing:	Yes	No	DK/NS	Pre-packaged	Custom made	Type / brand / details	Where purchased / eaten
Ham	☐	☐	☐	☐	☐		
Beef	☐	☐	☐	☐	☐		
Bacon, lettuce, tomato (BLT)	☐	☐	☐	☐	☐		
Chicken	☐	☐	☐	☐	☐		
Turkey	☐	☐	☐	☐	☐		
Other meat: Specify:_____	☐	☐	☐	☐	☐		
Salad	☐	☐	☐	☐	☐		
Cheese: Specify_____	☐	☐	☐	☐	☐		
Other filling: Specify_____	☐	☐	☐	☐	☐		

In the 4 weeks prior to illness, did you attend any of the following?

	Yes	No	DK/NS	Date	Food
Restaurants (specify)	☐	☐	☐		
1.				____/ ____ / ____	
2.				____/ ____ / ____	
3.				____/ ____ / ____	
Takeaway (specify)	☐	☐	☐		
1.				____/ ____ / ____	
2.				____/ ____ / ____	
3.				____/ ____ / ____	

Any left-over high risk foods available for testing? ☐ Yes ☐ No

Specify: _____

Comments and actions

Before this illness with *Listeria*, did a healthcare worker tell you to avoid certain foods to prevent listeriosis?
☐ Yes ☐ No

Information on *Listeria* requested? ☐ No ☐ Yes, date sent: _____ / _____ / _____

Premises/facility inspection required? ☐ Yes ☐ No
If yes:
Premises to be inspected by: _____

Will food samples be taken for analysis? ☐ Yes ☐ No
If yes, samples will be collected by (name of organisation or local council) _____

Please provide additional comments in the space provided if required: