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NCIRS Haemophilus influenzae type b

Enhanced surveillance notification (amended January 2010)

To be completed for:

- Isolation of H. influenzae type b from any normally sterile site, OR
- Identification of Hib antigen in cerebrospinal fluid, with other laboratory parameters consistent with meningitis.

Note: Diagnosis of epiglottitis by direct vision, laryngoscopy or X-ray without a positive sterile site culture is now NOT notifiable.

Patient Information State/Territory Notification (Unique) ID: Surname: (First 2 Letters) |____| First name: (First 2 Letters) Date of Birth: __ _|_ _|__ __ Sex: (M / F) |___| Postcode of Residence: | | | | State of Residence: | | Phone No: Treating doctor: Clinical Data Date of onset: 1. 2 Aboriginal or Torres Strait Islander: Yes Unknown Clinical diagnosis: 3. ☐ Epiglottitis ☐ Septicaemia without focus ☐ Cellulitis Other - please describe 4. Outcome: ☐ Discharged apparently well ☐ Discharged with abnormality - please specify __ Died **Risk Factors** 5. Premature (< than 37 weeks gestation) weeks Does the case have an underlying illness requiring regular medical supervision? 6. ☐ No underlying illness Immunosuppressive drug - please specify: Immunosuppressive condition - please specify Concenital or chromosomal abnormality - please specify

│Other - please specify:

Microbiology Data

7. 8.	Date of laboratory specimen Method of confirmation (if blood and another site, please indicate both): Blood culture					
9.	Laboratory perfo Address (if know	n):				
10.	Confirmation as t	ype b: Iney) ory, specify	□ мі □ No	DU (Melbourne) ot sent	☐ Not known reference laboratory	
Va	ccination Da	ata				
11.	Was the child vac	ccinated against Hib	?	Unknown		
12.		ation: Idhood Immunisatio record- Verbal rep Please s	oort from pare		eport from provider	
13.	Dates of Hib Vac	cination	Type/Brand	d	Batch Numbers	
	(Approximate if		(If Availab		(if Available)	
1	st	_		ComvaxPlease specify)		
2	nd	_ □ HibTITER □ □ Infanrix hexa	Other	Comvax (Please specify)		
3r	d	_□ HibTITER □ □ Infanrix hexa	Other.	Comvax(Please specify)		
4t	h	_ □ HibTITER □ □ Infanrix hexa	Other.	Comvax (Please specify)		
Rep	orted by:			Discount		
Telephone: ()				Please return this form to: Hib Enhanced Surveillance NCIRS, Kids Research Institute at The Children's Hospital at Westmead Locked Bag 4001, Westmead NSW 2145		
vate	of report: _			or fax to NCIRS:	02 9845 1418	