

NSW Shigellosis Questionnaire



Date of notification:		NCIMS ID:	
Date of interview:		Interviewer:	
Person interviewed (if not case):		NCIMS updated:	
High risk group* (see section 6): *Includes food handlers, healthcare workers, institutional residents, child care workers, children in child care, men who have sex with men		Is there an epi link to a confirmed case? NCIMS ID of epi-linked case:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Case status:	Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Excluded <input type="checkbox"/>		
Probable source:			

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.

SECTION 1: DEMOGRAPHIC DATA			
Surname:		Other names:	
Date of birth:	/ /	Age:	
Sex:	Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Please specify _____	Parent/carer name (if applicable):	
Street address:		Suburb:	
		Postcode:	
Home Tel:		Work Tel:	
Mobile:		Email:	
Country of birth:		Language spoken at home:	
Interpreter required?	Yes <input type="checkbox"/> → Language: _____ No <input type="checkbox"/>		
Are you of Aboriginal and/or Torres Strait Islander origin?	<input type="checkbox"/> Yes, Aboriginal but not Torres Strait Islander <input type="checkbox"/> Yes, Torres Strait Islander but not Aboriginal <input type="checkbox"/> Yes, Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Not Indigenous <input type="checkbox"/> Unknown <input type="checkbox"/> Not stated		
Occupation (full-time or part-time work, voluntary activities) / school / child care:	<input type="checkbox"/> Child in child care/pre-school <input type="checkbox"/> High-risk occupation* (*includes healthcare workers, food handlers, child care workers, sex workers) ↓ Record additional details in Section 6	<input type="checkbox"/> Child at home <input type="checkbox"/> Student - primary : _____ <input type="checkbox"/> Student – secondary: _____ <input type="checkbox"/> Student - other: _____ <input type="checkbox"/> Occupation - other: _____	

SECTION 2: TREATING DOCTOR / HOSPITAL and LABORATORY

Name of treating Dr:		Telephone:	
Address:		Facility type	<input type="checkbox"/> Hospital <input type="checkbox"/> GP <input type="checkbox"/> S100 GP <input type="checkbox"/> Sexual health clinic
Consent given by Doctor to interview:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date:	___/___/___
Emergency department visit for illness?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date of visit(s):	___/___/___
Admitted for illness?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date admitted :	___/___/___
Hospital:		Hospital MRN:	
Case deceased?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes: Date of death: ___/___/___	
Treated for illness?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes: <input type="checkbox"/> Rehydration <input type="checkbox"/> Antibiotics: _____ <input type="checkbox"/> Other, <i>please describe</i> :	
Serotype:	Sub-type:	Specimen collection date: ___/___/___	Specimen type: <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other
Test requested:	<input type="checkbox"/> PCR <input type="checkbox"/> Culture	Test Results:	<input type="checkbox"/> PCR+ <input type="checkbox"/> Culture
Antibiotic resistance:	Azithromycin: <input type="checkbox"/> Resistant <input type="checkbox"/> Susceptible <input type="checkbox"/> Not tested Amp/Amoxycillin: <input type="checkbox"/> Resistant <input type="checkbox"/> Susceptible <input type="checkbox"/> Not tested Ceftriaxone: <input type="checkbox"/> Resistant <input type="checkbox"/> Susceptible <input type="checkbox"/> Not tested Cotrimoxazole: <input type="checkbox"/> Resistant <input type="checkbox"/> Susceptible <input type="checkbox"/> Not tested Ciprofloxacin: <input type="checkbox"/> Resistant <input type="checkbox"/> Susceptible <input type="checkbox"/> Not tested Norfloxacin: <input type="checkbox"/> Resistant <input type="checkbox"/> Susceptible <input type="checkbox"/> Not tested		

SECTION 3: CLINICAL

Onset date of illness: ___/___/___	Duration : ___ days ___ hrs <input type="checkbox"/> ongoing diarrhoea		
Did [you/case] experience any of these following symptoms associated with the illness?			
Fever: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	If case reported fever: Temperature recorded °C		<input type="checkbox"/> DK / temp not taken
Diarrhoea: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Bloody stools: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Vomiting: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Headache: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Abdo pain: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Nausea: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Lethargy: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Joint/Muscle pain: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Other: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK if yes <i>specify</i> :			
Do you have any medical conditions which affect your immune system or are you on any medications that affect your immune system?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

EXPOSURE PERIOD

I'm going to ask some questions about what [you/the case] did before [you/the case] got sick, including some questions that are specifically about the 7 days before the start of [your/the case's] illness. Some of these questions are quite personal – please don't answer them if you would prefer not to.

The first day of illness was (day and date)

____/____/____

Seven days before this was (day and date)

____/____/____

It is often helpful to have a calendar or diary in front of you to help you remember what you did during this time.

SECTION 4: RISK FACTORS DURING EXPOSURE PERIOD

<p><i>If case identifies as Aboriginal or Torres Strait Islander:</i></p> <p>Were you living in or did you visit a small, rural or remote Aboriginal community in the 7 days before your illness began?</p>		<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	See public health actions in section 6
<p>Did you travel during any part of your exposure period?</p>	<input type="checkbox"/> Yes - Domestic travel where: <input type="checkbox"/> Yes -International travel where: <input type="checkbox"/> No <input type="checkbox"/> Unknown	Departure date: Return date: <i>(if multiple places, specify arrival and departure dates for each location)</i>	____/____/____ ____/____/____ ____/____/____ ____/____/____
	<p>Did you have contact (such as sharing a household, sharing a bathroom or sharing food) with anyone who had recently travelled?</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	What type of contact? <input type="checkbox"/> Household <input type="checkbox"/> Shared a bathroom <input type="checkbox"/> Shared food
			<input type="checkbox"/> Domestic travel <input type="checkbox"/> International travel
Relationship of traveller to case:			Did the traveller have any symptoms similar to you? <input type="checkbox"/> Yes – approx. onset date / / <input type="checkbox"/> No
<p>Did you have contact (such as sharing a household, sharing a bathroom or sharing food) with a person known or suspected to have a similar illness?</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	What type of contact? <input type="checkbox"/> Household <input type="checkbox"/> Shared a bathroom <input type="checkbox"/> Shared food	Relationship of person to case:
		Gender of the person? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both	Relationship of person to case: <input type="checkbox"/> Regular partner <input type="checkbox"/> Casual partner <input type="checkbox"/> Both <input type="checkbox"/> Multiple partners
<p>Did you have any sexual contact in the 7 days before your illness began?</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did any sexual partners report similar symptoms prior to your encounter? <input type="checkbox"/> Yes - approx. onset date / / <input type="checkbox"/> No	

If yes to being MSM from above complete the next 2 questions			
Did you visit any sex on premises venues?	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name/s of venue?	
Have you had a recent STI check-up?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If not recent- Shigella is very easy to catch and so is often a sexually transmitted disease. We recommend discussing getting an STI screen with your regular health professional)</i>		

Likely source of infection identified: **Yes** → **Skip section 5, possible Food sources**
 No → **Continue**

SECTION 5: POSSIBLE FOOD SOURCES

Exposure period (between 1 and 7 days prior to onset of illness):

____/____/____ to ____/____/____

Food premise type	Details	Where (name and location)	When (date) and what (food consumed)
Cafes, restaurants, bars	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Bakeries	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Takeaways, including from service stations, fast food outlets, etc.	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Farmers Markets or other market stalls	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Direct from farms	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Continental deli or specialty grocer (e.g. Asian supermarkets)	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Any other imported foods not specified above?	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Social gatherings, such as: festivals, weddings, parties, religious events work conferences?	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Dined at someone else's home?	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown		

SECTION 6: HIGH RISK GROUPS AND EXCLUSION

<input type="checkbox"/> Works in a high risk group OR attends a high risk setting, continue;		<input type="checkbox"/> No high risk group AND does not attend a high risk setting, skip this section.	
If yes, tick all that apply: <input type="checkbox"/> Commercial food handler <input type="checkbox"/> Lives or works in institutional setting → <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Child care worker <input type="checkbox"/> Child in child care or pre-school <input type="checkbox"/> Child in primary school		Institution type: <input type="checkbox"/> Hospital <input type="checkbox"/> Aged care facility <input type="checkbox"/> Mental health facility <input type="checkbox"/> Hostel/boarding house <input type="checkbox"/> Correctional facility <input type="checkbox"/> Military facility <input type="checkbox"/> Other - specify:	
Name of institution:		Tel:	
Address:		Fax:	
Contact person:		Email:	
Attended workplace/institution while symptoms were present or within 48 hours of last diarrhoea:		<input type="checkbox"/> Yes → Dates : <input type="checkbox"/> No * If yes contact Communicable disease branch	
Information and advice on shigellosis provided to premises/institution/child care centre/pre-school?		<input type="checkbox"/> Yes → Date provided: / / <input type="checkbox"/> No <input type="checkbox"/> N/A	
<input type="checkbox"/> Lives in or visited a small, rural/remote Aboriginal community		Public health unit to conduct a risk assessment and, where appropriate, undertake actions with environmental health and Aboriginal health organisations/Aboriginal health unit.	
<input type="checkbox"/> Sex worker		Sex workers should not engage in sex while infectious and should inform recent sexual contacts to watch out for symptoms and undergo testing for shigellosis if symptoms develop	

EXCLUSION

If case is a food handler, health care worker, child in child care or pre-school or child care worker:

EXCLUDE until at least 48 hours after diarrhoea ceases.

Cases should be informed infectivity may continue beyond official cut-off date

Exclusion discussed with case/guardian	<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No <input type="checkbox"/> N/A
Exclusion letter sent	<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No <input type="checkbox"/> N/A
Other public health actions	Specify:
Information sent to workplace/pre-school/child care	<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No <input type="checkbox"/> N/A

ISOLATION

If case is a resident of an institution e.g. aged care facility, residential care unit, correctional facility, etc.:

As far as practicable, **ISOLATE** from well residents until at least 48 hours after diarrhoea ceases.

Please note: Cases should be informed infectivity may continue beyond official cut-off date

SECTION 7: EDUCATION (ALL CASES)

Provide information on the nature of the infection and mode of transmission.

Education should include information about hygienic practices, particularly hand washing.

Hygiene and preventing transmission discussed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Information brochure provided to case	<input type="checkbox"/> Yes → Date sent: <input type="checkbox"/> No <input type="checkbox"/> N/A
If MSM, inform sexual contacts to watch out for symptoms and undergo testing for shigellosis if symptoms develop	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Privacy information requested by case:	<input type="checkbox"/> Yes → Date sent: <input type="checkbox"/> No <input type="checkbox"/> N/A

Isolation and restrictions

Whilst infectious (until 48 hours after diarrhoea ceases), we advise you to:

<u>Not</u> prepare or handle food for other people	<input type="checkbox"/> Informed N/A	<input type="checkbox"/>
Practice good hand hygiene	<input type="checkbox"/> Informed N/A	<input type="checkbox"/>
<u>Not</u> have sex	<input type="checkbox"/> Informed N/A	<input type="checkbox"/>
<u>Not</u> provide personal care to others	<input type="checkbox"/> Informed N/A	<input type="checkbox"/>
<u>Not</u> attend preschool, child care, school or high risk work	<input type="checkbox"/> Informed N/A	<input type="checkbox"/>
<u>Not</u> share utensils, towels or personal items with others	<input type="checkbox"/> Informed N/A	<input type="checkbox"/>
If living in a residential, aged care, correctional or similar facility: <u>Isolate</u> yourself as much as possible	<input type="checkbox"/> Informed N/A	<input type="checkbox"/>
<u>Not</u> swim for 2 weeks after the diarrhoea has stopped	<input type="checkbox"/> Informed N/A	<input type="checkbox"/>

If it is necessary, may we please contact you again?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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SECTION 8: CONTACT MANAGEMENT

Contacts are not subject to enforced exclusions.

Contacts that experience symptoms consistent with shigellosis should be encouraged to seek medical advice and testing for diagnostic purposes.

Symptomatic contacts not in a high risk group should be advised about exclusion while diarrhoea is present.

Symptomatic contacts in a high risk group should be excluded while awaiting microbial results, with further management in accordance with those results (otherwise until at least 48 hours after symptom resolution)..

Persons considered to be **contacts** include;

- immediate family, household members and sexual partners, including people who stayed and shared their primary bathroom facilities with the case
- persons who consumed food not subjected to further cooking that was prepared by the case
- if the case is a food handler, other food handlers in the same establishment
- if the case is in nappies, persons who provided direct care to the case
- if the case attends child care or preschool, other children and adults in the same classroom or care group.

Cases should be encouraged to inform their contacts about the risk, provide them with a Fact Sheet and recommend to get tested if they develop symptoms.

Name of Interviewer: _____

Signature: _____ Date: _____ / _____ / _____

