NCIRS ID:_____

NCIRS *Haemophilus influenzae type b*

Enhanced surveillance notification (amended January 2014)

To be completed for:

1 Isolation of H. influenzae type b from any normally sterile site, OR

2 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) |___|___|

Sex: (M / F) |___| Date of Birth: __ __|__ __|__ __ __ __

Postcode of Residence: |___|___|___|___| State of Residence: |___|___|___|

Aboriginal or Torres Strait Islander: ☐ Yes ☐ No ☐ Unknown

Treating doctor: …… Phone No: ……

Clinical Data

1. Date of onset: __ __|__ __|__ __ __ __

2. Place of acquisition:
   Either Australian Postcode |___|___|___|___| *or* Australian State |___|___|___|
   (*if postcode not known*)
   or, ☐ Other Country (specify): ……
   or, ☐ Unknown

3. Clinical diagnosis:
   ☐ Meningitis ☐ 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
6. Does the case have an underlying illness requiring regular medical supervision?
   ☐ No underlying illness
   ☐ Splenectomy
   ☐ Immunosuppressive drug (specify): .....
   ☐ Immunosuppressive condition (specify): .....
   ☐ Congenital or chromosomal abnormality (specify): .....
   ☐ Other (specify): .....

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Microbiology Data

7. Date of laboratory specimen __ __|__ __|__ __

8. Method of confirmation (if blood and another site, please indicate both):

☐ Blood culture ☐ CSF culture ☐ Other sterile site..... (Please specify)

☐ Antigen CSF ☐ Nucleic acid testing …… (Please specify specimen site) ☐ Other……

9. Laboratory performing microbiology: .....

Address (if known): .....

..... Telephone: .....

10. Confirmation as type b:

☐ ICPMR (Sydney) ☐ MDU (Melbourne) ☐ QHFSS (Brisbane)

☐ Other laboratory, specify …….. ☐ Not sent ☐ Not known

Note: All isolates should be confirmed as type b by an approved reference laboratory

Vaccination Data

11. Was the child vaccinated against Hib?

☐ Yes ☐ No ☐ Unknown ☐ NA (Adult or born before Jul 1988)

12. Source of information:

☐ Australian Childhood Immunisation Register

☐ Other written record (Please specify) ……

☐ Verbal report from provider

☐ Verbal report from parent, self or other (Please specify)……

13.

Dates of Hib Vaccination (Approximate if Necessary)	**Type/Brand** (If Available)			**Batch Numbers** (if Available)
1st __ __|__ __|__ __	☐ HibTITER	☐ Pedvax	☐ *Comvax*	
	☐ *Infanrix hexa*		☐ Other…… (Please specify)	.....
2nd __ __|__ __|__ __	☐ HibTITER	☐ Pedvax	☐ *Comvax*	
	☐ *Infanrix hexa*		☐ Other…… (Please specify)	.....
3rd __ __|__ __|__ _ _	☐ HibTITER	☐ Pedvax	☐ *Comvax*	
	☐ *Infanrix hexa*		☐ Other……. (Please specify)	.....
4th __ __|__ __|__ __	☐ HibTITER	☐ Pedvax	☐ *Comvax*	
	☐ *Infanrix hexa*		☐ Other…… (Please specify)	.....

Reported by:.....

Telephone: (.....) .....

Email:.....

Date of report: __ __|__ __|__ __

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
or fax to **NCIRS: 02 9845 1418**