Public Health England

H. Influenzae
Clinical follow-UP (Hib)

PLEASE SUPPLY PATIENT DETAILS

Name

NHS Number

Date of Birth:

Age (years):

Gender:

FOR PHE USE ONLY

Ref no

Specimen date:

Hospital/laboratory:

WE WOULD BE GRATEFUL IF YOU COULD COMPLETE THE QUESTIONNAIRE EVEN IF THE PATIENT HAS LEFT YOUR PRACTICE OR DIED EITHER AS A RESULT OF THE INFECTION OR ANY OTHER CAUSE.

1.Ethnic group ☐ White ☐ Black-Caribbean ☐ Black African ☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese ☐ Mixed/Other (please specify) _____

2. If patient is <1 year old, were they born prematurely? ☐ No ☐ Yes _____ weeks gestation

3. At the time of H.Influenzae infection, did the patient have any co-morbidities?

☐ Chronic heart disease ☐ Congenital/chromosomal abnormality
☐ Chronic lung disease* ☐ Immunosuppression/immunosuppressive drug
☐ Chronic liver disease ☐ CNS disease (CSF leak, VP shunt, etc)
☐ Chronic renal disease ☐ None
☐ Metabolic disease ☐ Malignancy
☐ Other

If any of the above ticked, please give details _____

4. Did the patient have a history of travel prior to their H.Influenzae infection?

Recent travel abroad? ☐ Yes ☐ No Date: _____ Country: _____

5.If patient born AFTER 1990, Hib and Meningococcal group C vaccine history

Hib dose 1 ☐ Yes ☐ No Vaccination date: _____ Batch No. _____
Hib dose 2 ☐ Yes ☐ No Vaccination date: _____ Batch No. _____
Hib dose 3 ☐ Yes ☐ No Vaccination date: _____ Batch No. _____
Hib dose 4 ☐ Yes ☐ No Vaccination date: _____ Batch No. _____

MenC dose 1 ☐ Yes ☐ No Vaccination date: _____ Batch No. _____
MenC dose 2 ☐ Yes ☐ No Vaccination date: _____ Batch No. _____
MenC dose 3 ☐ Yes ☐ No Vaccination date _____ Batch No. _____

Ref NO:

6. Clinical presentation of invasive Hib infection:

☐ Meningitis ☐ Pneumonia ☐ Septic arthritis* ☐ Bacteraemia
☐ Epiglottitis ☐ Cellulitis* ☐ Osteomyelitis* ☐ Other*

*please specify site/define "Other": _____

7. If presented with meningitis, any complications?

☐ Cerebral abscess ☐ Seizures ☐ Unilateral deafness ☐ Other
☐ Cerebral infarction ☐ VP shunt ☐ Bilateral deafness ☐ None

*if Other, please specify: _____

8. Was the patient admitted to an intensive care unit? ☐ No ☐ Yes

If yes, 8.1 reason for admission: _____

8.2 Name of Intensive Care Unit: _____

9. Outcome (Alive/Dead) _____ if died date of death _____

If died, 8.1. was a post-mortem performed ☐ No ☐ Yes

If post-mortem performed, 8.2. Name and address of coroner:

Name _____

Address: _____

_____

_____

If post-mortem NOT performed, 8.3. Cause of death on Death Certificate:

_____

_____

Form completed by: _____ Date _____ Tel _____

Please return completed form by POST using the pre-paid envelope or FAX to:
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