Public Health England

H. Influenzae Clinical follow-UP (Adult)

PLEASE SUPPLY PATIENT DETAILS

Name:

NHS Number

Date of Birth:

Age(months)

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

☐ Chronic heart disease
☐ Chronic lung disease*
☐ Chronic liver disease
☐ Chronic renal disease
☐ Metabolic disease
☐ Malignancy
☐ Other
☐ Immunosuppression/immunosuppressive drug
☐ CNS disease (CSF leak, VP shunt, etc)
☐ Recurrent upper respiratory tract infection (eg. sinusitis, chronic otitis media)
☐ Haemoglobinopathy
☐ Asplenia
☐ None

If any of the above ticked, please give details ____________________

*If asthmatic, please state if on regular oral steroid ☐ No ☐ Yes

3. Clinical presentation of invasive H.influenzae infection:

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

*please specify site/define "Other": ____________________

4. If presented with meningitis, any complications?

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

*if Other, please specify: ____________________

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

If yes, 5.1 reason for admission:____

5.2 Name of Intensive Care Unit: ____

6. Outcome (Alive/Dead) ______________ if died date of death________________

If died, 6.1. was a post-mortem performed ☐ No ☐ Yes

If post-mortem performed, 6.2. Name and address of coroner:

Name ____

Address: ____

____

____

If post-mortem NOT performed, 6.3. 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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