Public Health England

# H. Influenzae
# Clinical follow-UP (Child)

**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. IF UNABLE TO COMPLETE PLEASE PROVIDE NAME AND CONTACT DETAILS OF HOSPITAL CLINICIAN IF RELEVANT.

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

2. Was the child born prematurely? ☐ No ☐ Yes _____ weeks gestation

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

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

If any of the above ticked, please give details _____

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

4. Clinical presentation of invasive H.influenzae infection:

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

*please specify site/define "Other": _____



Ref NO:

5. If presented with meningitis, any complications

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

*If Other, please specify: _____

6. Was the patient admitted to an intensive care unit ☐ No ☐ Yes ☐ Not Known

If yes, 6.1 reason for admission: _____

6.2 Name of intensive care unit: _____

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

If died, 7.1 was a post-mortem performed ☐ No ☐ Yes

If post-mortem performed, 7.2 Name and address of coroner:

Name: _____

Address: _____

_____

_____

If post-mortem NOT performed, 7.3 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:
Dr Shamez Ladhani, Immunisation, Hepatitis, and Blood Safety Department, Public Health England, 61 Colindale Avenue, London NW9 5EQ.
Tel: 020 8327 7155
Fax: 020 8327 7404
E-mail: shamez.ladhani@phe.gov.uk



Ref NO: