Public Health England

H. Influenzae Clinical follow-UP (Infant)

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 infant 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
☐ None

☐ Congenital/chromosomal abnormality
☐ Immunosuppression/immunosuppressive drug
☐ CNS disease (CSF leak, VP shunt, etc)
☐ Recurrent upper respiratory tract infection (eg, sinusitis, chronic otitis media)
☐ Haemoglobinopathy
☐ Asplenia

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":____________________

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 infant admitted to an intensive care unit? ☐ No ☐ Yes

If yes, 6.1 reason for admission: ______________________

6.2 Name of intensive care unit: ______________________

7. Did the infant's MOTHER develop invasive H. Influenzae infection?

☐ No ☐ Yes ☐ Not Known

If yes, 7.1 Mother's full name : ______________________

7.2 Mother's date of birth: ______________________

7.3 Mother's NHS number: ______________________

8. 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: ______________________

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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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Public Health England, 61 Colindale Avenue, London NW9 5EQ.
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Ref NO: