***Listeria monocytogenes***

**Clinical Questionnaire**

**If cultures are available but have not been sent, please forward to:**

Gastrointestinal Bacterial Reference Unit

UKHSA, 61 Colindale Avenue, London NW9 5EQ

## Your details

**1.1** Microbiologist/Clinician Name: **1.2** Date of completion:

**1.3** Laboratory:

## Specimen details

**2.1** Specimen reference no.: **2.2** Specimen date:

**2.3** Source of culture: Blood  CSF  HVS  Other  (*please specify*) \_\_\_\_\_\_\_\_\_\_\_\_

1. **Patient details** *(‘patient’ refers to positive isolate)*

**3.1** First Name: **3.2** Surname:

**3.3** NHS number:

**3.4** Town: **3.5** Postcode:

**3.6** Date of Birth: **3.6** Age: years

**3.7** Gender: Male  Female  **3.8** Ethnicity:

1. **Clinical details**

**4.1** Date of onset of illness:

**4.2** Did the patient die? Yes  No

**4.3** Hospital of original admission: **4.4** Admission date:

**4.5** Principal *Listeria* illness (*tick all that apply*):

Meningitis  Septicaemia  Gastroenteritis  Other (*specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.6** What antibiotics have been used to treat this Listeria infection?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.7** Symptoms experienced (*tick all that apply*):

Nausea  Vomiting  Diarrhoea  Abdominal pain  Fever  Chills  Headache Myalgia  Arthralgia  Backache  Seizures  Ataxia

Tremors  Myoclonus  Nuchal rigidity  Confusion

Other  (*specify*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.8** Does the patient have an underlying illness/condition?

No  Yes  (*specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.9** Was the patient taking any (*please tick*):

immunosuppressives  cytotoxics  steroids  **or** None  **or** Unknown

(*if yes, please specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.10** Does the patient have reduced gastric acid secretion? Yes  No  Unknown

*If yes, please give details:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For pregnancy associated cases, please continue onto page 3**

**For non-pregnancy associated cases, please skip to page 5**

1. **Pregnancy-associated cases**

**5.1** **Mother’s details** (*if not recorded above*)

**5.1.1** First Name: **5.1.2** Surname:

**5.1.3** Town:  **5.1.4** Postcode:

**5.1.5** Date of Birth: **5.1.6** Age years

**5.1.7** Hospital of original admission:

### 5.2 Details of the pregnancy

**5.2.1** Outcome of pregnancy: Live birth  Still birth  Miscarriage  Still pregnant

**5.2.2** Date of Delivery / Miscarriage:

**5.2.3** Expected Date of Delivery (EDD):

**5.2.4** Gestation at pregnancy end: weeks

**5.2.5** During pregnancy did the mother have symptoms suggestive of Listeriosis?

Yes  No  *If yes, what were the main features of this illness (tick all that apply):*

Flu-like (pyrexia / myalgia / headache / fatigue)

Gastroenteritis  Abdominal pain  Night sweats

Other (*please specify)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.2.6** Date of onset of this illness:

**5.2.7** Gestational stage of first onset of this illness: weeks

**5.2.8** Was *Listeria* infection in the mother confirmed microbiologically? Yes  No

**5.3 Details of the infant** *(if applicable)*

**5.3.1** First Name: **5.3.2** Surname:

**5.3.3** Date of Birth: **5.3.4** Gender of infant: Male  Female

**5.3.5** If a live birth**,** did the infant survive? Yes  No

**5.3.6** If a live birth**,** was the infant ill with Listeriosis? Yes  No

**5.3.7** Please state age of infant at onset of illness? days

**5.3.8** Nature of the infant’s *Listeria* illness:

Meningitis  Septicaemia  Other  (*specify*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.3.9** Was the infant’s infection (if present) due to or thought to be due to vertical transmission from the mother? Yes  No

**5.3.10** Was the infant’s infection (if present) due to or thought to be due to cross contamination? Yes  No

# Thank you for completing this questionnaire

Please return this form via email to:

[phe.gastro@nhs.net](mailto:phe.gastro@nhs.net)

* If you have any specific questions about this questionnaire or *Listeria* surveillance, please contact:

Listeria Surveillance

Gastrointestinal Infections & Food Safety (One Health)

UK Health Security Agency

61 Colindale Avenue

London NW9 5EQ.

Email: [listeria@ukhsa.gov.uk](mailto:listeria@ukhsa.gov.uk)

Tel. 020 8327 6493

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Gastrointestinal Bacterial Reference Unit

UK Health Security Agency

61 Colindale Avenue

London NW9 5EQ.

Email: [GBRU@ukhsa.gov.uk](mailto:GBRU@ukhsa.gov.uk)

Tel. 020 8327 7341