

# CASE REPORT FORM

# Invasive Pneumococcal Disease

|                                     |                   |
|-------------------------------------|-------------------|
| Invasive pneumococcal disease _____ | EpiSurv No. _____ |
|-------------------------------------|-------------------|

|                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| <b>Reporting Authority</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                            |  |
| Name of Public Health Officer responsible for case _____                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |  |
| <b>Notifier Identification</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                            |  |
| <b>Reporting source*</b> <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory<br><input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> Other                                                                                                                    |  |                                                                                                            |  |
| Name of reporting source _____                                                                                                                                                                                                                                                                                                                                                                |  | Organisation _____                                                                                         |  |
| Date reported* _____                                                                                                                                                                                                                                                                                                                                                                          |  | Contact phone _____                                                                                        |  |
| Usual GP _____                                                                                                                                                                                                                                                                                                                                                                                |  | GP phone _____                                                                                             |  |
| <b>GP/Practice address</b> Number _____                    Street _____                    Suburb _____<br>Town/City _____                    Post Code _____ <input type="checkbox"/> GeoCode _____                                                                                                                                                                                          |  |                                                                                                            |  |
| <b>Case Identification</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                            |  |
| <b>Name of case*</b> Surname _____                    Given Name(s) _____                                                                                                                                                                                                                                                                                                                     |  |                                                                                                            |  |
| NHI number* _____                                                                                                                                                                                                                                                                                                                                                                             |  | Email _____                                                                                                |  |
| <b>Current address*</b> Number _____                    Street _____                    Suburb _____<br>Town/City _____                    Post Code _____ <input type="checkbox"/> GeoCode _____                                                                                                                                                                                             |  |                                                                                                            |  |
| Phone (home) _____                                                                                                                                                                                                                                                                                                                                                                            |  | Phone (work) _____                                                                                         |  |
| Phone (other) _____                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                            |  |
| <b>Case Demography</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                            |  |
| Location <b>TA*</b> _____                                                                                                                                                                                                                                                                                                                                                                     |  | <b>DHB*</b> _____                                                                                          |  |
| Date of birth* _____                                                                                                                                                                                                                                                                                                                                                                          |  | <b>OR    Age</b> _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years |  |
| <b>Sex*</b> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown                                                                                                                                                                                                                                                         |  |                                                                                                            |  |
| Occupation* _____                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                            |  |
| <b>Occupation location</b> <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school                                                                                                                                                                                                                                                                  |  |                                                                                                            |  |
| Name _____                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                            |  |
| <b>Address</b> Number _____                    Street _____                    Suburb _____<br>Town/City _____                    Post Code _____ <input type="checkbox"/> GeoCode _____                                                                                                                                                                                                      |  |                                                                                                            |  |
| <b>Alternative location</b> <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school                                                                                                                                                                                                                                                                 |  |                                                                                                            |  |
| Name _____                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                            |  |
| <b>Address</b> Number _____                    Street _____                    Suburb _____<br>Town/City _____                    Post Code _____ <input type="checkbox"/> GeoCode _____                                                                                                                                                                                                      |  |                                                                                                            |  |
| <b>Ethnic group case belongs to*</b> (tick all that apply)                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                            |  |
| <input type="checkbox"/> NZ European <input type="checkbox"/> Maori <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Maori<br><input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Tongan<br><input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan)                    *(specify) _____ |  |                                                                                                            |  |

Basis of Diagnosis

CLINICAL PRESENTATION\*

Pneumonia

☐ Yes
☐ No
☐ Unknown

Bacteraemia without focus

☐ Yes
☐ No
☐ Unknown

Meningitis

☐ Yes
☐ No
☐ Unknown

Empyema

☐ Yes
☐ No
☐ Unknown

Septic arthritis

☐ Yes
☐ No
☐ Unknown

Other

☐ Yes
☐ No
☐ Unknown

If other, specify \_\_\_\_\_

LABORATORY CRITERIA

Specimen\* (tick all with positive results)

Blood

☐ culture
☐ NAAT<sup>2</sup>

CSF

☐ culture
☐ antigen detection<sup>1</sup>
☐ NAAT

Pleural fluid

☐ culture
☐ antigen detection<sup>1</sup>
☐ NAAT

Joint fluid

☐ culture
☐ NAAT

Other sterile site specimen

☐ culture
☐ NAAT

(specify) \_\_\_\_\_

<sup>1</sup> refer to the case report form instructions

<sup>2</sup> nucleic acid amplification test

STATUS\*

☐ Under investigation
☐ Confirmed
☐ Not a case

ADDITIONAL LABORATORY DETAILS

Capsular type\* \_\_\_\_\_

ESR Updated

☐ Laboratory

Date result updated

Sample Number

Clinical Course and Outcome

Date of onset\* \_\_\_\_\_

☐ Approximate
☐ Unknown

Hospitalised\*

☐ Yes
☐ No
☐ Unknown

Date hospitalised\* \_\_\_\_\_

☐ Unknown

Hospital\* \_\_\_\_\_

Died\*

☐ Yes
☐ No
☐ Unknown

Date died\* \_\_\_\_\_

☐ Unknown

Was this disease the primary cause of death?\*

☐ Yes
☐ No
☐ Unknown

If no, specify the primary cause of death\* \_\_\_\_\_

Outbreak Details

Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?\*

☐ Yes

If yes, specify Outbreak No.\* \_\_\_\_\_

**Risk Factors**

|                                                                                                                                                                                                                                        |                           |                          |                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------|-------------------------------|
| <b>Premature &lt;37 weeks gestation (if case is &lt;1 year of age)*</b>                                                                                                                                                                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <b>Congenital or chromosomal abnormality</b> ( <i>includes Down's syndrome</i> )*                                                                                                                                                      | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <b>Chronic lung disease or Cystic Fibrosis*</b>                                                                                                                                                                                        | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <b>Anatomical or functional asplenia*</b>                                                                                                                                                                                              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <b>Immunocompromised*</b>                                                                                                                                                                                                              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <i>Includes HIV/AIDS, lymphoma, organ transplant, multiple myeloma, nephrotic syndrome, chronic drug therapy (e.g. chemotherapy or &gt;20 mg/d prednisolone in last year), dysgammaglobulinaemia and sickle cell anaemia.</i>          |                           |                          |                               |
| <b>Chronic illness*</b>                                                                                                                                                                                                                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <i>Includes CSF leak, intracranial shunts, diabetes, cardiac disease (angina, MI, heart failure, coronary bypass), pulmonary disease (asthma, bronchitis, emphysema), chronic liver disease, renal impairment and alcohol related.</i> |                           |                          |                               |
| <b>Cochlear implants*</b>                                                                                                                                                                                                              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <b>Current smoker*</b>                                                                                                                                                                                                                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <b>Smoking in the household (if case is &lt;5 years of age)*</b>                                                                                                                                                                       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <b>Attends childcare (if case is &lt;5 years of age)*</b>                                                                                                                                                                              | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <i>Attends childcare (regular attendance &gt;4 hours per week) in a grouped childcare setting outside the home.</i>                                                                                                                    |                           |                          |                               |
| <b>Resident in long term or other chronic care facility*</b>                                                                                                                                                                           | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| <b>Other risk factors including illness that requires regular medical review (specify)*</b>                                                                                                                                            |                           |                          |                               |
| _____                                                                                                                                                                                                                                  |                           |                          |                               |

**Protective Factors**

**At any time prior to onset, had the case been immunised with the pneumococcal polysaccharide or pneumococcal conjugate vaccine?\*** ☐ Yes ☐ No ☐ Unknown

If yes, specify vaccination details\*

|                               |                                                                                                                                    |                                                                                      |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <b>Source of information*</b> | <input type="radio"/> Patient/caregiver recall                                                                                     | <input type="radio"/> Documented                                                     |
| <b>Dose 1:*</b>               | <input type="radio"/> Polysaccharide <input type="radio"/> Conjugate <input type="radio"/> Unknown                                 |                                                                                      |
| Date given* _____             | Or age when first dose was given _____                                                                                             | <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years |
| <b>Dose 2:*</b>               | <input type="radio"/> Polysaccharide <input type="radio"/> Conjugate <input type="radio"/> Not given <input type="radio"/> Unknown |                                                                                      |
| Date given* _____             | Or age when second dose was given _____                                                                                            | <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years |
| <b>Dose 3:*</b>               | <input type="radio"/> Polysaccharide <input type="radio"/> Conjugate <input type="radio"/> Not given <input type="radio"/> Unknown |                                                                                      |
| Date given* _____             | Or age when third dose was given _____                                                                                             | <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years |
| <b>Dose 4:*</b>               | <input type="radio"/> Polysaccharide <input type="radio"/> Conjugate <input type="radio"/> Not given <input type="radio"/> Unknown |                                                                                      |
| Date given* _____             | Or age when fourth dose was given _____                                                                                            | <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years |
| <b>Dose 5:*</b>               | <input type="radio"/> Polysaccharide <input type="radio"/> Conjugate <input type="radio"/> Not given <input type="radio"/> Unknown |                                                                                      |
| Date given* _____             | Or age when fifth dose was given _____                                                                                             | <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years |
| <b>Dose 6:*</b>               | <input type="radio"/> Polysaccharide <input type="radio"/> Conjugate <input type="radio"/> Not given <input type="radio"/> Unknown |                                                                                      |
| Date given* _____             | Or age when sixth dose was given _____                                                                                             | <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years |

**NIR Vaccination Status (to be completed by ESR)**

☐ Fully vaccinated for age ☐ Partially vaccinated for age ☐ Not vaccinated ☐ Not applicable

Date status updated \_\_\_\_\_

NIR Reference \_\_\_\_\_

**Comments\***