

# CASE REPORT FORM

# Viral Haemorrhagic Fever

|                   |                                  |
|-------------------|----------------------------------|
| DiseaseName _____ | EpiSurv No. <u>EpiSurvNumber</u> |
|-------------------|----------------------------------|

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| <b>Disease Name</b>                                                                                                                                                                                                                                                                                                                   |  |
| DiseaseName _____                                                                                                                                                                                                                                                                                                                     |  |
| <b>Reporting Authority</b>                                                                                                                                                                                                                                                                                                            |  |
| Name of Public Health Officer responsible for case <span style="color: red;">OfficerName</span> _____                                                                                                                                                                                                                                 |  |
| <b>Notifier Identification</b>                                                                                                                                                                                                                                                                                                        |  |
| <b>Reporting source*</b> <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory<br><span style="color: red;">ReportSrc</span> <input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> Other                 |  |
| <b>Name of reporting source</b> <span style="color: red;">ReportName</span> _____ <b>Organisation</b> <span style="color: red;">ReportOrganisation</span> _____                                                                                                                                                                       |  |
| <b>Date reported*</b> <span style="color: red;">ReportDate</span> _____ <b>Contact phone</b> <span style="color: red;">ReportPhone</span> _____                                                                                                                                                                                       |  |
| <b>Usual GP</b> <span style="color: red;">UsualGP</span> _____ <b>Practice</b> <span style="color: red;">GPPracticeName</span> _____ <b>GP phone</b> <span style="color: red;">GPPhone</span> _____                                                                                                                                   |  |
| <b>GP/Practice address</b> Number _____ Street _____ Suburb _____<br><span style="color: red;">GPAddress</span> Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____                                                                                                                                                |  |
| <b>Case Identification</b>                                                                                                                                                                                                                                                                                                            |  |
| <b>Name of case*</b> Surname <span style="color: red;">Surname</span> _____ Given Name(s) <span style="color: red;">GivenName</span> _____                                                                                                                                                                                            |  |
| <b>NHI number*</b> <span style="color: red;">NHINumber</span> _____ <b>Email</b> <span style="color: red;">Email</span> _____                                                                                                                                                                                                         |  |
| <b>Current address*</b> Number _____ Street _____ Suburb _____<br><span style="color: red;">CaseAddress</span> Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____                                                                                                                                                 |  |
| <b>Phone (home)</b> <span style="color: red;">PhoneHome</span> _____ <b>Phone (work)</b> <span style="color: red;">PhoneWork</span> _____ <b>Phone (other)</b> <span style="color: red;">PhoneOther</span> _____                                                                                                                      |  |
| <b>Case Demography</b>                                                                                                                                                                                                                                                                                                                |  |
| <b>Location</b> <b>TA*</b> <span style="color: red;">TA</span> _____ <b>DHB*</b> <span style="color: red;">DHB</span> _____                                                                                                                                                                                                           |  |
| <b>Date of birth*</b> <span style="color: red;">DateOfBirth</span> _____ <b>OR</b> <b>Age</b> <span style="color: red;">Age</span> _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years <span style="color: red;">AgeUnits</span>                                                                |  |
| <b>Sex*</b> <span style="color: red;">Sex</span> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown                                                                                                                                                            |  |
| <b>Occupation*</b> <span style="color: red;">Occupation</span> _____                                                                                                                                                                                                                                                                  |  |
| <b>Occupation location</b> <span style="color: red;">PlaceOfWork1Type</span> <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school                                                                                                                                                        |  |
| <b>Name</b> <span style="color: red;">PlaceOfWork1</span> _____                                                                                                                                                                                                                                                                       |  |
| <b>Address</b> Number _____ Street _____ Suburb _____<br><span style="color: red;">PlaceOfWork1Address</span> Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____                                                                                                                                                  |  |
| <b>Alternative location</b> <span style="color: red;">PlaceOfWork2Type</span> <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school                                                                                                                                                       |  |
| <b>Name</b> _____                                                                                                                                                                                                                                                                                                                     |  |
| <b>Address</b> Number _____ Street _____ Suburb _____<br><span style="color: red;">PlaceOfWork2Address</span> Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____                                                                                                                                                  |  |
| <b>Ethnic group case belongs to*</b> (tick all that apply)                                                                                                                                                                                                                                                                            |  |
| <input type="checkbox"/> NZ European <span style="color: red;">EthNZEuroean</span> <input type="checkbox"/> Maori <span style="color: red;">EthMaori</span> <input type="checkbox"/> Samoan <span style="color: red;">EthSamoan</span> <input type="checkbox"/> Cook Island Maori <span style="color: red;">EthCookIslandMaori</span> |  |
| <input type="checkbox"/> Niuean <span style="color: red;">EthNiuean</span> <input type="checkbox"/> Chinese <span style="color: red;">EthChinese</span> <input type="checkbox"/> Indian <span style="color: red;">EthIndian</span> <input type="checkbox"/> Tongan <span style="color: red;">EthTongan</span>                         |  |
| <input type="checkbox"/> Other (such as Dutch, Japanese) <span style="color: red;">EthOther</span> *(specify) <span style="color: red;">EthSpecify1</span> _____ <span style="color: red;">EthSpecify2</span> _____                                                                                                                   |  |

|                                                                                                                                                                                                                                                                                           |                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| <b>DiseaseName</b> _____                                                                                                                                                                                                                                                                  | EpiSurv No. <b>EpiSurvNumber</b> _____                                                                                   |
| <b>Basis of Diagnosis</b>                                                                                                                                                                                                                                                                 |                                                                                                                          |
| <b>CLINICAL CRITERIA (refer to case definition)</b>                                                                                                                                                                                                                                       |                                                                                                                          |
| <b>Fits Clinical Description*</b> <b>FitClinDes</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                      |                                                                                                                          |
| <b>LABORATORY CRITERIA (refer to case definition)</b>                                                                                                                                                                                                                                     |                                                                                                                          |
| <b>Laboratory confirmation of disease*</b> <b>LabConf</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results                                                                                                        |                                                                                                                          |
| If yes, specify laboratory confirmation method (tick all that apply)*                                                                                                                                                                                                                     |                                                                                                                          |
| Isolation of organism from clinical specimen <b>IsolOrg</b>                                                                                                                                                                                                                               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results |
| Detection of organism by NAAT from clinical specimen <b>NAAT</b>                                                                                                                                                                                                                          | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results |
| Positive IgM antibody <b>PosIgM</b>                                                                                                                                                                                                                                                       | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results |
| Significant rise in antibody level (IgG) <b>SigAntibody</b>                                                                                                                                                                                                                               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results |
| Detection of antigen by ELISA <b>Elisa</b>                                                                                                                                                                                                                                                | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results |
| Other positive test* <b>OthPosTest</b> _____                                                                                                                                                                                                                                              |                                                                                                                          |
| <b>EPIDEMIOLOGICAL CRITERIA (refer to case definition)</b>                                                                                                                                                                                                                                |                                                                                                                          |
| <b>Contact with a probable or confirmed case of the same disease*</b> <b>ConfCase</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                    |                                                                                                                          |
| <b>CLASSIFICATION*</b> <b>Status</b> <input type="radio"/> Under investigation <input type="radio"/> Suspect <input type="radio"/> Probable <input type="radio"/> Confirmed <input type="radio"/> Not a case                                                                              |                                                                                                                          |
| <b>Clinical Course and Outcome</b>                                                                                                                                                                                                                                                        |                                                                                                                          |
| <b>Date of onset*</b> <b>OnsetDt</b> _____ <input type="checkbox"/> Approximate <b>OnsetDtApprox</b> <input type="checkbox"/> Unknown <b>OnsetDtUnknown</b>                                                                                                                               |                                                                                                                          |
| <b>Hospitalised*</b> <b>Hosp</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                         |                                                                                                                          |
| <b>Date hospitalised*</b> <b>HospDt</b> _____ <input type="checkbox"/> Unknown <b>HospDtUnknown</b>                                                                                                                                                                                       |                                                                                                                          |
| <b>Hospital*</b> <b>HospName</b> _____                                                                                                                                                                                                                                                    |                                                                                                                          |
| <b>Died*</b> <b>Died</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                 |                                                                                                                          |
| <b>Date died*</b> <b>DiedDt</b> _____ <input type="checkbox"/> Unknown <b>DiedDtUnknown</b>                                                                                                                                                                                               |                                                                                                                          |
| <b>Was this disease the primary cause of death?*</b> <b>DiedPrimary</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown<br>If no, specify the primary cause of death* <b>DiedOther</b> _____                                                             |                                                                                                                          |
| <b>Outbreak Details</b>                                                                                                                                                                                                                                                                   |                                                                                                                          |
| <b>Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*</b><br><input type="checkbox"/> Yes <b>Outbrk</b> If yes, specify Outbreak No.* <b>OutbrkNo</b> _____                                                                      |                                                                                                                          |
| <b>Risk Factors</b>                                                                                                                                                                                                                                                                       |                                                                                                                          |
| <b>Was the case overseas during the incubation period for this disease?*</b> <b>Overseas</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown<br>(refer to the Communicable Disease Control Manual or Ministry of Health guidance for incubation periods) |                                                                                                                          |
| If yes, date arrived in New Zealand* <b>DtArrived</b> _____                                                                                                                                                                                                                               |                                                                                                                          |
| Specify countries visited (from most recent to least recent)*                                                                                                                                                                                                                             |                                                                                                                          |
| Country/Region                                                                                                                                                                                                                                                                            | Date entered      Date departed                                                                                          |
| Last: <b>LastCountry</b> _____                                                                                                                                                                                                                                                            | <b>LastDtEntered</b> _____ <b>LastDtDeparted</b> _____                                                                   |
| Second Last: <b>SecCountry</b> _____                                                                                                                                                                                                                                                      | <b>SecDtEntered</b> _____ <b>SecDtDeparted</b> _____                                                                     |
| Third Last: <b>ThirdCountry</b> _____                                                                                                                                                                                                                                                     | <b>ThirdDtEntered</b> _____ <b>ThirdDtDeparted</b> _____                                                                 |

|                                                                                                                                                                                      |                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>DiseaseName</b> _____                                                                                                                                                             | EpiSurv No. <b>EpiSurvNumber</b> _____                                                                    |
| <b>Risk Factors continued</b>                                                                                                                                                        |                                                                                                           |
| <b>During the time overseas:</b>                                                                                                                                                     |                                                                                                           |
| <b>Did the case visit or work in caves or mines?*</b> <b>Caves</b>                                                                                                                   | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| If yes, specify cave exposure <b>CavesSpec</b> _____                                                                                                                                 |                                                                                                           |
| <b>Did the case have contact with an animal reservoir for this disease?*</b> <b>ExpAnimal</b>                                                                                        | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| If yes, specify animal exposure <b>ExpAnimalSpec</b> _____                                                                                                                           |                                                                                                           |
| <b>Did the case handle or consume meat or animal products e.g. bush meat or unpasteurised milk?*</b> <b>ConsAnimal</b>                                                               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| If yes, specify exposure detail <b>ConsAnimSpec</b> _____                                                                                                                            |                                                                                                           |
| <b>Was the case potentially exposed to body fluids / blood / tissue from a confirmed, probable or suspect case during the incubation period for this disease?*</b> <b>BodyFluids</b> | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| If yes, what was the nature of exposure?                                                                                                                                             |                                                                                                           |
| Household exposure <b>Household</b>                                                                                                                                                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| Sexual exposure <b>Sexual</b>                                                                                                                                                        | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| Dead body exposure <b>Corpse</b>                                                                                                                                                     | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| Occupational exposure (e.g. healthcare worker, laboratory worker etc) <b>ExpOccup</b>                                                                                                | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| If yes, specify occupational exposure <b>ExpOccSpec</b> _____                                                                                                                        |                                                                                                           |
| Other exposure to body fluids / blood / tissue from a case <b>OthExp</b>                                                                                                             | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| If yes, specify other exposure <b>OthExpSpec</b> _____                                                                                                                               |                                                                                                           |
| <b>Other risk factor(s) for disease</b> <b>RiskSpec</b> _____                                                                                                                        |                                                                                                           |
| <b>Protective Factors</b>                                                                                                                                                            |                                                                                                           |
| <b>Prior to onset, had case been immunised with appropriate vaccine?*</b> <b>Immunised</b>                                                                                           |                                                                                                           |
| <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA <input type="radio"/> Unknown                                                                            |                                                                                                           |
| If yes, specify date of last vaccination* <b>ImmDate</b> _____                                                                                                                       |                                                                                                           |
| If yes, how was vaccination status confirmed* <b>ImmBasis</b>                                                                                                                        |                                                                                                           |
| <input type="radio"/> Patient/Caregiver recall <input type="radio"/> Documented <input type="radio"/> NA <input type="radio"/> Unknown                                               |                                                                                                           |
| <b>Management</b>                                                                                                                                                                    |                                                                                                           |
| <b>CASE MANAGEMENT</b>                                                                                                                                                               |                                                                                                           |
| <b>Was the case excluded from work or school, pre-school or childcare for an appropriate period?</b> <b>Excluded</b>                                                                 | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA <input type="radio"/> Unknown |
| <b>Was appropriate infection control advice given?</b> <b>InfControl</b>                                                                                                             | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA <input type="radio"/> Unknown |
| <b>CONTACT MANAGEMENT</b>                                                                                                                                                            |                                                                                                           |
| <b>Flight number(s) if case infectious while on board a flight*</b>                                                                                                                  |                                                                                                           |
| Last flight <b>Flight1No</b> _____ 2nd to last flight <b>Flight2No</b> _____ 3rd to last flight <b>Flight3No</b> _____ 4th to last flight <b>Flight4No</b> _____                     |                                                                                                           |
| <b>Attendance at school, preschool or childcare</b> <b>AttendSch</b>                                                                                                                 | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| <b>Does case live or work in an institution (e.g. prison, boarding hostel)</b> <b>Instutn</b>                                                                                        | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                          |
| If yes, specify detail <b>InstutnSpec</b> _____                                                                                                                                      |                                                                                                           |
| <b>Number of contacts identified (if applicable)</b> <b>NumCont</b> _____                                                                                                            |                                                                                                           |
| <b>Number of contacts followed up according to national or local protocols (if applicable)</b> <b>NumContProt</b> _____                                                              |                                                                                                           |
| <b>Comments*</b>                                                                                                                                                                     |                                                                                                           |
| <b>Comments</b>                                                                                                                                                                      |                                                                                                           |