

# CASE REPORT FORM

# Leptospirosis

Leptospirosis		EpiSurv No. EpiSurvNumber	
<b>Reporting Authority</b>			
Name of Public Health Officer responsible for case OfficerName			
<b>Notifier Identification</b>			
<b>Reporting source*</b> <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory ReportSrc <input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> Other			
Name of reporting source ReportName		Organisation ReportOrganisation	
Date reported* ReportDate	Laboratory sample date SampleDate	Contact phone ReportPhone	
Usual GP UsualGP	Practice GPPPracticeName	GP phone GPPhone	
GP/Practice address Number		Street	Suburb
GPAddress		Town/City	Post Code <input type="checkbox"/> GeoCode
<b>Case Identification</b>			
Name of case* Surname Surname		Given Name(s) GivenName	
NHI number* NHINumber		Email Email	
Current address* Number		Street	Suburb
CaseAddress		Town/City	Post Code <input type="checkbox"/> GeoCode
Phone (home) PhoneHome		Phone (work) PhoneWork	Phone (other) PhoneOther
<b>Case Demography</b>			
Location TA* TA		DHB* DHB	
Date of birth* DateOfBirth		OR Age Age	<input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years AgeUnits
Sex* Sex		<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown	
Occupation* Occupation			
Occupation location PlaceOfWork1Type		<input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
Name PlaceOfWork1			
Address Number		Street	Suburb
PlaceOfWork1Address		Town/City	Post Code <input type="checkbox"/> GeoCode
Alternative location PlaceOfWork2Type		<input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
Name PlaceOfWork2			
Address Number		Street	Suburb
PlaceOfWork2Address		Town/City	Post Code <input type="checkbox"/> GeoCode
<b>Ethnic group case belongs to*</b> (tick all that apply)			
<input type="checkbox"/> NZ European EthNZEuroean <input type="checkbox"/> Maori EthMaori <input type="checkbox"/> Samoan EthSamoan <input type="checkbox"/> Cook Island Maori EthCookIslandMaori			
<input type="checkbox"/> Niuean EthNiuean <input type="checkbox"/> Chinese EthChinese <input type="checkbox"/> Indian EthIndian <input type="checkbox"/> Tongan EthTongan			
<input type="checkbox"/> Other (such as Dutch, Japanese) EthOther    *(specify) EthSpecify1    EthSpecify2			

<b>Leptospirosis</b>	EpiSurv No. <span style="border: 1px solid black; padding: 2px;">EpiSurvNumber</span>
<b>Basis of Diagnosis</b>	
<b>CLINICAL CRITERIA</b>	
<b>Fits clinical description*</b> <span style="color: red;">FitClinDes</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
<b>LABORATORY CRITERIA</b>	
<b>Meets laboratory confirmation criteria for disease*</b> <span style="color: red;">LabConf</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
<b>Isolation of <i>Leptospira</i> from clinical specimen</b> <span style="color: red;">Isolation</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
<b>Detection of <i>Leptospira</i> nucleic acid from clinical specimen</b> <span style="color: red;">NAAT</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
<b>Four-fold or greater rise in antibody titre in paired sera by microagglutination test (MAT)</b> <span style="color: red;">Titre4x</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
<b>Single high antibody titre of <math>\geq 400</math> by microagglutination test (MAT)</b> <span style="color: red;">Titre400</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
<b>Single raised antibody titre of <math>&lt; 400</math> by microagglutination test (MAT)</b> <span style="color: red;">TitreLT400</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
<b>CLASSIFICATION*</b> <span style="color: red;">Status</span>	
<input type="radio"/> Under investigation <input type="radio"/> Probable <input type="radio"/> Confirmed <input type="radio"/> Not a case	
<b>ADDITIONAL LABORATORY DETAILS</b>	
Serovar (specify)* <span style="color: red;">Serovar</span>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Clinical Course and Outcome</b>	
<b>Date of onset*</b> <span style="color: red;">OnsetDt</span>	<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> <input type="checkbox"/> Approximate <span style="color: red;">OnsetDtApprox</span> <input type="checkbox"/> Unknown <span style="color: red;">OnsetDtUnknown</span>
<b>Hospitalised*</b> <span style="color: red;">Hosp</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
<b>Date hospitalised*</b> <span style="color: red;">HospDt</span>	<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> <input type="checkbox"/> Unknown <span style="color: red;">HospDtUnknown</span>
<b>Hospital *</b> <span style="color: red;">HospName</span>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Died*</b> <span style="color: red;">DiedDt</span>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
<b>Date died*</b> <span style="color: red;">DiedDt</span>	<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> <input type="checkbox"/> Unknown <span style="color: red;">DiedDtUnknown</span>
<b>Was this disease the primary cause of death?</b> <span style="color: red;">DiedPrimary</span>	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
<b>If no, specify the primary cause of death*</b> <span style="color: red;">DiedOther</span>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<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>	
<input type="checkbox"/> Yes <span style="color: red;">Outbrk</span> If yes, specify Outbreak No.* <span style="color: red;">OutbrkNo</span>	
<div style="border: 1px solid black; width: 150px; height: 20px; display: inline-block;"></div>	
<b>Risk Factors</b>	
<b>Exposure to farm or wild animals or their products in 20 days before illness?</b> <span style="color: red;">ExpAnimal</span>	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes, specify exposure in detail* <span style="color: red;">ExpAnimSpec</span>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Exposure to streams, rivers, lakes in 20 days before illness? (e.g. swimming, canoeing)*</b> <span style="color: red;">ExpWatr</span>	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes, specify exposure(s) in detail* <span style="color: red;">ExpWatrSpec</span>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Was the case overseas during the incubation period (range = 4-20 days) for leptospirosis?</b> <span style="color: red;">Overseas</span>	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
<b>Other risk factor for leptospirosis (specify)*</b> <span style="color: red;">RiskOthSpecify</span>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Were any of these activities part of employment?</b> <span style="color: red;">ExpOccup</span>	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes, specify* <span style="color: red;">ExpOccSpec</span>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

<b>Leptospirosis</b>	EpiSurv No. <span style="border: 1px solid black; padding: 0 20px;">EpiSurvNumber</span>
<b>Protective Factors</b>	
<b>If exposure to farm animals or their products, was herd immunised against leptospirosis?*</b> <span style="color: red;">HerdImmun</span>	
<div style="display: flex; flex-direction: column; gap: 10px;"> <div><input type="radio"/> Fully immunised</div> <div><input type="radio"/> Partially immunised</div> <div><input type="radio"/> Not immunised at all</div> <div><input type="radio"/> Unknown</div> </div>	
<b>Management</b>	
<b>CASE MANAGEMENT</b>	
<b>Were antibiotics given for this episode of leptospirosis?</b> <span style="color: red;">AbxGiven</span> <div style="display: flex; justify-content: flex-end; gap: 20px; margin-top: 5px;"> <input type="radio"/> Yes         <input type="radio"/> No         <input type="radio"/> Unknown       </div>	
Date commenced <span style="color: red;">AbxDate</span> <div style="display: flex; align-items: center; margin-top: 5px;"> <input style="width: 150px; height: 25px; border: 1px solid black;" type="text"/> <input type="checkbox"/> Unknown <span style="color: red;">AbxDateUnknown</span> </div>	
<b>Comments*</b>	
<div style="border: 1px solid black; height: 500px; margin-top: 5px;"></div>	