

# CASE REPORT FORM

# Listeriosis

|                                                                                                                                                                                                                                                                                      |                                   |                                                                                                                           |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------|
| DiseaseName                                                                                                                                                                                                                                                                          |                                   | EpiSurv No. EpiSurvNumber                                                                                                 |                          |
| <b>Disease Name</b> DiseaseName                                                                                                                                                                                                                                                      |                                   |                                                                                                                           |                          |
| <input type="radio"/> Listeriosis <input type="radio"/> Pregnancy associated listeriosis                                                                                                                                                                                             |                                   |                                                                                                                           |                          |
| <b>Reporting Authority</b>                                                                                                                                                                                                                                                           |                                   |                                                                                                                           |                          |
| Name of Public Health Officer responsible for case OfficerName                                                                                                                                                                                                                       |                                   |                                                                                                                           |                          |
| <b>Notifier Identification</b>                                                                                                                                                                                                                                                       |                                   |                                                                                                                           |                          |
| <b>Reporting source*</b><br>ReportSrc <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory <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>DiseaseName</b> <input style="width: 90%;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | EpiSurv No. <input style="width: 80%;" type="text" value="EpiSurvNumber"/>                                                                                                                                                                                                                                                                                                                                                              |
| <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>Clinical Features*</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Pregnancy associated case*</b><br>Illness in mother <span style="color: red;">IllMother</span> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown<br>Preterm labour <span style="color: red;">Labour</span> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown<br>Illness in infant <span style="color: red;">IllInfant</span> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown<br>Intrauterine death <span style="color: red;">Death</span> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <b>Not pregnancy associated case*</b><br>Meningitis <span style="color: red;">Meningitis</span> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown<br>Septicaemia <span style="color: red;">Septicaemia</span> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown<br>Other (specify) <span style="color: red;">OthSymSpec</span> <input style="width: 150px;" type="text"/> |
| <b>LABORATORY CRITERIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Isolation of <i>Listeria monocytogenes</i> from a normally sterile site*</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Isolation<br>If yes, specify site:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Mother</b> <span style="color: red;">MothrSite</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="radio"/> blood culture<br><input type="radio"/> high vaginal swab                                                                                                                                                                                                                                                                                                                                                          |
| <b>Foetus/neonate</b> <span style="color: red;">FoetSite</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="radio"/> blood culture<br><input type="radio"/> CSF<br><input type="radio"/> body swabs<br><input type="radio"/> placental tissue, foetal tissue<br>Other (specify)* <span style="color: red;">FoetSitOther</span> <input style="width: 150px;" type="text"/>                                                                                                                                                              |
| <b>Not pregnancy associated case</b> <span style="color: red;">NonPSite</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> blood culture<br><input type="radio"/> CSF<br>Other (specify)* <span style="color: red;">NonPSitOther</span> <input style="width: 150px;" type="text"/>                                                                                                                                                                                                                                                           |
| <b>CLASSIFICATION*</b> <span style="color: red;">Status</span> <input type="radio"/> Under investigation <input type="radio"/> Confirmed <input type="radio"/> Not a case <a href="#" style="float: right; font-size: 0.8em;">i</a>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>ADDITIONAL LABORATORY DETAILS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Serotype (specify) <span style="color: red;">Serotype</span> <input style="width: 150px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Clinical Course and Outcome</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Date of onset*</b> <span style="color: red;">OnsetDt</span> <input style="width: 100px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <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> <input style="width: 100px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Unknown <span style="color: red;">HospDtUnknown</span>                                                                                                                                                                                                                                                                                                                                                         |
| <b>Hospital*</b> <span style="color: red;">HospName</span> <input style="width: 150px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Died*</b> <span style="color: red;">Died</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                        |
| <b>Date died*</b> <span style="color: red;">DiedDt</span> <input style="width: 100px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                        |
| <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                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If no, specify the primary cause of death* <span style="color: red;">DiedOther</span> <input style="width: 150px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <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> <input style="width: 100px;" type="text"/>                                                                                                                                                                                                                                                                                                                      |

DiseaseName

EpiSurv No. EpiSurvNumber

## Risk Factors

### PREGNANCY ASSOCIATED CASES

#### Pregnancy details

Due date\* DueDate

☐ Unknown DueDateUnknown

Date of delivery\* DelivDate

☐ Unknown DelivDateUnknown

Gestation at date of delivery\* GestationWk weeks

Foetus/infant died\* InfanDied

☐ Yes ☐ No ☐ Unknown

Date died\* InfDthDate

☐ Unknown InfDthDateUnknown

If foetus/infant died from disease other than listeriosis, specify\* InfDthSpec

### NOT PREGNANCY ASSOCIATED CASES

Underlying illness\* UndIllness

☐ Yes ☐ No ☐ Unknown

If yes, specify\* UndIllSpec

Receiving immunosuppressive drugs\* ImmunoDrugs

☐ Yes ☐ No ☐ Unknown

If yes, specify\* ImmunoDSpec

Admitted to hospital for treatment of another illness (other than listeriosis)\* HospTrtment

☐ Yes ☐ No ☐ Unknown

If yes, specify\* HospTrtSpec

### ALL CASES

Was case overseas during incubation period (range = 3-70 days) for listeriosis?

\*Overseas

☐ Yes ☐ No ☐ Unknown

Other risk factors for listeriosis, specify\* RiskOthSpecify

## Source

Was a source confirmed by\*

a) Epidemiological evidence\* SceConfEpi

☐ Yes ☐ No ☐ Unknown

e.g. part of an identified common source outbreak (also record in outbreak section) or person to person contact with a known case

b) Laboratory evidence\* SceConfLab

☐ Yes ☐ No ☐ Unknown

e.g. organism or toxin of same type identified if food or drink consumed by case

Specify confirmed source(s)\*

☐ From consumption of contaminated food or drink, specify food or drink ConfFD

ConfFDName ConfFDSpec

☐ From contact with infected animal, specify type of animal ConfInfAnim ConfInfAnimSpec

☐ Person to person contact with another case, specify case ConfPP ConfPPSpec

☐ From other confirmed source, specify source ConfOtherSce

ConfOtherSceSpec

|                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| DiseaseName <input style="width: 95%;" type="text"/>                                                                                                                                                                                                                                                                                                                                                     | EpiSurv No. <span style="border: 1px solid black; padding: 0 5px;">EpiSurvNumber</span> |
| <b>Source continued</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |
| If not, was a <i>probable</i> source identified?* <span style="color: red;">SceProb</span> <span style="margin-left: 100px;"><input type="radio"/> Yes</span> <span style="margin-left: 20px;"><input type="radio"/> No</span> <span style="margin-left: 20px;"><input type="radio"/> Unknown</span>                                                                                                     |                                                                                         |
| Specify <i>probable</i> source(s)*                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |
| <input type="checkbox"/> From consumption of contaminated food or drink, specify food or drink <span style="color: red;">ProbFD</span><br><div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span style="color: red;">ProbFDName</span> <input style="width: 25%;" type="text"/> <span style="color: red;">ProbFDSpec</span> <input style="width: 50%;" type="text"/> </div> |                                                                                         |
| <input type="checkbox"/> From contact with infected animal, specify type of animal <span style="color: red;">ProbInfAnim</span> <span style="float: right; margin-right: 50px;"><span style="color: red;">ProbInfAnimSpec</span> <input style="width: 15%;" type="text"/></span>                                                                                                                         |                                                                                         |
| <input type="checkbox"/> Person to person contact with another case, specify relationship <span style="color: red;">ProbPP</span> <span style="float: right; margin-right: 50px;"><span style="color: red;">ProbPPSpec</span> <input style="width: 15%;" type="text"/></span>                                                                                                                            |                                                                                         |
| <input type="checkbox"/> From other probable source, specify source <span style="color: red;">ProbOtherSce</span><br><span style="color: red;">ProbOtherSceSpec</span> <input style="width: 90%;" type="text"/>                                                                                                                                                                                          |                                                                                         |
| <b>Management</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                         |
| <b>CASE MANAGEMENT</b> <span style="color: red;">Excluded</span>                                                                                                                                                                                                                                                                                                                                         |                                                                                         |
| Case excluded from work or school / pre-school / childcare until well? <span style="margin-left: 20px;"><input type="radio"/> Yes</span> <span style="margin-left: 20px;"><input type="radio"/> No</span> <span style="margin-left: 20px;"><input type="radio"/> NA</span> <span style="margin-left: 20px;"><input type="radio"/> Unknown</span>                                                         |                                                                                         |
| <b>Comments*</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                         |
| <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Comments</div> <div style="border: 1px solid black; min-height: 350px;"></div>                                                                                                                                                                                                                                                   |                                                                                         |