

# CASE REPORT FORM

# Invasive Pneumococcal Disease

Invasive pneumococcal disease _____	EpiSurv No. _____
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## Reporting Authority

Name of Public Health Officer responsible for case \_\_\_\_\_

## Notifier Identification

**Reporting source\***     General Practitioner     Hospital-based Practitioner     Laboratory  
    Self-notification     Outbreak Investigation     Other

**Name of reporting source** \_\_\_\_\_ **Organisation** \_\_\_\_\_

**Date reported\*** \_\_\_\_\_ **Contact phone** \_\_\_\_\_

**Usual GP** \_\_\_\_\_ **Practice** \_\_\_\_\_ **GP phone** \_\_\_\_\_

**GP/Practice address** Number \_\_\_\_\_ Street \_\_\_\_\_ Suburb \_\_\_\_\_  
   Town/City \_\_\_\_\_ Post Code \_\_\_\_\_  GeoCode \_\_\_\_\_

## Case Identification

**Name of case\*** Surname \_\_\_\_\_ Given Name(s) \_\_\_\_\_

**NHI number\*** \_\_\_\_\_ **Email** \_\_\_\_\_

**Current address\*** Number \_\_\_\_\_ Street \_\_\_\_\_ Suburb \_\_\_\_\_  
   Town/City \_\_\_\_\_ Post Code \_\_\_\_\_  GeoCode \_\_\_\_\_

**Phone (home)** \_\_\_\_\_ **Phone (work)** \_\_\_\_\_ **Phone (other)** \_\_\_\_\_

## Case Demography

**Location TA\*** \_\_\_\_\_ **DHB\*** \_\_\_\_\_

**Date of birth\*** \_\_\_\_\_ **OR** **Age** \_\_\_\_\_  Days     Months     Years

**Sex\***     Male     Female     Indeterminate     Unknown

**Occupation\*** \_\_\_\_\_

**Occupation location**     Place of Work     School     Pre-school

**Name** \_\_\_\_\_

**Address** Number \_\_\_\_\_ Street \_\_\_\_\_ Suburb \_\_\_\_\_  
   Town/City \_\_\_\_\_ Post Code \_\_\_\_\_  GeoCode \_\_\_\_\_

**Alternative location**     Place of Work     School     Pre-school

**Name** \_\_\_\_\_

**Address** Number \_\_\_\_\_ Street \_\_\_\_\_ Suburb \_\_\_\_\_  
   Town/City \_\_\_\_\_ Post Code \_\_\_\_\_  GeoCode \_\_\_\_\_

**Ethnic group case belongs to\*** (tick all that apply)

NZ European     Maori     Samoan     Cook Island Maori  
 Niuean     Chinese     Indian     Tongan  
 Other (such as Dutch, Japanese, Tokelauan)    \*(specify) \_\_\_\_\_

**Basis of Diagnosis**

**CLINICAL PRESENTATION\***

- |                           |                           |                          |                               |
|---------------------------|---------------------------|--------------------------|-------------------------------|
| Pneumonia                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| Bacteraemia without focus | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| Meningitis                | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| Empyema                   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| Septic arthritis          | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| Other                     | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |

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

**LABORATORY CRITERIA**

**Specimen\*** (tick all with positive results)

- |                             |  |  |   |
|-----------------------------|--|--|---|
| Blood                       | <input type="checkbox"/> culture   | <input type="checkbox"/> NAAT <sup>2</sup> | <sup>1</sup> refer to the case report form instructions |
| CSF                         | <input type="checkbox"/> culture <input type="checkbox"/> antigen detection <sup>1</sup> | <input type="checkbox"/> NAAT              | <sup>2</sup> nucleic acid amplification test            |
| Pleural fluid               | <input type="checkbox"/> culture <input type="checkbox"/> antigen detection <sup>1</sup> | <input type="checkbox"/> NAAT              |   |
| Joint fluid                 | <input type="checkbox"/> culture   | <input type="checkbox"/> NAAT              |   |
| Other sterile site specimen | <input type="checkbox"/> culture   | <input type="checkbox"/> NAAT              |   |

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

**STATUS\***

- Under investigation     Confirmed     Not a case

**ADDITIONAL LABORATORY DETAILS**

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

ESR Updated        Laboratory \_\_\_\_\_  
 Date result updated \_\_\_\_\_    Sample Number \_\_\_\_\_

**Clinical Course and Outcome**

**Date of onset\*** \_\_\_\_\_     Approximate     Unknown

**Hospitalised\***     Yes     No     Unknown

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

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

**Died\***     Yes     No     Unknown

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

**Was this disease the primary cause of death?\***     Yes     No     Unknown

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

**Outbreak Details**

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

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

**Risk Factors**

**Premature <37 weeks gestation (if case is <1 year of age)\***  Yes  No  Unknown

**Congenital or chromosomal abnormality (includes Down's syndrome)\***  Yes  No  Unknown

**Chronic lung disease or Cystic Fibrosis\***  Yes  No  Unknown

**Anatomical or functional asplenia\***  Yes  No  Unknown

**Immunocompromised\***  Yes  No  Unknown  
*Includes HIV/AIDS, lymphoma, organ transplant, multiple myeloma, nephrotic syndrome, chronic drug therapy (e.g. chemotherapy or >20 mg/d prednisolone in last year), dysgammaglobulinaemia and sickle cell anaemia.*

**Chronic illness\***  Yes  No  Unknown  
*Includes CSF leak, intracranial shunts, diabetes, cardiac disease (angina, MI, heart failure, coronary bypass), pulmonary disease (asthma, bronchitis, emphysema), chronic liver disease, renal impairment and alcohol related.*

**Cochlear implants\***  Yes  No  Unknown

**Current smoker\***  Yes  No  Unknown

**Smoking in the household (if case is <5 years of age)\***  Yes  No  Unknown

**Attends childcare (if case is <5 years of age)\***  Yes  No  Unknown  
*Attends childcare (regular attendance >4 hours per week) in a grouped childcare setting outside the home.*

**Resident in long term or other chronic care facility\***  Yes  No  Unknown

**Other risk factors including illness that requires regular medical review (specify)\***  
 \_\_\_\_\_  
 \_\_\_\_\_

**Protective Factors**

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

If yes, specify vaccination details\*

**Source of information\***  Patient/caregiver recall  Documented

**Dose 1:\***  Polysaccharide  Conjugate  Unknown  
 Date given\* \_\_\_\_\_ Or age when first dose was given \_\_\_\_\_  Weeks  Months  Years

**Dose 2:\***  Polysaccharide  Conjugate  Not given  Unknown  
 Date given\* \_\_\_\_\_ Or age when second dose was given \_\_\_\_\_  Weeks  Months  Years

**Dose 3:\***  Polysaccharide  Conjugate  Not given  Unknown  
 Date given\* \_\_\_\_\_ Or age when third dose was given \_\_\_\_\_  Weeks  Months  Years

**Dose 4:\***  Polysaccharide  Conjugate  Not given  Unknown  
 Date given\* \_\_\_\_\_ Or age when fourth dose was given \_\_\_\_\_  Weeks  Months  Years

**Dose 5:\***  Polysaccharide  Conjugate  Not given  Unknown  
 Date given\* \_\_\_\_\_ Or age when fifth dose was given \_\_\_\_\_  Weeks  Months  Years

**Dose 6:\***  Polysaccharide  Conjugate  Not given  Unknown  
 Date given\* \_\_\_\_\_ Or age when sixth dose was given \_\_\_\_\_  Weeks  Months  Years

**NIR Vaccination Status (to be completed by ESR)**  
 Fully vaccinated for age  Partially vaccinated for age  Not vaccinated  Not applicable  
 Date status updated \_\_\_\_\_ NIR Reference \_\_\_\_\_

**Comments\***

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