

**CASE REPORT FORM****Leptospirosis**

Leptospirosis \_\_\_\_\_

EpiSurv No. \_\_\_\_\_

**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 YearsSex\*  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) \_\_\_\_\_

Leptospirosis		EpiSurv No. _____	
<b>Basis of Diagnosis</b>			
<b>CLINICAL CRITERIA</b>			
Fits clinical description*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
<b>LABORATORY CRITERIA</b>			
Meets laboratory confirmation criteria for disease*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Isolation of <i>Leptospira</i> from clinical specimen	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
Detection of <i>Leptospira</i> nucleic acid from clinical specimen	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
Four-fold or greater rise in antibody titre in paired sera by microagglutination test (MAT)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
Single high antibody titre of $\geq 400$ by microagglutination test (MAT)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
Single raised antibody titre of $< 400$ by microagglutination test (MAT)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Done <input type="radio"/> Awaiting Results
<b>CLASSIFICATION*</b>	<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)* _____			
<b>Clinical Course and Outcome</b>			
Date of onset* _____	<input type="checkbox"/> Approximate	<input type="checkbox"/> Unknown	
Hospitalised*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Date hospitalised* _____	<input type="checkbox"/> Unknown		
Hospital * _____			
Died*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Date died* _____	<input type="checkbox"/> Unknown		
Was this disease the primary cause of death?*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If no, specify the primary cause of death* _____			
<b>Outbreak Details</b>			
Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*			
<input type="checkbox"/> Yes		If yes, specify Outbreak No.* _____	
<b>Risk Factors</b>			
Exposure to farm or wild animals or their products in 20 days before illness?*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify exposure in detail* _____			
Exposure to streams, rivers, lakes in 20 days before illness? (e.g. swimming, canoeing)*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify exposure(s) in detail* _____			
Was the case overseas during the incubation period (range = 4-20 days) for leptospirosis?*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Other risk factor for leptospirosis (specify)* _____			
Were any of these activities part of employment?*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, specify* _____			

