



Infectious Disease Control Unit, Texas Department of State Health Services

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Haemophilus influenzae type B
Case Track Record

NBS PATIENT ID#: _____

FINAL STATUS:

- CONFIRMED PROBABLE RULED OUT/DROPPED/NOT A CASE

NBS PATIENT INVESTIGATION#: _____

Patient's Name: Last First
Address:
City: County: Zip:
Region: Phone:
Parent/Guardian:
Physician: Phone:
Physician's Address:

Reported By:
Agency:
Phone:
Date:
Report Given to:
Organization:
Phone:
Date:

DEMOGRAPHICS:

DATE OF BIRTH: AGE: SEX: Male Female Unknown
RACE: White Black Asian Native Hawaiian or Other Pac. Islander Am. Indian or Alaska Native Unknown Other:
HISPANIC: Yes No Unknown

CLINICAL DATA: Onset Date: / /

TYPE OF INFECTION: (check all that apply)

- Primary Bacteremia Pneumonia Peritonitis
Meningitis Cellulitis Septic Arthritis
Otitis Media Epiglottitis Other:

Hospitalized at: _____

Admitted: / / Discharged: / /

OUTCOME: Survived Died / / Unknown

LABORATORY DATA: DATE FIRST POSITIVE CULTURE OBTAINED: / / (Lab must be attached, if not typed at DSHS)

Specimen from which organism was isolated: (check all that apply) Blood Pleural Fluid Placenta Pericardial Fluid CSF

Peritoneal Fluid Joint Other Normally Sterile Site:

What was the serotype? Type b Not Typable Not Tested or Unknown Other:

VACCINATION HISTORY: CDC Objective: 90% of pertussis cases must have a vaccination history reported.

VACCINATED: Yes No Unknown

1 HIB: / / Type: Manufacturer: Lot #:
2 HIB: / / Type: Manufacturer: Lot #:
3 HIB: / / Type: Manufacturer: Lot #:
4 HIB: / / Type: Manufacturer: Lot #:

If no, indicate reason: Religious Exemption Medical Contraindication Evidence of Immunity Previous Disease- Lab Confirmed

Previous Disease- MD Diagnosed Under Age Parental Refusal Unknown Other: _____

HOUSEHOLD CONTACTS: Were control activities initiated?: Yes No Unknown If no, explain: _____

Table with 6 columns: Name, Relation to Case, Age, Vaccination HX, *Symptoms/Date of Onset, Type of Prophylaxis/Date Treated

*Investigations must be completed on all symptomatic contacts of confirmed or probable cases

Patient Name: _____

Jurisdiction: _____

POSSIBLE SPREAD CONTACTS:

Setting: No Spread Day-care School College Work Home Dr. Office Hospital ER Hospital Inpatient
Hospital Outpatient Military Jail Church Travel Unknown Other: _____

Name (s) of Settings: _____

Name	Relation to Case	Age	Vaccination HX	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Investigations must be completed on all contacts with symptoms*

PROPHYLAXIS RECOMMENDATIONS:

Haemophilus influenzae, type B (HIB) (small gram-negative rods); incubation period is probably short, usually only 2-4 days.

Who should receive prophylaxis?

- All "family contacts" (members of the patient's household) if there is another child under 4 years of age residing in the home.
- Prophylaxis should strongly be considered for all staff and children--regardless of age--in the day-care classroom in which an invasive Hib infection has occurred, and in which one or more children under 2 years of age have been exposed.
- Children in the day-care classroom who have been vaccinated with the Hib vaccine SHOULD also receive rifampin.
- Hospital personnel DO NOT need prophylaxis.

Rifampin Dosage:*

- Adults: 600 mg PO once a day x 4 days.
- Infants and children (1 month-12 years): 20 mg/kg** PO once a day x 4 days.

In addition to the routine medications used to treat *H. influenzae* infections, the index case should receive the above regimen before going home from the hospital in order to eradicate pharyngeal carriage of the organism.

* Before administering rifampin, note that rifampin:

- is not recommended for use during pregnancy.
- interferes temporarily with effectiveness of oral contraceptives.
- will turn urine, tears, saliva an orange/red color; soft contact lenses will be permanently stained if worn while taking rifampin.

** The maximum dosage of rifampin should not exceed a total of 600 mg per dose.

COMMENTS:

CDC Objective: 85% of vaccine preventable cases must be investigated and reported to the CDC within 30 days of initial report.

Date Investigation Initiated: ____/____/____ Date Investigation Completed: ____/____/____ Date Reported to DSHS: ____/____/____

Investigator's Name: _____ Agency name: _____ Phone :() _____

Closed in NBS? Yes No

If confirmed or probable, notification submitted? Yes No