

CASE REPORT FORM

Listeriosis

EpiSurv No. _____
Disease Name
<input type="radio"/> Listeriosis <input type="radio"/> Listeriosis - perinatal
Reporting Authority
Name of Public Health Officer responsible for case _____
Notifier Identification
Reporting source* <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 _____ Organisation _____
Date reported* _____ Contact phone _____
Usual GP _____ Practice _____ GP phone _____
GP/Practice address Number _____ Street _____ Suburb _____ Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____
Case Identification
Name of case* Surname _____ Given Name(s) _____
NHI number* _____ Email _____
Current address* Number _____ Street _____ Suburb _____ Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____
Phone (home) _____ Phone (work) _____ Phone (other) _____
Case Demography
Location TA* _____ DHB* _____
Date of birth* _____ OR Age _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years
Sex* <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown
Occupation* _____
Occupation location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school
Name _____
Address Number _____ Street _____ Suburb _____ Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____
Alternative location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school
Name _____
Address Number _____ Street _____ Suburb _____ Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____
Ethnic group case belongs to* (tick all that apply)
<input type="checkbox"/> NZ European <input type="checkbox"/> Maori <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Maori <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Tongan <input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) *(specify) _____

Basis of Diagnosis**CLINICAL CRITERIA**

Fits Clinical Description* Yes No Unknown

Clinical Features***Perinatal Case***

Illness in mother Yes No Unknown
 Preterm labour Yes No Unknown
 Illness in infant Yes No Unknown
 Intrauterine death Yes No Unknown

Non-perinatal Case*

Meningitis Yes No Unknown
 Septicaemia Yes No Unknown
 Other (specify) _____

LABORATORY CRITERIA

Isolation of *Listeria monocytogenes* from a normally sterile site* Yes No Not Done Awaiting Results

If yes, specify site:*

Mother blood culture
 high vaginal swab

Foetus/neonate blood culture
 CSF
 body swabs
 placental tissue, foetal tissue
 Other (specify)* _____

Non-perinatal case blood culture
 CSF
 Other (specify)* _____

STATUS* Under investigation Confirmed Not a case

ADDITIONAL LABORATORY DETAILS

Serotype (specify) _____

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 No Unknown
 If yes, specify Outbreak No.* _____

Risk Factors**PERINATAL CASES****Pregnancy details**Due date* _____ UnknownDate of delivery* _____ Unknown

Gestation at date of delivery* _____ weeks

Foetus/infant died* Yes No UnknownDate died* _____ Unknown

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

NON-PERINATAL CASESUnderlying illness* Yes No Unknown

If yes, specify* _____

Receiving immunosuppressive drugs* Yes No Unknown

If yes, specify* _____

Admitted to hospital for treatment of another illness (other than listeriosis)* Yes No Unknown

If yes, specify* _____

ALL CASESWas case overseas during incubation period (range = 3-70 days) for listeriosis?* Yes No Unknown

Other risk factors for listeriosis, specify* _____

SourceWas a source *confirmed* by*a) Epidemiological evidence* 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* 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

 From contact with infected animal, specify type of animal

 Person to person contact with another case, specify case

 From other confirmed source, specify source

Source continuedIf not, was a *probable* source identified?* Yes No UnknownSpecify *probable* source(s)* From consumption of contaminated food or drink, specify food or drink From contact with infected animal, specify type of animal Person to person contact with another case, specify relationship From other probable source, specify source**Management****CASE MANAGEMENT**

Case excluded from work or school / pre-school / childcare until well?

 Yes No NA Unknown**Comments***