EPID/DS/TY/2017

# Surveillance of Enteric Fever (Typhoid and Paratyphoid Fever)
# Case Investigation Form

**The Public Health Inspector should investigate and complete this form. Medical Officer of Health is responsible for the completeness and the accuracy of the data provided. Necessary data should be obtained from the patient, his/her relatives and from the relevant documents. Early investigation and return is utmost important.**

| | |
|---|---|
| Week Ending of notification ☐☐ ☐☐ ☐☐ d d m m y y | Serial No. ☐☐☐☐ Please write the serial number given in the ID register in the MOH office. |

## A. Patient Details

1.Name of the patients (BLOCK LETTERS).....

2.Residential Address.....

3.Date of Birth ☐☐ ☐☐ ☐☐☐☐ (dd / mm / yyyy)

| 4. Age ☐☐ ☐☐ y y / m m | 6. Ethnic group ☐ 1. Sinhalese ☐ 2. Tamil ☐ 3. Moor ☐ 4. Others ☐ 5. Unknown | **7. Does the patient work as a food handler?*** ☐ 1. Yes ☐ 2. No * Those who involved in preparation, storage (both raw and cooked food), serving or selling food in a commercial food facility. (Those who only transporting but not physically touching food– not considered as food handlers) | 8. Occupation ..... | 9. RDHS Division ..... | 10. MOH Area ..... |
|---|---|---|---|---|---|
| 5. Sex ☐ 1. Male ☐ 2. Female ☐ 3. Unknown | | | FOR OFFICE USE ONLY ☐☐ | ☐☐ | ☐☐ |
| | | | | 11. PHI Area ..... FOR OFFICE USE ONLY ☐☐ | 12.GN Division ..... ☐☐ |

## B. Present Illness / Outcome

| 13.Date of onset of symptoms: ☐☐ ☐☐ ☐☐ d d m m y y | 15. Was the patient admitted to hospital? ☐ 1. Yes → to Q. 16 ☐ 2. No } Skip to Q.24 ☐ 3. Not known | 20. Date of discharge / transfer / death ☐☐ ☐☐ ☐☐ d d m m y y |
|---|---|---|
| 14. Where did the patient first seek medical advice? ☐ 1. Government hospital ☐ 2. Private hospital ☐ 3. Private practitioner ☐ 4. Aurvedic Institute (Public / Private) ☐ 5. Other (Specify) ..... | 16. If yes, date of admission ☐☐ ☐☐ ☐☐ d d m m y y | 21. If transferred, name of the hospital ..... 22. Ward ..... 23. BHT No. ..... |
| | 17. Name of the hospital ..... 18. Ward ..... 19. BHT No. ..... | 24. Outcome of the case ☐ 1. Cured ☐ 2. Died ☐ 3. Not known ☐ 4. Other (Specify) ..... |

## C. Clinical Data

**Surveillance case definition:** An illness often characterized by insidious onset of sustained fever, headache, malaise, anorexia, coated tongue in children, relative bradycardia, splenomegaly, constipation / diarrhoea, non-productive cough and may have a skin rash.

| 25. Symptoms and signs | 26. Complications | |
|---|---|---|
| ☐ 1. Fever ☐ 2. Headache ☐ 3. Malaise ☐ 4. Diarrhoea ☐ 5. Constipation ☐ 6. Poor appetite ☐ 7. Non-productive cough ☐ 8. Other (Specify) ..... | ☐ 1. Intestinal bleeding / perforations ☐ 2. Pneumonia ☐ 3. Pancreatitis ☐ 4. Meningitis ☐ 5. Other (Specify) ..... | **For office use only** Compatible with the surveillance case definition ☐ 1. Yes ☐ 2. No |

## D. Laboratory Findings

27. Laboratory tests done: ☐ 1. Yes ☐ 2. No ☐ 3. Reports not yet available ☐ 4.Unknown

28. If yes, please fill the following, If no, skip to Q 29.

| | Name of the test | Date /s | Result (Positive, Negative or Titre / Interpretation) | | | |
|---|---|---|---|---|---|---|
| **Biochemical test** | SAT | | | | | |
| | | | ***S. Typhi*** | ***S. Paratyphi A*** | ***S. Paratyphi B*** | ***S. Paratyphi C*** |
| **Microbiological test** | Blood Culture | | | | | |
| | Urine Culture | | | | | |
| | Stool Culture | | | | | |
| FOR OFFICE USE ONLY | | Confirmed case of | | | | |

## E. Travel History

29. Has the patient travelled outside his / her usual place of stay, 30 days prior to the onset of the illness? ☐ 1. Yes ☐ 2. No

30. If yes, please list the administrative district of the place/s visited? (Eg. Visited and consumed food/ water from Kalawana, should be written as Rathnapura) Do not write the same district twice.

1…….. 2…….. 3…….. 4……..

31. Reason/s for such travel/s,

☐ 1. As a part of the job ☐ 2. To get done official/private work ☐ 3. Trips, ☐ 4.Visiting relatives / friends
☐ 5. Other (Specify)…….

## F. Personal and Domestic Hygiene

| 32. Water Supply | 33. Type of drinking water | 34. Type of latrine |
|---|---|---|
| ☐ 1. Pipe - NWSDB | ☐ 1. Boiled | ☐ 1. Flush |
| ☐ 2. Pipe - CWS | ☐ 2. Chlorinated | ☐ 2. Water seal |
| ☐ 3. Own Well | ☐ 3. Filtered | ☐ 3. Pit |
| ☐ 4. Common Well | ☐ 4. Un-boiled, Un-chlorinated or unfiltered | ☐ 4. No latrine |
| ☐ 5. Tube well | ☐ 5. Other (Specify) …….. | ☐ 5. Other (specify)…… |
| ☐ 6. Stream / River | ☐ 6. not known | ☐ 6. Not known |
| ☐ 7. Other (specify)…… | | |

## G. Vaccination Status

35. Has the patient received vaccination against Typhoid in the past? ☐ 1. Yes ☐ 2. No

| 36. If yes, | Date of Immunization (dd/mm/yy) | Place of Immunization * |
|---|---|---|
| First Typhoid vaccine received, | | |
| Booster dose received (Last) | | |

* MOH Office / Government Hospital / Field clinic / Private Hospital / GP / Not Known / Other

## H. Further Information

37. Presence of risk factors

☐ 1. Consume alcohol ☐ 2. Consume illicit liquor ☐ 3. Attended gatherings / festivals recently ☐ 4. Other(Specify).....

38. Is this patient identified as a **typhoid carrier**? ☐ 1. Yes ☐ 2. No ☐ 3. Don't know (According to the diagnosis card/s)

39. If yes, is the carrier previously identified in the PHI area? ☐ 1. Yes ☐ 2. No ☐ 3. Don't know

40. Remarks:.....

**Completed by,**

Signature: .....
Name:.....
Date:.....
Designation: PHI

**Checked by,**

Signature: .....
Name:.....
Date:.....
Designation: MOH

SEAL of the MOH Office