



Invasive Pneumococcal Disease (IPD) Enhanced Surveillance Form



PATIENT DETAILS

Sex: M F NK*

County: HSE Area: LHO:

CIDR Event ID No.

Patient's name: Country of birth:

Patient's address:

Patient's phone: DOB: Age:

Source of notification: Laboratory Clinician Name of notifier:

Date of notification:

CLINICAL DETAILS

| | Yes | No | NK |
|--------------------------------|--------------------------|--------------------------|-----------------------------|
| Bacteraemia with pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Meningitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bacteraemia without focus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bacteraemia with other focus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If other focus, please specify | <input type="text"/> | | |
| Date of onset of symptoms | <input type="text"/> | <input type="checkbox"/> | NK <input type="checkbox"/> |

Hospitalised: Yes No NK

Date hospitalised:

If Yes, name of hospital:

Hospital number:

Duration of stay (days):

RISK FACTORS ** Yes No Under Investigation NK

** (see NIAC Guidelines for additional information)

| | Yes | No | NK |
|---|--------------------------|--------------------------|--------------------------|
| Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Current Smoker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic heart disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic lung disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic liver disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic renal disease/nephrotic syndrome | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hx of previous invasive bacterial disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Immunosuppressive condition or therapies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Yes | No | NK |
|------------------------------------|--------------------------|--------------------------|--------------------------|
| Asplenia or splenic dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Complement deficiency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CSF leaks (congenital or acquired) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Intracranial shunt | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recipient of cochlear implant | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Contact with another IPD case | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If other, please specify:

VACCINATION

PCV vaccination status: Vaccinated Incompletely vaccinated Unvaccinated Unknown

| Dates PCV vaccinations | Name/Type/Brand | Batch Numbers |
|--------------------------------|----------------------|----------------------|
| 1st dose: <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 2nd dose: <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 3rd dose: <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 4th dose: <input type="text"/> | <input type="text"/> | <input type="text"/> |

PPV vaccination status: Vaccinated (1 dose) Vaccinated (2 doses) Unvaccinated Unknown

| Date PPV vaccination | Name/Type/Brand | Batch Numbers |
|---|----------------------|----------------------|
| Most recent vaccination: <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Previous vaccination*: <input type="text"/> | <input type="text"/> | <input type="text"/> |

*More than one dose is only recommended for individuals at increased risk.

LABORATORY

| | Pos | Neg | Not Done | | Pos | Neg | Not Done | |
|---------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|---|
| Blood culture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other sterile fluid culture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Please specify other fluid site: <input type="text"/> |
| CSF Culture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other sterile fluid PCR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Please specify other fluid site: <input type="text"/> |
| CSF PCR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sterile site antigen | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Please specify sterile site: <input type="text"/> |
| Blood PCR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urinary antigen | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other laboratory tests: <input type="text"/> |

Date 1st positive specimen:

Isolate sent to reference laboratory? Yes No NK

Reference lab name: Serotype:

FINAL CASE CLASSIFICATION & OUTCOME

Case Classification: Confirmed Probable Possible

Outcome: Recovered Recovering Still ill Long-term sequelae Died NK

If died: Date of death: Was death due to IPD? Yes No NK

Form completed by: Position: Date completed:

*NK=Not known

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For Local HSE Area Use Only

FURTHER PATIENT DETAILS

Parent/guardian details

Parent/guardian name

Parent/guardian phone

GP details

GP's name

GP's address

GP's phone

Hospital details

(Hospital name, see page 1 of form) If hospitalised please complete the following

Ward name

Consultant name

Follow-up Notes

Was vaccination recommended? Yes No Unk

Was vaccination initiated as per NIAC recommendations? Yes No Unk

Immunological assessment recommended? Yes No Unk

Immunological assessment undertaken? Yes No Unk

Immunoglobulin assay results (IgG, IgM, IgA)

| | Normal | Abnormal | Unk | Complement assays (C1, C2, C3, C4, CH50) | | |
|-----|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | | | | Normal | Abnormal | Unk |
| IgG | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | C1 | <input type="checkbox"/> | <input type="checkbox"/> |
| IgM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | C2 | <input type="checkbox"/> | <input type="checkbox"/> |
| IgA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | C3 | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | C4 | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | CH50 | <input type="checkbox"/> | <input type="checkbox"/> |

Serotype specific pneumococcal antibody Date taken (1)

Serotype specific pneumococcal antibody Date taken (2)

Comments/Other notes

Thank you for completing this form. Please return the completed form to your local Department of Public Health

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