

Enteric Fever Case Investigation Form

INTERVIEWER DETAILS		
1. Interviewer name:	2. Date of interview: <u>DD / MM / YYYY</u>	
3. Interviewer phone no.:	4. Department:	
PATIENT DETAILS		
5. First name & Surname:		
6. DOB/(Age):	7. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
8. Phone no.:		
9. Place of residence (in the last month before illness):		
Town/City:	District:	Province:
10. Occupation:	11. Place of Work:	
11.1 For children: Name of crèche/school attended:		
12. Works in a food handling trade? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Works in a child/elderly/health care-giving setting? <input type="checkbox"/> Yes <input type="checkbox"/> No		
DISEASE PRESENTATION		
14. Date of onset? <u>DD / MM / YYYY</u>		
15. Symptoms/Signs: <input type="checkbox"/> Fever <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Malaise/Fatigue		
(tick all that apply) <input type="checkbox"/> Headache <input type="checkbox"/> Constipation <input type="checkbox"/> Myalgia <input type="checkbox"/> Respiratory symptoms (e.g. cough)		
<input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Rose Spots (red macules/rash)		
<input type="checkbox"/> Hepatomegaly (enlarged liver) <input type="checkbox"/> Splenomegaly (enlarged spleen)		
<input type="checkbox"/> Other, Specify: _____		
16. Complications (tick all that apply): <input type="checkbox"/> Intestinal bleed <input type="checkbox"/> Intestinal perforation <input type="checkbox"/> Renal failure		
<input type="checkbox"/> Encephalopathy (altered mental state eg confusion, loss of consciousness, seizures)		
17. Outcome: <input type="checkbox"/> Recovered /Discharged <input type="checkbox"/> Still ill /Still admitted <input type="checkbox"/> Died Date of death: <u>DD / MM / YYYY</u>		
CLINIC/HOSPITAL DETAILS		
18. Name of the clinician:	19. Phone no.:	
20. Facility name:	21. Date of 1 st consultation: <u>DD / MM / YYYY</u>	
22. Name of referring facility (if applicable):		
23. Admitted to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
LABORATORY INVESTIGATIONS		
24. Date of specimen collection: <u>DD / MM / YYYY</u>		
25. Lab name:	26. Lab number:	
27. Test/s performed for enteric fever diagnosis: (tick all that apply)		
<input type="checkbox"/> Blood Culture <input type="checkbox"/> Stool Culture		
<input type="checkbox"/> Other, specify: _____		

40: Is your water source: Private (only used by your family) Communal (shared by multiple families known to you)
 Public (shared by people known and unknown to you)

41: Do you treat your water before drinking? Y N

41.1: if yes, indicate how: Boil Chemical (Bleach/chlorine tablets) Other (Specify) _____

42. Main sanitation in the household: Flush toilet Chemical toilet Latrine Bucket None
 Other (Specify) _____

43. Where is your toilet situated? Inside Outside Other (Specify) _____

44: Is your toilet: Private (only used by your family) Communal (shared by multiple families known to you)
 Public (shared by people known and unknown to you)

45: Do you have the following in your dwelling?

Fridge Yes No Unknown **Food Preparation area** Yes No Unknown

Freezer Yes No Unknown **Sink to wash hands** Yes No Unknown

Soap for handwashing at the sink Yes No Unknown

46. Do you store water in your home? Yes No

If yes, in what type of container is water stored? (tick all that apply)

Plastic container Metal container Open container Closed container with lid

How is water removed from the container? (tick all that apply)

With hands With a spoon/cup/jug With a tap Other, specify: _____

47. Who prepares most of the meals in your home? (name and relationship to case): _____

Does he/she wash hands before preparing food? Yes No

Has he/she ever had a similar illness to yours? Yes No

48. Do you grow your own vegetables at home? Yes No

If yes, from where do you get the water for your vegetable garden? _____

What do you use to fertilise your vegetable garden? _____

Additional notes / comments / actions taken:

ENVIRONMENTAL ASSESSMENT

45. List all environmental samples collected: (if applicable)

Type of sample (food/water/milk)	Place / Address where collected	Lab no.	Result

Name of lab(s) processing samples: _____

CONTACT TRACING

1. Identify contacts at risk of infection, including: household members, care-givers of the case, and people who may have eaten the implicated food or water/beverages.
 2. Investigate all contacts as per guidelines. List all below:

Name	Age (years)	Sex (M/F)	History of enteric fever (Y/N)	Occupation	Physical address	Stool sample collected (Y/N)	Lab number/result	Referred for treatment (Y/N)