NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

Division of Public Health Surveillance and Response
Centre for Vaccines and Immunology
(NICD) 24-hour hotline number: 0800 212 552
Compiled: 28 Feb 2025

CASE INVESTIGATION FORM: HAND, FOOT AND MOUTH DISEASE

I. PATIENT INFORMATION

Surname:		Name/s:			
Date of birth:	DD / MM / YYYY	Age:_____ Days ☐ Month ☐ Years ☐	Sex:	Male ☐	Female ☐
Contact Tel./Cell:	(000) 0000000	Occupation:			
Physical home address:					
District:	Province:				

Name of the investigator:	Contact no of investigator:	Date of investigation:

II. CLINICAL INFORMATION

Fever: Yes ☐ No ☐ Date of onset: DD / MM / YYYY Rash: Yes ☐ No ☐ Date of onset: DD / MM / YYYY ☐ Palms ☐ Fingers ☐ Mouth ulcers ☐ Buttocks ☐ Soles of ulcers Painful: Yes ☐ No ☐ Characteristics: Maculopapular ☐ Papulovesicular ☐	Other signs & symptoms (Please tick) ☐ Poor / loss of appetite ☐ Body malaise ☐ Sore throat ☐ Nausea & vomiting ☐ Difficulty breathing Others, specify: _____	Are there any other complications? Yes ☐ No ☐ IF YES, specify: _____ **Clinical working/final diagnosis:** _____ _____

III. EXPOSURE HISTORY

Travel history within 12 weeks to an area with an ongoing HFMD outbreak? Yes ☐ No ☐ Unknown ☐
Are there other known cases in the community/school/preschool/crèche/day-care? Yes ☐ No ☐ Unknown ☐
Where did the exposure probably occur?
☐ Day care ☐ Pre-school/crèche ☐ School ☐ Community ☐ Home
☐ HealthCare Facility ☐ Others, Specify:_____

IV. LABORATORY TESTS

Specimen	If YES, Date collected	Date sent to laboratory	Date received at laboratory	Results: Pos, Neg, not done	Specify organism detected/Pos	Date of result
Blood						
Throat swab						
Vesicle swab						
Rectal swab						
Stool						

V. CLASSIFICATION

Suspected case of HFMD ☐ Confirmed case of HFMD ☐

VI. CLINICAL MANAGEMENT/ OUTCOME

Medical consultation: Yes ☐ No ☐ If YES, Facility Name: _____ Type of facility: ☐ Public ☐ Private Date of consultation : DD / MM / YYYY	Patient Admitted: Yes ☐ No ☐ If YES, Facility Name: _____ Date of admission: DD / MM / YYYY Patient Outcome: ☐ Alive ☐ Dead ☐ Discharged Date Died/Discharged: DD / MM / YYYY

SUBMIT COMPLETED FORM WITH SPECIMEN TO: Centre for Vaccines and Immunology, National Institute for Communicable Diseases, National Health Laboratory Service, 1 Modderfontein Road, Sandringham 2192, South Africa
EMAIL COMPLETED FORM TO: nishipp@nicd.ac.za /outbreak@nicd.ac.za