Centre for Vaccines and Immunology
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Reference: Enterovirus Case Investigation Form

Enterovirus Case Investigation Form

Please complete and submit the Case Investigation Form to Provincial Communicable Diseases Control Officer and NICD (wayneh@nicd.ac.za; heatherh@nicd.ac.za)

Enteroviral Meningitis Case Definitions

A Suspected Case:

An individual presenting with meningitis or encephalitis symptoms (these may include headache, vomiting, fever, stiff neck, loss of appetite, photophobia), and an 'aseptic' picture on CSF (lymphocytic predominance with normal or slightly raised CSF protein) and negative for bacterial pathogens on CSF investigation.

A Confirmed Case:

An individual presenting with meningitis or encephalitis symptoms (see above) and detection of enterovirus/es from CSF.

SECTION A: INTERVIEWER DETAILS

A1. Name and surname of interviewer:_____

A2. Contact Details: Cell_____A3. Email address_____

A4. Date: _____ A5. Position/role in health service_____

SECTION B: PATIENT DEMOGRAPHICS

B1. Name(s): _____ B2. Surname: _____

B3. Country of birth: _____ B4. Immigration date to South Africa _____

B5. Age of patient: _____ B6. Date of birth: / /_____

B7. South African ID/ Passport number: _____

B8. Gender: Female ☐ Male ☐ Other ☐

B9. Race: Black ☐ Coloured ☐ Indian ☐ White ☐ Other ☐

B10. Residential Address: _____

_____

_____

B11. District _____

B12. Province_____

B13. Telephone: Home_____Cell_____

B14. Name of place of occupation/school: _____

SECTION C: ADMISSION/ CLINICAL DETAILS

C1. Name of health facility: _____

C2. Was patient admitted to hospital: Yes ☐ No ☐ Not Known ☐

C3. If yes, date of admission (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

C4. Patient Hospital Number_____

C5. Ward_____ C6. Ward contact details _____

C7. Symptoms **Date of onset of symptoms (DD/MM/YYYY)** ☐☐/☐☐/☐☐☐☐

1. ☐ Fever
2. ☐ Headache
3. ☐ Nausea
4. ☐ Lack of appetite
5. ☐ Lack of energy
6. ☐ Vomiting
7. ☐ Stiff neck
8. ☐ Irritability
9. ☐ Sensitivity to light
10. ☐ Diarrhoea
11. ☐ Paralysis
12. ☐ Rash
13. ☐ Other (Specify)_____

C8. Signs

1.	Bulging fontanelle	Yes ☐ No ☐
2.	Reduced level of consciousness	Yes ☐ No ☐
3.	Rash (any site)	Yes ☐ No ☐
4.	Seizures	Yes ☐ No ☐
5.	Rapid breathing	Yes ☐ No ☐
6.	Elevated temperature >38˚C	Yes ☐ No ☐
7.	Rash on hands	Yes ☐ No ☐
8.	Rash on feet	Yes ☐ No ☐
9.	Mouth ulcers or sores	Yes ☐ No ☐
10.	Weakness or paralysis of any limb	Yes ☐ No ☐
11.	Other (Specify)_____	

C9. Clinical diagnosis

☐ Meningitis ☐ Encephalitis ☐ Meningoencephalitis ☐ Gastro-enteritis

☐ Hand, foot and mouth disease ☐ Other, specify_____

C10. CSF results:

NHLS Specimen reference number:_____.

Date of specimen submission_____

Neutrophil count_____. Lymphocyte count_____Red cell count _____

Protein_____Glucose_____Chloride_____

Bacterial culture result:_____.

Enterovirus PCR result: _____

C11. Outcome

1. Discharged ☐ **Y** **N** ☐

If yes, (DD/MM/YYYY)

☐☐/ ☐☐/ ☐☐☐☐

2. Transfer to another hospital ☐ **Y** **N** ☐

If yes, date of transfer (DD/MM/YYYY)

☐☐/ ☐☐/ ☐☐☐☐

Name of hospital transferred to_____

3. Still in hospital ☐ **Y** **N** ☐

If yes, date of completion of CIF (DD/MM/YYYY)

☐☐/ ☐☐/ ☐☐☐☐

4. Died ☐ **Y** **N** ☐

If yes, date of death (DD/MM/YYYY)

☐☐/ ☐☐/ ☐☐☐☐

SECTION D: RISK FACTORS (For cases attending school or crèche)

D1. Did patient attend school or crèche the month before she became ill? ☐ Yes ☐ No If yes name of school or crèche _____ Grade_____

Address:_____D2. Time spent at school /crèche per week (hours)_____

D3. Number of children in class, specify _____

D4 Does patient have contact with other children other than at school /crèche? ☐ Yes ☐ No

If yes, where did contact occur ☐ Church ☐ Park/playground ☐ Other, specify_____

D5. Place of residence

☐ Flat/Apartment ☐ House ☐ Hostel ☐ Other, specify_____

D6. How many rooms in house are used for sleeping? _____

D7. How many people stay in the same household as patient? Specify_____

D8. Of these people, how many are children <15 years? _____

D9. Does patient have any underlying illness/ medical condition? ☐ Yes ☐ No ☐ Don't know

☐ Diabetes ☐ Epilepsy ☐ Asthma ☐ TB ☐ HIV ☐ other, specify_____

D10. Was patient admitted to hospital in the last 12 months (excluding recent admission)?

☐ Yes, how many times? ☐ reason, specify_____

☐ No ☐ Don't know

D11. Did patient have contact with people who were sick before becoming ill?

☐ Yes ☐ No ☐ Don't know

If yes, Name of contact_____

Relationship to patient_____

Do you know what the contact was ill from? ☐ Yes ☐ No

If yes, please specify _____

D12. Where did contact take place?

☐ Home ☐ School/ Crèche ☐ Church ☐ Park ☐ Other, please specify_____

D13. Has the patient experienced any problems a week after being discharged? Yes ☐ No ☐

If yes, specify_____

D14. Have you had any concerns since the patient's admission? Yes ☐ No ☐

If yes, specify_____

SECTION D: ADDITIONAL COMMENTS/REMARKS