# Listeria Case Investigation Form Instruction Sheet

This instruction sheet should be used in conjunction with the *Listeria* case investigation form (CIF) - Updated September 2017.

**A CIF should be complemented for all lab-confirmed *Listeria* isolations from normally-sterile sites, i.e. causing invasive disease.**

**Interviewer Details**

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| **Name** | Name of person completing the CIF |
| **Surname** | Surname of person completing the CIF |
| **Contact number** | Reliable contact number of person completing the CIF |
| **Date investigation initiated** | The date on which completion of the CIF was initiated in the format **dd/mm/yyyy** |
| **Date investigation completed** | The date on which the CIF was finalised in the format **dd/mm/yyyy** |

**Laboratory Information**

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| **Laboratory name** | The name of the laboratory where the isolate was grown or the case was confirmed |
| **Laboratory specimen no.** | The laboratory number on the sample or on the laboratory register related to this case |
| **Specimen type** | Choose the appropriate option or options if *Listeria* was isolated from more than one specimen type. Options are limited to **Blood, CSF** and **Other**. If selecting **Other**, please specify the specimen type in the space provided. **Other** refers to swabs or fluids taken from normally-sterile body sites. |

**Source(s) of Information**

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| **Interview** | Select **Yes** if an interview was conducted in the completion of the CIF and **No** if an interview was not conducted. |
| **Medical record review** | Select **Yes** if a medical record review was conducted in the completion of the CIF and **No** if no medical records were found, if the patient was not admitted or if a medical record review was not possible at the time. |
| **Person(s) interviewed** | Select an option or options to indicate the person or people that were interviewed in the completion of the CIF. **Relative** refers to any relation other than a parent that lives with the patient. **Parent** of the patient if the patient is a child. **Caregiver** refers to a person responsible for the care and well-being of the patient other than a parent or relative. **Guardian** refers to the legal guardian of a child or a patient that has been placed under the legal responsibility of a guardian. **Patient** is the person from whom the organism has been isolated. **Partner** refers to a spouse or life-partner of the patient. |
| **Telephonic interview** | Select **Yes** if a telephonic interview was conducted in the completion of the CIF and **No** if a telephonic interview was not conducted. |
| **Telephone number** | If a telephonic interview was conducted record the telephone number used to contact the person interviewed. |

**Demographic Details**

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| **Name** | Name of the patient as recorded on laboratory form or medical record |
| **Surname** | Surname of the patient as recorded on laboratory form or medical record |
| **Date of birth** | Use only actual date of birth either verified by interview or taken from a road-to-health-card or as recorded on laboratory form |
| **Age** | Calculate age of the patient on the day of specimen collection |
| **Age units** | If the patient is 29 days old and less, record age in **Days**. If the patient is 30 days to 59 months old, record age in **Months**. If the patient in 60 months old and older, record age in . If the patient in 60 months old and older, record age in **Years**. |
| **Age unknown** | Tick if age is unknown |
| **Gender** | State if the patient is male (M), female (F) or if the gender cannot be determined state unknown (U). Do not assume from the patient’s name. |
| **Contact number** | Record the patient’s contact number for potential follow-up investigation |
| **Race** | Select the race classification the patient identifies as. If the patient choose not to disclose or identifies to a race classification other than the provided options or if the race is unknown, select other and provide detail in the space provided. Do not assume from the patient’s name. |
| **Home address** | Address of the place where the patient is/was residing at the time of illness onset |
| **Code** | Area postal code linked to residential address |
| **District** | Municipal district where the patient resides |
| **Province** | Provincial demarcation where the patient resides |
| **Occupation** | State the full-time (most of day) job the patient undertakes. If the patient is a neonate or child that is not of school going age, occupation can be captured as **not applicable.** |
| **Place of employment** | State the place/company/institution where the patient is employed or attends school or crèche or spends most of the day. If the patient is a neonate or child that is not of school going age or unemployed, place of employment can be captured as **not applicable.** |
| **Identity number** | Used to verify date of birth. Can be established through an interview or from the RTHC. Select unknown if it is not possible to source |
| **Has patient lived in South Africa for the last month?** | In the last month refers in the 30 days prior to illness. If the patient has travelled, please record which country the patient has travelled from. |

**Clinical Details**

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| **Symptomatic** | Fill in “Y” if the patient had any of the symptoms listed below or “N” if the patient was not symptomatic or “U” if the information cannot be established. |
| **If symptomatic date of onset of symptoms** | The date of onset of illness in the format **dd/mm/yyyy** |
| **If symptomatic, tick all the listed symptoms below that the person experienced:** | Select any (either one or many) of the symptoms listed that are related to this episode of illness. This information can be gathered from medical records and through interview. If other symptoms not listed as an option have been noted by the patient or in the medical records for this episode of illness, select other and specify in the space provided. |
| **Temperature (°C)** | Recorded patient temperature on date of presentation or unknown |
| **Blood pressure** | Systolic/diastolic BP (mmHg) or unknown |
| **Mechanical ventilation** | Mark “Yes” (ventilation) or “No” (no ventilation) or “Unknown”. Oxygen masks = “ No” |
| **Cardiac arrest** | Mark “Yes” or “No” or “Unknown” in relation to whether or not the patient has a recorded episode of cardiac arrest or unknown if the information cannot be established. |
| **GCS** | Total/15 or unknown. This should be retrieved from the patient’s admission notes. If GCS is recorded as separate numbers sum them so as to record GCS as a single number out of 15. |
| **Mental status** | Record mental status or unknown. If mental status is known, double-check that the recorded GCS correlates.  **Alert**: patient fully conscious – GCS=15  **Disorientated**: Confused, responds to verbal commands, drowsy child – GCS= 13 to 14  **Stuporous:** Responds to painful stimuli, partially unconscious – GCS=9 to 12  **Sedated**: Ventilated patients, nearly unconscious due to medication or a seizure – GCS= >8 or <15 |
| **Patient diagnosis** | Select a confirmed diagnosis. **Bacteraemia/Sepsis** if the organism was detected via a blood culture but no specific clinical diagnosis or site of infection has been recorded. **Meningitis** if the organism was cultured from a CSF specimen or if the clinician has recorded that the patient’s diagnosis was meningitis. **Pneumonia** if the organism was detected via a blood culture or the doctor has recorded a diagnosis of pneumonia. **Granulomatosis infantiseptica** if the doctor has recorded a diagnosis or not seeing miliary pyogranulomatous lesions on the patient’s body as manifestations of neonatal listeriosis. **Other** select if another diagnosis has been recorded for this episode of illness and state in the space provided. |

**Host Risk Factors**

Select any of the host risk factors or conditions predisposing the individual to infection with *Listeria* as recorded in the medical records or ascertained through an interview. If any other immune-compromising conditions have been recorded please list in the space provided.

**Admission Details**

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| **Admitted** | State either “Y” if the patient was admitted or “N” if the patient was not admitted or “U” if this information cannot be determined. |
| **Previous admissions in the last year** | State either “Y” if the patient was previously admitted or “N” if the patient was not previously admitted. If the patient is a neonate this question pertains to the mother of the child. |
| **Number of previous admissions** | State the number of previous admissions in the last year. If the patient is a neonate this question pertains to the mother of the child. |
| **Date of current admission** | State the admission date for this episode of illness in the format **dd/mm/yyyy**. If the patient is a neonate this question pertains to the mother of the child. |
| **Hospital name** | The name of hospital where the diagnosis was made and the case alerted. |
| **Ward** | The name of the ward that the patient was admitted to for treatment. |
| **Outcome** | Select one of the options for outcome at the time of CIF completion. |
| **Adult ward/Paediatric ward** | Select the type of ward the patient was admitted to. If not recorded in medical record or not easily attainable, look at the patient’s age to see if patient would go to adult or paediatric ward. |
| **Hospital number** | Hospital number as indicated on the medical record of the hospital referred to above. |
| **Outcome date** | The date for which the outcome referred to above was recorded in the format **dd/mm/yyyy.** |
| **Was patient referred?** | State either “Y” if the patient was referred or “N” if the patient was not referred or “U” if this information cannot be determined. If the patient is a neonate this question pertains to the mother of the child. |
| **Name of referring facility** | If the patient was referred state the name of the referring facility where the patient was admitted/placed. If the patient is a neonate this question pertains to the mother of the child. |
| **Date of referral** | State the referral date for this episode of illness in the format **dd/mm/yyyy**. If the patient is a neonate this question pertains to the mother of the child. |
| **Date of first presentation** | State the date the patient presented to the initial healthcare facility for this episode of illness in the format **dd/mm/yyyy**. If the patient is a neonate this question pertains to the mother of the child. |
| **Was patient transferred to another hospital?** | State either “Y” if the patient was referred or “N” if the patient was not referred or “U” if this information cannot be determined. If the patient is a neonate this question pertains to the mother of the child. |
| **Date of transfer** | State the transfer date for this episode of illness in the format **dd/mm/yyyy**. If the patient is a neonate this question pertains to the mother of the child. |

**HIV Information**

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| **HIV status on presentation** | At this admission was the patient HIV positive, negative or unknown? |
| **If positive when was the diagnosis made?** | Date in the format **dd/mm/yyyy** of diagnosis of HIV or unknown |
| **Source of HIV status** | **For positive status**: Select how the positive HIV status was reported. Select other and specify in the space provided, e.g. lab report |
| **If negative when was the last test done?** | Date of last test in the format **dd/mm/yyyy.** Date to be within the last 6 months. If longer, patient to be retested. |
| **HIV status now** | After the patient was retested, what is the status |
| **For child <18 months: Was HIV PCR done?** | Mark N/A if the patient is >18 months old. Mark whether or not this test was done for all children under 18 months. |
| **Date PCR done** | If PCR was done, state the date the PCR was done in the format **dd/mm/yyyy.** |
| **For child ≤5 years: What was the mother’s HIV status during pregnancy?** | Was the mother HIV positive, negative or unknown during pregnancy? |
| **Date of mother’s HIV test** | Record in the format **dd/mm/yyyy** or unknown |
| **Source of HIV status** | **For positive or negative status**: Select how the positive HIV status was reported. Select other and specify in the space provided, e.g. lab report |
| **If mother was HIV positive during pregnancy, which ARVs were given?** | Select one of the options. If other specify in the space provided. |
| **Date mother started on ARV therapy** | Record in the format **dd/mm/yyyy** or unknown |
| **Mother’s CD4 count in pregnancy** | Absolute value or unknown, if known record the date or list date as unknown if the information cannot be established. |
| **Most recent CD4 count** | Mark N/A or not done is the patient is HIV negative, HIV is unknown or the test was not performed at any stage. Do not mix up CD4 absolute and percentage. CD4 percentage refers to CD4% of lymphocytes not CD4% of white cells. Include the date of the CD4 count closest to the specimen collection date. |
| **Most recent viral load** | Mark N/A or not done if the patient is HIV negative, HIV unknown or the test was not performed at any stage. Include the date of the viral load taken closest to the specimen collection date. |
| **Any antiretroviral use** | Select one of the options to indicate the patient’s antiretroviral use. |
| **If ARVs use is *Current* what was the date of initiation?** | Record in the format **dd/mm/yyyy** or unknown |

**Neonate only (≤29 old) related questions**

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| **Did the mother have gastrointestinal illness during pregnancy?** | Select an option to answer if the mother of the child had symptoms of gastroenteritis during pregnancy or unknown. |
| **If yes, how long (weeks) into the pregnancy when the illness occurred?** | If the mother had gastrointestinal illness during pregnancy, indicated how many weeks into the pregnancy the illness occurred or unknown. |
| **Did the mother receive treatment for the illness?** | Select an option to answer if the mother of the child received treatment for gastrointestinal illness during pregnancy or unknown. |
| **Did the mother visit a traditional healer prior to illness?** | Select an option to answer if the mother of the child visited a traditional healer prior to her gastrointestinal illness during pregnancy or unknown. |
| **Outcome of the baby** | Select an option that accurately reflects the vital status of the baby |

**Residential Information – Applicable to all patients**

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| **How long has the patient lived at the home address provided?** | Provide a duration in weeks, months or years for the duration of time the patient (or parent in the cases of a neonate) has resided at the home address provided |
| **How many people live in the home?** | State the number of people including the patient that reside in the home |
| **How many rooms in the home?** | State the number of formal (divided) rooms in the home |
| **Type of housing** | Select the option that best describes the home that the patient (or parent in the cases of a neonate) resides in |
| **Water source** | Select the option that best describes the manner in which the water is attained at the home. If other, describe water in the space provided. |
| **Sanitation** | Select the option that best describes the sanitation facilities available which are available the home. If other, describe sanitation facilities in the space provided. |
| **Does the home have formal kitchen?** | Select an option to answer if the home has an established kitchen or unknown. |
| **Does the home have refrigerated food storage?** | Select an option to answer if the home has a refrigerator for food storage or unknown. |

**Food Exposure Related Information - Applicable to all patients**

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| **Where did the patient purchase his/her food in the 3 months prior to onset of illness?** | If the patient is a neonate this question pertains to the mother – List the **3** main shops by name and their respective locations from where the patient purchases his/her food in the 90 days prior to illness. If the shop is either an informal or spaza shop emphasis must be placed on obtaining a good description of the shops location. |
| **Did the patient eat at take-away shops, restaurants or fast-food stores in the 3 months prior to the onset of illness?** | If the patient is a neonate this question pertains to the mother – if the response is *Yes* - List the **3** main venues by name and their respective locations from where the patient ate out in the 90 days prior to illness. Emphasis must be placed on obtaining a good description of the shops location. |
| **Did the patient purchase food from an informal trader/vendor a month prior to onset of illness?** | Select an option to answer if the patient (or mother of the patient is a neonate) purchase food from an informal trader/vendor in the 30 day period prior to onset of illness or unknown. |
| **Name of trader/vendor** | If the response is *Yes* to the previous question, state the name of the trader/vendor to the best of the patient’s (or mother of the patient is a neonate) ability |
| **Location** | Emphasis must be placed on obtaining a good description of the trader’s/vendor’s location. |
| **Does the patient grow or produce his/her own food items?** | Select an option to answer if the patient (or mother of the patient is a neonate) grows their fruits and vegetable at home or produces any other food items at home or unknown. |
| **If yes, list** | If the response is *Yes* to the previous question, list all items that are produced at home. |
| **Did the patient consume the following food items a month prior to onset of illness?** | Select all categories or food options that apply to the patient’s (or mother of the patient is a neonate) dietary choices in the 30 days prior to the patient’s onset of illness. |

**Environmental Exposure Information - Applicable to all patients**

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| **Did the patients seek treatment from a traditional healer in the 3 months prior to onset of illness?** | Select an option to answer if the patient (or mother of the patient is a neonate) purchase food from an informal trader/vendor in the 30 day period prior to onset of illness or unknown. |
| **Name of traditional healer** | If the response is *Yes* to the previous question, state the name of the traditional healer to the best of the patient’s (or mother of the patient is a neonate) ability. |
| **Location of healer** | Emphasis must be placed on obtaining a good description of the trader’s/vendor’s location. |

**Data Capture Information - To be completed by person capturing data at the NICD**

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| **Data capture date** | In the format **dd/mm/yyyy** |
| **Data capturer name** | First name and surname of the person who captured the information collected on the CI into the CED database |
| **Database record number** | Auto-assigned MS Access database record number linking the paper CIF to the electronic database. |