

CASE INVESTIGATION FORM

EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH

LEPTOSPIROSIS - Field version
EPID/DS/LEPTO/FV/2008

The Public Health Inspector should investigate and complete this form. Medical Officer of Health is responsible for the completeness and accuracy of data provided. Necessary data should be obtained from the patient, his/her relatives and from the diagnosis card. Early investigation and return are essential.

| | | | | | | |
|-----------------------------|--|--|--|------------|---|---|
| Week ending of notification | <input type="text"/> <input type="text"/> d d | <input type="text"/> <input type="text"/> m m | <input type="text"/> <input type="text"/> y y | Serial No: | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Please write the Serial No given in the Infectious Disease Register (ID Register) in the MOH Office |
|-----------------------------|--|--|--|------------|---|---|

A. PARTICULARS OF PATIENT (PLEASE TICK THE APPROPRIATE BOX WHERE APPLICABLE)

| | | | | | | |
|---|--|--|-------------------|---|---|---|
| 1. Name of the patient (BLOCK LETTERS) | | | | | | |
| 2. Residential address | | | | | | |
| 3. Age | | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> y y m m | 4. Date of birth: | | | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/ mm/ yyyy) |
| 5. Sex <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female <input type="checkbox"/> 3. Not known | 6. Ethnic group <input type="checkbox"/> 1. Sinhalese <input type="checkbox"/> 2. Tamil <input type="checkbox"/> 3. Moor <input type="checkbox"/> 4. Others <input type="checkbox"/> 5. Not known | 7. Occupation | | 8. DPDHS Division | | 9. MOH area |
| | | FOR OFFICE USE ONLY | | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |

B. PRESENT ILLNESS/ OUTCOME

| | | |
|---|---|--|
| 10. Date of onset of symptoms: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> d d m m y y | 13. if yes, date of admission <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> d d m m y y | 18. If 'Yes' from where the patient was transferred? 19. BHT No. of transferring hospital: 20. Outcome of the case <input type="checkbox"/> 1. Cured <input type="checkbox"/> 4. Still in hospital <input type="checkbox"/> 2. Died <input type="checkbox"/> 5. Not known <input type="checkbox"/> 3. Transferred to (specify): Hospital 21. Date of discharge/ transfer or death <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> d d m m y y |
| 11. Where did the patient first seek medical advice? <input type="checkbox"/> 1. Government hospital <input type="checkbox"/> 2. Private hospital <input type="checkbox"/> 3. Private practitioner <input type="checkbox"/> 4. Ayurvedic institution (public/private) <input type="checkbox"/> 5. Other (specify) 12. Was patient admitted to hospital? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Not known } To Q. 22 | 14. Name of hospital: 15. Ward: 16. BHT No: 17. Was patient transferred from some other hospital? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No | |

C. CLINICAL DATA

Case definition: acute febrile illness with headache, myalgia and prostration associated with any of the following: conjunctival suffusion, meningeal irritation, anuria/oliguria/proteinuria, jaundice, haemorrhage, cardiac arrhythmia/failure, skin rash AND history of exposure to infected animal/contaminated environment AND laboratory isolation of pathogenic leptospirosis/ positive serology (MAT)

22. Symptoms and complications: *If available, refer to patient's notes/ diagnosis card before completing this section*

| | |
|---|--|
| <input type="checkbox"/> 1. Acute fever (Sudden onset of fever) | <input type="checkbox"/> 7. Meningeal irritation |
| <input type="checkbox"/> 2. Headache | <input type="checkbox"/> 8. Anuria/oliguria (No urine output or reduced urine output) |
| <input type="checkbox"/> 3. Myalgia (severe muscle pain) | <input type="checkbox"/> 9. Haemorrhage (Bleeding from unusual sites. Eg.: gum bleeding, bleeding from rectum, vomiting of blood, blood stained urine, bleeding under the skin etc.) |
| <input type="checkbox"/> 4. Prostration (Severe tiredness or lack of energy) | <input type="checkbox"/> 10. Cardiac failure/ arrhythmia |
| <input type="checkbox"/> 5. Jaundice (Yellowish discolouration of skin or eyes) | <input type="checkbox"/> 11. Skin rash |
| <input type="checkbox"/> 6. Conjunctival suffusion (Redness of eyes) | <input type="checkbox"/> 12. Other (specify)..... |

For office use only Compatible with the case definition: 1. Yes 2. No

D. LABORATORY DIAGNOSIS

23. Laboratory tests done: 1. Yes 2. No 3. Not known

24. If yes,

| Test | Blood | | | Urine | | | Other body tissues | | |
|-----------------------------|-------|---|----------------|-------|---|----------------|--------------------|---|----------------|
| | + | - | Not known / NA | + | - | Not known / NA | + | - | Not known / NA |
| Culture | | | | | | | | | |
| Proteinuria (Urine albumin) | | | | | | | | | |

25. Was blood taken for serology?

1. Yes 2. No 3. Not known

26. If yes,

| Investigation – MAT* | 1 st specimen | 2 nd specimen |
|---|--------------------------|--------------------------|
| Date of collection of specimen | | |
| Laboratory (MRI/ Other govt./Private/ Not known) | | |
| Results (Mark NA if test results are not available and PP if pending) | | |

*MAT = Microscopic Agglutination Test

27. Other laboratory investigation results:

E. INFORMATION ON DISEASE TRANSMISSION

28. Possible source of contamination:

- 1. Paddy field
- 2. Other agricultural land (sugar cane, chena)
- 3. Marshy/ muddy land
- 4. Other water related source (sewer, irrigation, fisheries)
- 5. Animal husbandry, veterinary
- 6. Other (specify):

30. History of a recent skin lesion/ injury

1. Yes 2. No 3. Not known

31. Did any of the patient's family members, companions, associates or neighbours develop a similar illness (within a one month period) with acute fever, headache, myalgia, prostration and any other signs mentioned under question 21?

1. Yes 2. No 3. Not known

29. Grama Sevaka Division/s where the likely source/s of contamination is/are located

- i.
- ii.
- iii.
- iv.

F. PROPHYLAXIS

32. Was the patient on chemoprophylactic treatment for leptospirosis at the time of onset of illness?

1. Yes 2. No 3. Not known

33. If yes, How many weekly doses have taken before onset of illness?

34. Has the patient taken prophylaxis regularly? 1. Yes 2. No 3. Not known

35. Remarks:

Signature: Name:

Date: Designation: