

CASE INVESTIGATION FORM
 EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH

LEPTOSPIROSIS – Sentinel Site
 EPID/DS/LEPTO/SS/2008

The ICNO / Designated person in the institution for Sentinel Surveillance should investigate and complete this form. Medical Officer (Public Health) should coordinate the activity. Necessary data should be obtained from the hospital by referring to the BHT / Physician or from the diagnosis card. Additional information should be obtained from the patient and his/her relatives. Early investigation and return are essential.

Week Ending: of notification	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> d d m m 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
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A. PARTICULARS OF PATIENT (Please (✓) appropriate box where applicable)

1. Name of 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"/> 9. Unknown	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"/> 9. Unknown	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
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)	14. Name of hospital: 15. Ward: 16. BHT No:	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
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	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"/> 2. Headache
<input type="checkbox"/> 3. Myalgia (severe muscle pain)
<input type="checkbox"/> 4. Prostration (Severe tiredness or lack of energy)
<input type="checkbox"/> 5. Jaundice (Yellowish discolouration of skin or eyes)
<input type="checkbox"/> 6. Conjunctival suffusion (Redness of eyes)
<input type="checkbox"/> 7. Meningeal irritation
<input type="checkbox"/> 8. Anuria/oliguria (No urine output or reduced urine output) | <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"/> 10. Cardiac failure/ arrhythmia
<input type="checkbox"/> 11. Skin rash
<input type="checkbox"/> 12. Cough
<input type="checkbox"/> 13. Haemoptysis
<input type="checkbox"/> 14. Breathlessness
<input type="checkbox"/> 15. Other (specify)..... |
|---|---|

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

D. LABORATORY DIAGNOSIS

23. Any laboratory investigations performed? 1. Yes 2. No 3. Unknown

24. If yes,

Test	Blood			Urine			Other body fluids		
	+	-	Non Known / NA	+	-	Non Known / NA	+	-	Non Known / NA
Culture									
Proteinuria (Urine albumin)									

27. Other laboratory investigation results:

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

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):

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

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

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

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:

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Signature: Name:

Date: Designation:.....

Please return to:
Epidemiologist, Epidemiology Unit, 231, De Saram Place, Colombo 10
email: chepid@slnet.lk Tel: 011-2695112 / 2681548 Fax: 011-2696583