Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Acute Flaccid Paralysis

Name of DRU: **Address:**	Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport

I. PATIENT INFORMATION:

Patient Number: | Patient's First Name | Middle Name | Last Name

Complete Address: | District: | ILHZ:

Sex: ☐Male ☐Female

Date of Birth: MM DD YY

Age: ☐Days ☐Months ☐Years

Patient Admitted? ☐Yes ☐ No ☐Unknown

Date Admitted/ Seen/Consult: MM DD YY

Date of Report: MM DD YY

Date of Investigation: MM DD YY

II. CLINICAL DATA (Put a check [√] in the appropriate box)

PRODROME	PARALYSIS	SITE OF FLACCID PARALYSIS	Sensory Status	Deep Tendon Reflexes	Motor Status
Fever: ☐ Y ☐ N ☐ U Cough: ☐ Y ☐ N ☐ U Diarrhea/Vomiting: ☐ Y ☐ N ☐ U Muscle pain: ☐ Y ☐ N ☐ U Meningeal signs: ☐ Y ☐ N ☐ U	Date onset: _____/_____/_____ Present at birth?: ☐ Y ☐ N ☐ U Asymmetric?: ☐ Y ☐ N ☐ U PROGRESSION Paralysis fully developed within 3 to 14 days from onset of illness? ☐ Y ☐ N ☐ U Direction of paralysis: ☐ Ascending ☐ Descending ☐ Unknown	Right arm: ☐ Y ☐ N ☐ U Left arm: ☐ Y ☐ N ☐ U Right leg: ☐ Y ☐ N ☐ U Left leg: ☐ Y ☐ N ☐ U Breathing muscles: ☐ Y ☐ N ☐ U Neck muscles: ☐ Y ☐ N ☐ U Facial muscles: ☐ Y ☐ N ☐ U **Working / final Diagnosis**: _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

NOTE: Instructions on the grading/ scoring of the sensory status, deep tendon reflexes and motor status are presented at the back of this page.

III. EPIDEMIOLOGIC DATA

History of neurologic disorder?: ☐ Y ☐ N ☐ U If YES, specify disorder:_____

Did the patient travel in another province, city or country within 60 days prior to onset of paralysis? ☐ Y ☐ N ☐ U

If YES, specify place:_____ Date traveled: From_____/_____/_____ To _____/_____/_____

Other AFP cases in patient's community within 60 days of patient's paralysis? ☐ Y ☐ N ☐ U

Does the patient had any history of injection, fall, trauma and/ or animal bite ? ☐ Y ☐ N ☐ U If YES, specify : _____

IV. IMMUNIZATION HISTORY

Total OPV doses received: _____ **Date last dose of OPV :** _____/_____/_____ **Is this a "Hot case"?** ☐ Y ☐ N

V. LABORATORY DATA

Stool sample #	Collected?	If YES, date taken	Date sent to RITM	Date received RITM	Result	Date result
1	☐ Y ☐ N	___/___/___	___/___/___	___/___/___	☐ NEG ☐ 1 ☐ 2 ☐ 3 ☐ NPEV ☐ Other, specify_____	___/___/___
2	☐ Y ☐ N	___/___/___	___/___/___	___/___/___	☐ NEG ☐ 1 ☐ 2 ☐ 3 ☐ NPEV ☐ Other, specify_____	___/___/___

Adequate? ☐ Y ☐ N Other Information (to be provided by the laboratory): **ITD-result:** ☐ Sabin-like ☐ Wild poliovirus ☐ VDPV

VI. 60-DAY FOLLOW-UP

Expected date of follow-up:_____/_____/_____ Actual date of follow-up conducted:_____/_____/_____

P.E. done? ☐ Y ☐ N If NO, reason for no examination: ☐ Patient died ☐ Lost to follow-up ☐ Other, specify_____

Residual paralysis at 60 days?: ☐ Y ☐ N ☐ U Atrophy?: ☐ Y ☐ N ☐ U

Other observations:_____

Case Investigation Form

Acute Flaccid Paralysis

VII. CLASSIFICATION (TO BE FILLED UP BY THE EXPERT PANEL ONLY)			
FINAL CLASSIFICATION	**IF VAPP**	**CLASSIFICATION CRITERIA**	**FINAL DIAGNOSIS**
☐ Confirmed wild polio ☐ Vaccine-derived poliovirus (VDPV) ☐ Vaccine-associated paralytic polio (VAPP) ☐ Polio-compatible ☐ Discarded non-polio AFP ☐ Not AFP Date classified: _____/_____/_____	☐ Recipient VAPP ☐ Contact VAPP ☐ Unknown	☐ Laboratory ☐ Lost to follow-up ☐ Death ☐ With residual paralysis ☐ Without residual paralysis	

AFP Case definition:

- Any child less than 15 years of age with acute flaccid paralysis, **OR**
- A person of any age in whom poliomyelitis is suspected.

Hot Case Description:

- An AFP case that is <5 years old with < 3 doses of OPV and has fever at the onset of asymmetrical paralysis, **OR**
- An AFP case or a person of any age whose stool specimen(s) has L20B+ isolate.

Grading/Scoring of Sensory Status, Deep Tendon Reflexes and Motor Status:

A. Sensory status is presented in percentage and categorized as follows:

- ≤ 25% = Absent
- ≥ 25% but <100% = Reduced
- 100% = Normal

B. Deep tendon reflexes (DTRs) are presented in (+) symbol and categorized as follows:

- none or 0 = absent
- + = reduced
- ++ = normal
- +++ with/without clonus = increased or exaggerated

C. **Motor status** is presented in fraction and categorized as follows:

- 0/5 = absent or no movement
- 1/5 to 3/5 = reduced movement (with movement but not against resistance or gravity)
- 4/5 to 5/5 = normal (movement with full resistance and against gravity)

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Adverse Event Following Immunization

Name of DRU: **Address:**	**Type**: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport

I. PATIENT INFORMATION: Patient Number: | Patient's First Name | Middle Name | Last Name

Complete Address:		Sex: ☐Male ☐Female	Date of Birth:	*MM*	*DD*	*YYYY*	Age:	☐Days ☐Months ☐Years
District:	ILHZ:							
Patient Admitted? ☐ Yes ☐No ☐Unknown	Date Admitted/ Seen/ Consult	*MM*	*DD*	*YYYY*	Name of hospital/health facility:			
Address of hospital/health facility:			Date onset of illness	*MM*	*DD*	*YYYY*	*TIME* (hh:min:sec) ___:___:___ AM / PM	
Date next higher level notified:	*MM*	*DD*	*YYYY*	*TIME* (hh:min:sec) ___:___:___ AM/PM	Interval from onset of illness to notification: _____days _____hours			
Date of Investigation:	*MM*	*DD*	*YYYY*	*TIME* (hh:min:sec) ___:___:___ AM/PM	Interval from notification to investigation: _____days _____hours			

II. TYPE OF SERIOUS AEFI (See back page for descriptions): check all that apply

1. LOCAL	***2. CENTRAL NERVOUS SYSTEM***	***3. OTHER ADVERSE EVENTS***	
☐ Injection site abscess	☐ Acute paralysis	☐ Anaphylactoid reaction	☐ Osteitis/osteomyelitis
☐ Lymphadenitis	☐ Encephalopathy	☐ Anaphylactic shock	☐ Persistent screaming (inconsolable continuous crying lasting at least 3 hours)
☐ Severe local reaction (redness and/or swelling centered at the site of injection)	☐ Seizures	☐ Neuritis	☐ Sepsis
		☐ Disseminated BCG infections	☐ Thrombocytopenia
		☐ Hypotensive-hyporesponsive episode (shock collapse)	☐ Toxic shock syndrome

4. OTHER SEVERE and UNUSUAL EVENTS OCCURRING WITHIN 4 WEEKS AFTER IMMUNIZATION AND NOT COVERED UNDER ITEM NOS. 1, 2 or 3	☐ Any death of a vaccine recipient temporarily linked (within 4 weeks) to immunization, where no other clear cause of death can be established. ☐ Other severe/unusual event (specify):_____

III. MOST RECENT VACCINATION HISTORY:

Date of vaccination:____/____/____ Time of vaccination: ____:____: ____ ☐ AM ☐ PM

Name of vaccinator:_____ Vaccinator : ☐ Physician ☐ Nurse ☐ Midwife ☐ Other_____

Place of vaccination: ☐ Health center ☐ BHS ☐ Public hospital ☐ Private hospital ☐ Private clinic ☐ Outreach

☐ Other (specify): _____

VACCINE/S RECEIVED	**DETAILS OF VACCINE**				**DETAILS OF DILUENT IF USED**			
Vaccine type (ex: BCG, measles, etc.)	**Dose Num-ber/vial**	**Lot/Batch number**	**Manufacturer**	**Expiry date**	**Dose Number/ vial**	**Lot/Batch number**	**Manufacturer**	**Expiry date**

Did the patient receive any vaccination within 4 weeks prior to this adverse event? ☐ Y ☐ N ☐ U (If YES, complete the information below).

VACCINE/S RECEIVED	**DETAILS OF VACCINE**				
Vaccine type (ex: BCG, measles, etc.)	**Dose number (single/multiple)**	**Lot/Batch number**	**Manufacturer**	**Expiry date**	**Date given**

IV. MEDICAL HISTORY:

Did the patient take other medications at the time of vaccination?

☐ Y ☐ N ☐ U If YES, what were these medications?

_____

Does the patient had history of similar reaction? ☐ Y ☐ N ☐ U

Does the patient had history of allergy? ☐ Y ☐ N ☐ U

If YES, what are these allergies?_____

Birth defects: ☐ Y ☐ N ☐ U

Family history of similar event? ☐ Y ☐ N ☐ U

Is the patient suffering from other medical conditions?

☐ Y ☐ N ☐ U

If YES, what are these conditions? _____

_____

Case Investigation Form

Adverse Event Following Immunization

V. CAUSALITY ASSESSMENT AND FINAL DIAGNOSIS: (TO BE FILLED UP AFTER CLASSIFICATION BY THE BOARD)

What is the cause of AEFI?

☐ Program-error ☐ Vaccine reaction
☐ Coincidental ☐ Unknown
☐ Injection Reaction

Final diagnosis:_____

If program-error, was it due to

☐ non-sterile injection ☐ vaccine prepared incorrectly
☐ wrong administration technique
☐ improper vaccine transport or storage
☐ Other, specify_____

VI. OUTCOME:

Outcome: ☐ Alive Patient sustained disability? ☐ Yes ☐No ☐Unknown

If YES, specify type of disability:_____

☐ Died Date died: ____/____/____

☐ Unknown

Definition of Terms:

- AEFI is any untoward medical occurrence which follows immunization and which does not necessarily have a causal relationship with the usage of the vaccine. The adverse event may be any unfavourable or unintended sign, abnormal laboratory finding, symptom or disease.
- A cluster of AEFI is defined as two or more cases of the same adverse event related in time, place or vaccine administered.
- Serious medical condition is defined as those that are life-threatening and those that result in hospitalization (or prolonged hospitalization), disability (or have the potential to result in disability) or death.

LOCAL ADVERSE EVENTS:

- ***Injection-Site Abscess:*** Occurrence of a fluctuant or draining fluid-filled lesion at the site of injection with or without fever.
- ***Lymphadenitis (includes suppurative lymphadenitis):*** Occurrence of either: at least one lymph node, 1.5 cm in size (one adult finger width) or larger; or a draining sinus over a lymph node. Almost exclusively caused by BCG and then occurring within 2 to 6 months after receipt of BCG vaccine, on the same side as inoculation (mostly axillary).
- ***Severe local reaction:*** Redness and/or swelling centered at the site of injection and one or more of the following: swelling beyond the nearest joint; pain, redness and swelling of more than 3 days duration; or requires hospitalization.

CENTRAL NERVOUS SYSTEM ADVERSE EVENTS:

- ***Acute Paralysis***
  - Acute onset of flaccid paralysis within 4 to 30 days of receipt of oral polio-virus vaccine (OPV), or within 4 -75 days after contact with a vaccine recipient, with neurological deficits remaining 60 days after onset, or death.
  - Guillain-Barré Syndrome (GBS): Acute onset of rapidly progressive, ascending, symmetrical flaccid paralysis, without fever at onset of paralysis and with sensory loss. Cases are diagnosed by cerebrospinal fluid (CSF) investigation showing dissociation between cellular count and protein content. GBS occurring within 30 days after immunization should be reported.
- ***Encephalopathy:*** Encephalopathy is an acute onset of major illness temporally linked with immunization and characterized by any two of the following three conditions: Seizures; Severe alteration in level of consciousness lasting for one day or more; and Distinct change in behavior lasting one day or more. Cases occurring within 72 hours after vaccination should be reported.
- ***Encephalitis:*** Encephalitis is characterized by encephalopathy and signs of cerebral inflammation and, in many cases, CSF pleocytosis and/or virus isolation. Any encephalitis occurring within 1 to 4 weeks following immunization should be reported.
- ***Meningitis:*** Acute onset of major illness with fever, neck stiffness/positive meningeal signs (Kernig, Brudzinski). Symptoms may be subtle to similar to those of encephalitis. CSF examination is the most important diagnostic measure: CSF pleocytosis and/or detection of microorganism (Gram stain or isolation).
- ***Seizures:*** Seizures lasting from several minutes to more than 15 minutes and not accompanied by focal neurological signs or symptoms. Febrile Seizures or Afebrile Seizures. Onset is usually 0 to 2 days.

OTHER ADVERSE EVENTS:

- ***Anaphylactoid Reaction (acute hypersensitivity reaction):*** Exaggerated acute reaction, occurring within 2 hours after immunization, characterized by one or more of the following: (1) wheezing and shortness of breath due to bronchospasm; (2) laryngospasm/laryngeal edema; (3) one or more skin manifestations, e.g. hives, facial edema, or generalized edema.
- ***Anaphylactic Shock:*** Circulatory failure (e.g. alteration of the level of consciousness, low arterial blood pressure, weakness or absence of peripheral pulses, cold extremities secondary to reduced peripheral circulation, flushed face and increased perspiration) with or without bronchospasm and/or laryngospasm/laryngeal edema leading to respiratory distress occurring immediately (0 to1 hr) after immunization.
- ***Neuritis:*** Dysfunction of nerves supplying the arm/shoulder/gluteal area without other involvement of nervous system. A deep steady, often severe aching pain in the shoulder and upper arm or gluteal area followed in days or weakness by weakness and wasting in arm/shoulder/gluteal muscles. Sensory loss may be present, but is less prominent. May present on the same or the opposite side to the injection and sometimes affects both arms or gluteal area. Onset is usually 2 to 28 days.
- ***Disseminated BCG infection:*** Disseminated infection occurring within 1 to 12 months after BCG vaccination and confirmed by isolation of Mycobacterium bovis BCG strain.
- ***Hypotensive-Hyporesponsive Episode (shock collapse):*** Sudden onset of paleness, decreased level or loss of responsiveness, decreased level or loss of muscle tone (occurring within 24 hours of vaccination). The episode is transient and self-limiting.
- ***Osteitis/Osteomyelitis:*** Inflammation of the bone either due to BCG immunization (occurring within 8 to 16 months after immunization) or caused by other bacterial infection.
- ***Persistent Screaming:*** Inconsolable continuous crying lasting at least 3 hours accompanied by high-pitched screaming. Onset 0 to 24 hrs.
- ***Sepsis:*** Acute onset of severe generalized illness due to bacterial infection and confirmed by positive blood culture.
- ***Thrombocytopenia:*** Platelet count of 100,000 cells or less per mm3. Onset is 15 to 35 days.
- ***Toxic-Shock Syndrome:*** Abrupt onset of fever, vomiting and watery diarrhea within a few hours of immunization, often leading to death within 24-48 hours.

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Anthrax

(ICD 10 Code: A22)

Name of DRU: **Address:**	Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport

I. PATIENT INFORMATION:	Patient Number:	Patient's First Name	Middle Name	Last Name

Complete Address:		Sex:	☐Male ☐Female	Date of Birth:	MM	DD	YY	Age:	☐Days ☐Months ☐Years
District:	ILHZ:								

Occupation:	Name Workplace:
	Address of Workplace:

II. CLINICAL INFORMATION:	Admitted? ☐Yes ☐No ☐Unknown	Date Admitted/ Seen/Consult	MM	DD	YY	Date Onset of Illness	MM	DD	YY

Signs and Symptoms:			
	☐ Fever	☐ Stomach pain	☐ Neck pain
	☐ Upset stomach (nausea)	☐ Vomiting blood	☐ Itchy skin
	☐ Headache	☐ Bloody diarrhea	☐ Black scab on skin
	☐ Dry cough	☐ Sweating excessively	☐ Skin lesions
	☐ Sore throat	☐ Extreme tiredness	Describe lesion: _____
	☐ Trouble swallowing	☐ Pain or tightness in the chest	_____
	☐ Trouble breathing	☐ Sore muscles	☐ Other (list): _____
			_____

III. POTENTIAL RISK FACTORS IN THE 15-60 DAYS PRIOR TO ONSET OF SIGNS/SYMPTOMS

☐ Y ☐ N ☐ U Is the patient's occupation associated with animals or agriculture?
☐ Y ☐ N ☐ U Has the patient been exposed to Anthrax Vaccine or to anthrax-vaccinated animals?
☐ Y ☐ N ☐ U Does the patient have occupational or other exposure to hides, wool, furs, bone meal or other animal products?
☐ Y ☐ N ☐ U Contact with live or dead animals? (cattle, sheep, goats, horses, pigs and other herbivores both livestock and wildlife)
☐ Y ☐ N ☐ U Does the patient have a history of travel **beyond his/her usual place of residence/surroundings?**
☐ Y ☐ N ☐ U Does the patient work in a laboratory?
☐ Y ☐ N ☐ U Have any household members experienced similar symptoms recently?
☐ Y ☐ N ☐ U Has the patient eaten undercooked meat? (cattle, sheep, goats, horses, pigs and other herbivores both livestock and wildlife)
☐ Y ☐ N ☐ U Did the patient receive unusual letters or packages? (e.g. containing threats or unusual messages)
☐ Y ☐ N ☐ U Has the patient opened mails for others?
☐ Y ☐ N ☐ U Was the patient present or nearby when an envelope that contained any form of powder was opened?

IV. CLINICAL FORMS, CLASSIFICATION AND OUTCOME:

CLINICAL FORMS	CASE CLASSIFICATION	OUTCOME
☐ Cutaneous	☐ Suspected Case	☐ Alive
☐ Gastrointestinal	☐ Probable Case	☐ Died, Date died: ____/____/____
☐ Pulmonary	☐ Confirmed Case	☐ Unknown
☐ Meningeal		
☐ Unknown		

V. LABORATORY TESTS:

Specify Specimen	If YES, date taken			Type of laboratory test done	Results N=Negative; I=Indeterminate; U-Unknown		Date result		
	MM	DD	YY		*Positive for:*	☐N ☐I ☐U	MM	DD	YY
	MM	DD	YY		*Positive for:*	☐N ☐I ☐U	MM	DD	YY

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Anthrax

(ICD 10 Code: A22)

CASE DEFINITION/CLASSIFICATION:

Suspected Case:

An illness suggestive of one of the known anthrax clinical forms as described above. No definitive, presumptive, or suggestive laboratory evidence of Bacillus anthracis, or epidemiologic evidence relating it to anthrax

a) **Cutaneous Anthrax:**
An acute illness, or post-mortem examination revealing a painless skin lesion developing over 2 to 6 days from a papular through a vesicular stage into a depressed black eschar with surrounding edema. Fever, malaise and lymphadenopathy may accompany the lesion.

b) **Inhalation Anthrax:**
An acute illness, or post-mortem examination revealing a prodrome resembling a viral respiratory illness, followed by hypoxia, dyspnea or acute respiratory distress with resulting cyanosis and shock. Radiological evidence of mediastinal widening or pleural effusion is common.

c) **Gastrointestinal Anthrax:**
An acute illness, or post-mortem examination revealing severe abdominal pain and tenderness, nausea, vomiting, hematemesis, bloody diarrhea, anorexia, fever, abdominal swelling and septicemia.

d) **Oropharyngeal Anthrax:**
An acute illness, or post-mortem examination revealing a painless mucosal lesion in the oral cavity or oropharynx, with cervical adenopathy, edema, pharyngitis, fever, and possibly septicemia.

e) **Meningeal Anthrax:**
An acute illness, or post-mortem examination revealing fever, convulsions, coma, or meningeal signs. Signs of another form will likely be evident as this syndrome is usually secondary to the above syndromes.

Probable Case:

A clinically compatible illness that does not meet the confirmed case definition, but with one of the following:

- Epidemiological link to a documented anthrax environmental exposure;
- Evidence of B. anthracis in clinical specimens collected from a normally sterile site (such as blood or cerebrospinal fluid [CSF]) or lesion of other affected tissue (skin, pulmonary, reticuloendothelial, or gastrointestinal)

Confirmed Case:

A clinically compatible illness with one of the following:

- Culture and identification of B. anthracis from clinical specimens
- Demonstration of B. anthracis antigens in tissues by immunohistochemical staining using both B. anthracis cell wall and capsule monoclonal antibodies;

Documented anthrax environmental exposure AND evidence of B. anthracis DNA in clinical specimens collected from a normally sterile site (such as blood or CSF) or lesion of other affected tissue (skin, pulmonary, reticuloendothelial, or gastrointestinal).

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Measles-Rubella

(ICD 10 Code: B05; B06)

Name of DRU: DRU Complete Address:	Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport

I. PATIENT INFORMATION

Patient Number	EPI ID	Patient's First Name	Middle Name	Last Name

Complete Address:	Sex: ☐ Male ☐ Female Pregnant? ☐Y ☐ N ☐ U If Yes, weeks of pregnancy _____	Date of Birth: MM DD YY ____/____/____	Age: _____ ☐ Days ☐ Months ☐ Years
District: ILHZ:	Patient admitted? ☐ Y ☐ N	Date Admitted/ Seen/Consult	MM DD YY
Name of parent/caregiver:	Contact Nos.:		

Date of Report:	MM	DD	YY	Name of reporter:	Contact Nos.:
Date of Investigation:	MM	DD	YY	Name of investigator/s:	Contact Nos.:

II. CLINICAL DATA

Fever: ☐ Y ☐ N
Date onset: ____/____/____
Rash: ☐ Y ☐ N
Date onset: ____/____/____
Cough: ☐ Y ☐ N
Koplik sign: ☐ Y ☐ N
Runny nose/coryza: ☐ Y ☐ N
Red eyes/conjunctivitis: ☐ Y ☐ N

Arthralgia/arthritis: ☐ Y ☐ N
Swollen lymphatic nodules: ☐ Y ☐ N

If yes, specify location:
☐ cervical ☐ sub-occipital
☐ post-auricular
☐ others, specify
_____

Are there any complications?
☐ Y ☐ N
If YES, specify: _____
Other symptoms:
_____
Working/Final Diagnosis:
_____

III. VACCINATION HISTORY AND VITAMIN A SUPPLEMENTATION

Patient received measles-containing vaccine (MCV)? ☐ Y ☐ N

If Yes, indicate the number of doses whichever is applicable: MV___ MR___ MMR___

Date last dose received MCV: _____/_____/_____

Was vaccination received during special campaigns? ☐ Y ☐ N

If patient did not receive any MCV, state the reason/s:

☐ Mother was busy
☐ Against belief
☐ Medical contraindication
☐ Fear of side effects
☐ Child was sick
☐ No vaccine available
☐ Vaccinator not available
☐ Not eligible for vaccination
☐ Forgot schedule
☐ Other reasons, specify
_____

Was the patient given Vitamin A during this illness? ☐ Y ☐ N

IV. EXPOSURE HISTORY

History of travel in another province, city or country: ☐N ☐Y If Yes: If YES, specify place:_____

Date traveled: From_____/_____/_____ To _____/_____/_____

Indicate timing of travel relative to rash onset:
☐ <7 days from rash onset ☐ 7-21 days from rash onset ☐ >21 days from rash onset

Tick the type of place where exposure probably occur: ☐Day care ☐Barangay ☐Home ☐School ☐Health Care Facility ☐Dormitory ☐ work place ☐Others, specify _____

*Was there contact with a measles/rubella case (or individual with rash and fever) 7-21 days prior to rash onset? ☐ Y ☐ N ☐ U
If YES, full name of contact: _____ Date of contact ___/___/____
Name of barangay & municipality/city :_____
* Are there other known cases with fever and rash (regardless of presence of 3 C's) in the community? ☐ Y ☐ N ☐ U

** Note: If the answer to any of the last two questions is YES, coordinate with the ESU for validation and field investigation*

Measles-Rubella Case Investigation Form

V. LABORATORY TESTS

Specimen collected (Put ✓ in the box Provided)	If YES, Date Collected	Date sent to RITM	Date received in RITM (to be filled up by RITM)	Measles IgM Result	Rubella IgM Result	Virus Isolation Result	PCR Result
☐Serum	___ /___ /___	___ /___ /___					
☐Dried Blood Spot	___ /___ /___	___ /___ /___					
☐Oropharyngeal/ Nasopharyngeal swab?	___ /___ /___	___ /___ /___					
☐OraCol?	___ /___ /___	___ /___ /___					

VI. FINAL CLASSIFICATION

- ☐ Laboratory confirmed measles
- ☐ Epi-linked confirmed measles
- ☐ Clinically Measles compatible
- ☐ Vaccine-associated measles
- ☐ Laboratory confirmed rubella
- ☐ Epi-linked confirmed rubella
- ☐ Discarded as non-measles/ non-rubella

VII. SOURCE OF INFECTION

- ☐ Endemic
- ☐ Imported
- ☐ Import-related
- ☐ Unknown

VIII. OUTCOME: ☐ Alive ☐ Died ☐ Unknown Date died:___/___/___

FINAL DIAGNOSIS: _____

CASE DEFINITION

Suspected case: Any person with fever and maculopapular rash (non-vesicular) and either cough, coryza (runny nose) or conjunctivitis (red eyes)

CLASSIFICATION

1. Laboratory-confirmed measles case: *A suspected measles case that has been confirmed by the National Measles Laboratory (NML) of the Re-search Institute for Tropical Medicine as positive for measles IgM antibodies and/or positive for measles virus isolation or Polymerase Chain Reaction (PCR).*

2. Epidemiologically linked confirmed measles case: *A suspect measles case that has not been confirmed by a laboratory but temporally and geographically related, with dates of rash onset occuring between 7-21 days apart, to a laboratory-confirmed case or, in the event of a chain of transmission, to another epidemiologically-linked measles case.*

3. Clinically measles compatible case: *A suspect measles case for which no adequate specimen was taken and which has not been linked epi-demiologically to a laboratory confirmed measles case or another laboratory-confirmed communicable disease.*

***4. Laboratory-confirmed rubella case*:** A suspected measles case that has been confirmed by the NML as positive for rubella IgM antibodies.

***5. Epidemiologically linked confirmed rubella case*:** A patient with a febrile rash illness that is negative for measles and epidemiologically-linked to a laboratory-confirmed rubella case

6. Discarded as Non-measles and Non-Rubella: A suspect case that has been investigated and discarded as a non-measles and non-rubella case using (1) laboratory testing by the NML or (2) epidemiological linkage to a laboratory-confirmed case/outbreak of another communicable disease that is neither measles nor rubella.

LABORATORY CONFIRMATION:

- Positive serologic test result for anti-measles IgM antibodies
- Fourfold rise in anti-measles IgG antibodies in acute and convalescent serum
- Isolation of measles virus
- Dot immunobinding assay
- Polymerase chain reaction testing for measles nucleic acid

Therapeutic Dosage of Vitamin A for Measles cases:

- 50,000 IU for children <6 months old
- 100,000 IU for children 6 to 11 months old
- 200,000 IU for children 12 to 71 months old

Note:
The therapeutic dosage of Vitamin A for measles cases should be given upon diagnosis regardless of when the last dose of vitamin A capsule was given.

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Meningococcal Disease

(ICD 10 Code: A39)

Name of DRU: **Address:**									Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport		
I. PATIENT INFORMATION:	Patient Number:	Patient's First Name		Middle Name		Last Name					
Complete Address:			Sex: ☐Male ☐Female	Date of Birth:	MM	DD	YY	Age:	☐Days ☐Months ☐Years		
District:	ILHZ:										
Occupation:		Name Workplace:									
		Address of Workplace:									
If student:	Name of School:		Address of School:								
II. CLINICAL INFORMATION:	Admitted? ☐Yes ☐No ☐Unknown		Date Admitted/ Seen/Consult	MM	DD	YY	Date Onset of Illness	MM	DD	YY	
Signs and Symptoms:	☐Fever ☐Headache ☐Maculopapular rash ☐Petechia ☐Purpura ☐Other lesions:		☐Seizure ☐Stiff neck ☐Vomiting ☐Change of sensorium ☐Drowsiness ☐Other signs / symptoms:				☐Malaise ☐Cough ☐Sore throat ☐Runny nose ☐Dyspnea				
Clinical Presentation: ☐Meningitis ☐Septicemia ☐Both		Case Classification: ☐Suspected Case ☐Probable Case ☐Confirmed Case		Outcome: ☐Alive ☐Died, Date Died _____/_____/_____ ☐Unknown							
III. CASE MANAGEMENT:	Were blood/CSF extracted before the first dose of antibiotics was given to the patient? ☐Yes ☐No ☐Unknown										
What antibiotics were given in the hospital?											

IV. LABORATORY TESTS:

Specimen	If YES, date taken			Type of laboratory test done	Results N=Negative; I=Indeterminate; U-Unknown; ND= Not Done		Date result		
CSF	MM	DD	YY	Culture	*Positive for:*	☐N ☐I ☐U ☐ND	MM	DD	YY
	MM	DD	YY	Latex agglutination	*Positive for:*	☐N ☐I ☐U ☐ND	MM	DD	YY
	MM	DD	YY	Gram stain	*Positive for:*	☐N ☐I ☐U ☐ND	MM	DD	YY
Blood	MM	DD	YY	Culture	*Positive for:*	☐N ☐I ☐U ☐ND	MM	DD	YY

Case Investigation Form

Meningococcal Disease

V. PAST HISTORY:	Did the PATIENT or CLOSE CONTACT/S interact with a suspected or confirmed meningococcal case within 2 weeks before onset of illness? ☐Yes, the patient ☐Yes, close contact/s (name/s) _____ ☐No ☐Unknown
If yes, what was the name of the suspected or confirmed meningococcal case?	
What is the address of the suspected or confirmed meningococcal case?	
Where did the patient or close contact/s interact with the meningococcal case?	When? MM/DD/YY / Number of Days?
Did the PATIENT travel within 2 weeks prior to illness? ☐Yes ☐No ☐Unknown	If yes, where?
Did a CLOSE CONTACT/S of the patient travel within 2 weeks prior to illness? ☐Yes ☐No ☐Unknown	If yes, who and where?
Did the PATIENT attend any social gathering within 2 weeks prior to illness? ☐Yes ☐No ☐Unknown	If yes, where?
Did the PATIENT have upper respiratory tract infection within 2 weeks prior to illness? ☐Yes ☐No ☐Unknown	
Did a CLOSE CONTACT/S have upper respiratory tract infection within 2 weeks prior to the patient's illness? ☐Yes ☐No ☐Unknown, If Yes, who?	

CASE DEFINITION/CLASSIFICATION:

- ***Suspected case:*** A person with sudden onset of fever (>38.5°C rectal or >38.0°C axillary) **and one or more** of the following:
  - neck stiffness
  - altered consciousness
  - other meningeal signs
  - petechial or purpural rash

  Note*:* *In patients <1 year, suspect meningitis when fever is accompanied by bulging fontanels*

- ***Probable case:*** A suspected case as defined above **AND** with Turbid cerebrospinal fluid (with or without positive Gram stain) **OR** ongoing epidemic and epidemiological link to a confirmed case.

- ***Confirmed case:*** A suspected **OR** probable case with laboratory confirmation.

LABORATORY CONFIRMATION:

- Positive cerebrospinal fluid (CSF) antigen detection or culture.
- Positive blood culture.

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Neonatal Tetanus

Name of DRU: **Address:**				Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport							
I. PATIENT INFORMATION:	Patient Number:	Patient's First Name		Middle Name		Last Name					
Complete Address:			Sex:	☐ Male ☐ Female	Date of Birth:	MM	DD	YY	Age in days:		
District:	ILHZ:										
Patient Admitted? ☐ Yes ☐ No ☐ Unknown		Date Admitted/ Seen/Consult	MM	DD	YY	Date Onset of Illness	MM	DD	YY		
Date of Report:	MM	DD	YY	Date of Investigation:	MM	DD	YY	Mother's Full Name:			

II. CLINICAL DATA:

In the first 2 days of life did the baby has normal suck and cry?
☐ Yes ☐ No ☐ Unknown

After 2 days of life, was the baby unable to suck and cry normally?
☐ Yes ☐ No ☐ Unknown

After 2 days of life, did the baby have body stiffness or muscle spasm? ☐ Yes ☐ No ☐ Unknown

Was the umbilical stump infected? (bad smell, pus)
☐ Yes ☐ No ☐ Unknown

III. MOTHER'S INFORMATION:

Prenatal Care

No. of total pregnancies:_____
Live births:_____ Living children:_____

How many prenatal care visits did the mother make to a health facility during her pregnancy?
_____

When was the first prenatal visit?___/____/___

Is the prenatal care history reported by:
☐ Card ☐ Recall ☐ Both ☐ Unknown

State reason for no or late prenatal care:_____

Immunization Status

How many doses of TT has the mother received?_____ doses ____unknown

Date last dose given:_____/____/_____

If she received 2 doses, were they given during this pregnancy? ☐ Y ☐ N ☐ U

Is the immunization status reported by:
☐ Card ☐ Recall ☐ Both ☐ Unknown

If she has a card, copy the dates of all TT immunizations recorded on the card:
TT1:_____/_____/_____
TT2:_____/_____/_____
TT3:_____/_____/_____
TT4:_____/_____/_____
TT5:_____/_____/_____

Is the child protected at birth*?
☐ Yes ☐ No ☐ Unknown

IV. DELIVERY PRACTICES:

Place of delivery: ☐ Home ☐ Hospital/lying-in/clinic ☐ Other, specify: _____

If born in a hospital/lying-in/clinic, give name and address of the hospital/lying-in/clinic: _____

Who attended the delivery? ☐ Physician ☐ Nurse ☐ MIdwife
☐ Hilot ☐ Unknown ☐ Other, specify:_____

Cord was cut using: ☐ Scissors ☐ Blade
☐ Bamboo ☐ Unknown ☐ Other, specify:_____

If Hilot, was he/she trained? ☐ Yes ☐ No ☐ Unknown

Stump treated (dressed) with: ☐ Alcohol ☐ Povidone iodine
☐ Unknown ☐ Other, specify:_____

V. CLASSIFICATION AND OUTCOME:

CASE CLASSIFICATION	OUTCOME
☐ Suspected Case ☐ Confirmed Case	☐ Alive ☐ Died Date died: ____/____/____ ☐ Unknown

Case Investigation Form

Neonatal Tetanus

CASE DEFINITIONS:

Clinically Confirmed Case:

- *Any neonate (≤ 28 days of life) that sucks and cries normally during the first 2 days of life, and becomes ill from 3 to 28 days of age and develops an inability to suck and diffuse muscle rigidity (stiffness) and spasms (jerking of the muscles), which may include trismus, clenched fists or feet, continuously pursed lips, and/or curved back (opisthotonus).*

- *Any neonate diagnosed as a case of tetanus by a physician.*

NOTE*:*

- *Neonatal tetanus case is confirmed based solely on clinical criteria.*
- *Any neonatal death occurring in babies 3-28 days old with no apparent cause should be suspected as NT and evaluated according to the above criteria. However, only clinically confirmed NT cases shall be fully investigated using the NT CIF.*
- *In calculating age, the day of birth is considered the first day of life (i.e., the baby is 1 day old on the day he/she was born).*

Protection at Birth (PAB) is defined as any of the following:

- If mother had 2 TT doses during this pregnancy, provided ≥1 month apart, or
- If mother had ≥3 TT doses anytime prior to pregnancy with this child.

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Paralytic Shellfish Poisoning

(ICD 10 Code: T61.2)

Name of DRU: **Address:**	Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport

I. PATIENT INFORMATION:	Patient Number:	Patient's First Name	Middle Name / Last Name

Complete Address: District: / ILHZ:	Sex:	☐ Male ☐ Female	Date of Birth:	*MM*	*DD*	*YY*	Age: ☐ Days ☐ Months ☐ Years

Patient Admitted? ☐ Yes ☐ No ☐ Unknown	Date Admitted/ Seen/Consult	*MM*	*DD*	*YY*	Date Onset of Ill-ness	*MM*	*DD*	*YY*

II. EXPOSURE HISTORY:

Specify place where suspected shellfish was harvested:_____

Are there other members of household/community who shared the same meal? ☐ Yes ☐ No ☐ Unknown

III. CLASSIFICATION AND OUTCOME:

FINAL CLASSIFICATION	OUTCOME
☐ Suspected Case ☐ Confirmed Case	☐ Alive ☐ Died Date died: ____/____/____ ☐ Unknown

Name of DRU: **Address:**	Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport

I. PATIENT INFORMATION:	Patient Number:	Patient's First Name	Middle Name / Last Name

Complete Address:	Sex:	☐ Male ☐ Female	Date of Birth:	*MM*	*DD*	*YY*	Age: ☐ Days ☐ Months ☐ Years

Patient Admitted? ☐ Yes ☐ No ☐ Unknown	Date Admitted/ Seen/Consult	*MM*	*DD*	*YY*	Date Onset of Ill-ness	*MM*	*DD*	*YY*

II. EXPOSURE HISTORY:

Specify place where suspected shellfish was harvested:_____

Are there other members of household/community who shared the same meal? ☐ Yes ☐ No ☐ Unknown

III. CLASSIFICATION AND OUTCOME:

FINAL CLASSIFICATION	OUTCOME
☐ Suspected Case ☐ Confirmed Case	☐ Alive ☐ Died Date died: ____/____/____ ☐ Unknown

CASE DEFINITION/CLASSIFICATION:

- ***Suspected case:*** A person who develops one or more of the following signs and symptoms after taking shellfish meal or soup:

  Sensory : paresthesias (tingling sensations on skin), numbness (lack of sensation) of the oral mucosa and lips, numbness of the extremities
  Motor: difficulty in speaking, swallowing, or breathing, weakness or paralysis of the extremities

- ***Probable Case*:** Not applicable

- ***Confirmed case:*** A suspected case in which laboratory tests (biologic or environmental) have confirmed exposure.

LABORATORY CONFIRMATION:

- Detection of saxitoxin in epidemiologically implicated food, serum or urine of cases

(Please use the back page)

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Paralytic Shellfish Poisoning

(ICD 10 Code: T61.2)

Name of DRU: **Address:**				Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport								
I. PATIENT INFORMATION:	Patient Number:	Patient's First Name		Middle Name		Last Name						
Complete Address: District:	ILHZ:	Sex:	☐ Male ☐ Female	Date of Birth:	*MM*	*DD*	*YY*	Age:	☐ Days ☐ Months ☐ Years			
Patient Admitted? ☐ Yes ☐ No ☐ Unknown		Date Admitted/ Seen/Consult	*MM*	*DD*	*YY*	Date Onset of Ill-ness	*MM*	*DD*	*YY*			

II. EXPOSURE HISTORY:

Specify place where suspected shellfish was harvested:_____

Are there other members of household/community who shared the same meal? ☐ Yes ☐ No ☐ Unknown

III. CLASSIFICATION AND OUTCOME:

FINAL CLASSIFICATION	OUTCOME
☐ Suspected Case ☐ Confirmed Case	☐ Alive ☐ Died Date died: ____/____/____ ☐ Unknown

Name of DRU: **Address:**				Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport								
I. PATIENT INFORMATION:	Patient Number:	Patient's First Name		Middle Name		Last Name						
Complete Address:		Sex:	☐ Male ☐ Female	Date of Birth:	*MM*	*DD*	*YY*	Age:	☐ Days ☐ Months ☐ Years			
Patient Admitted? ☐ Yes ☐ No ☐ Unknown		Date Admitted/ Seen/Consult	*MM*	*DD*	*YY*	Date Onset of Ill-ness	*MM*	*DD*	*YY*			

II. EXPOSURE HISTORY:

Specify place where suspected shellfish was harvested:_____

Are there other members of household/community who shared the same meal? ☐ Yes ☐ No ☐ Unknown

III. CLASSIFICATION AND OUTCOME:

FINAL CLASSIFICATION	OUTCOME
☐ Suspected Case ☐ Confirmed Case	☐ Alive ☐ Died Date died: ____/____/____ ☐ Unknown

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Rabies

Name of DRU: **Address:**	Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport

I. PATIENT INFORMATION:	Patient Number:	Patient's First Name	Middle Name	Last Name

Complete Address:	Sex:	☐ Male ☐ Female	Date of Birth:	*MM*	*DD*	*YY*	Age:	☐ Days ☐ Months ☐ Years
District: ILHZ:								

Patient Admitted? ☐Yes ☐No ☐Unknown	Date Admitted/ Seen/Consult	*MM*	*DD*	*YY*	Date Onset of Illness	*MM*	*DD*	*YY*

II. EXPOSURE HISTORY:

Type of exposure: ☐ bite ☐ saliva ☐ scratch ☐ Unknown ☐ Other, specify _____ Date of Bite:_____

Place where bitten:_____ Site of Body bitten:_____

Category of Exposure:

☐ Feeding/touching an animal

☐ Licking of intact skin(with reliable history and thorough physical examination)

☐ Exposure to patient with signs and symptoms of rabies by sharing of eating or drinking untensils

☐ Casual contact(talking to, visiting and feeding suspected rabies cases) and routine delivery of health care to patient with signs and symptoms Of rabies

☐ Nibbling of uncovered skin with or without bruising/hematoma

☐ Minor scratches/abrasions without bleeding

☐ Minor scratches/abrasions which are induced to bleed

☐ All Category II exposures on the head and neck area are considered Category III and should be managed as such

☐ Transdermal bites(puncture wounds,lacerations,avulsions) or scratches/abrasions with spontaneous bleeding

☐ Licks on broken skin

☐ Exposure to a rabies patient through bites,contamination of mucous membranes(eyes,oral/nasal mucosa,genital/anal mucous membranes) or Open skin lesions with body fluids through splattering and mouth-to-mouth resuscitation.

☐ Handling of infected carcass or ingestion of raw infected meat

☐ All Category II exposures on head and neck area

Type of animal: ☐ dog ☐ cat ☐ bat ☐ Other, specify_____

Lab. diagnosis done? ☐ Yes ☐No ☐Unknown If Yes, result: _____

Animal status: ☐ domestic ☐ stray ☐ wild ☐ Other, specify _____

Outcome of biting animal: ☐ alive ☐ died ☐ killed intentionally Place of Incidence: _____

III. VACCINATION HISTORY:

Animal vaccination history:	Patient History:	
☐ Vaccinated ☐ Unvaccinated ☐ Unknown	Wound cleaned?: ☐Yes ☐No ☐Unknown Patient given RIG?: ☐Yes ☐No ☐Unknown (RIG is Rabies Immunoglobulin) Patient given rabies vaccine?: ☐Yes ☐No ☐Unknown	Date vaccine started:_____ Brand Name of Vaccine:_____ Route of Administration: ☐ IM ☐ Intradermal Post exposure completed ☐ Yes ☐ No

IV. CLASSIFICATION AND OUTCOME:

FINAL CLASSIFICATION	OUTCOME
☐ Suspected Case ☐ Probable Case ☐ Confirmed Case	☐ Alive ☐ Died Date died: ____/____/____ ☐ Unknown

Philippine Integrated Disease Surveillance and Response

Case Investigation Form

Rabies

CASE DEFINITION/CLASSIFICATION:

- ***Suspected Case*:** A person presenting with an acute neurological syndrome (encephalitis) dominated by forms of hyperactivity (furious rabies) or paralytic syndromes (dumb rabies) that progresses towards coma and death, usually by respiratory failure, within 7 to 10 days after the first symptom if no intensive care is instituted.

- ***Probable case:*** A suspected case plus history of contact with suspected rabid animal.

  Note: *Bites or scratches from a suspected animal can usually be traced back in the patient medical history. The incubation period may vary from days to years but usually falls between 30 and 90 days.*

- ***Confirmed case:*** A suspected case that is laboratory confirmed.

LABORATORY CONFIRMATION:

One or more of the following:

- Detection of rabies viral antigens by direct fluorescent antibody (FA) in clinical specimens, preferably brain tissue (collected post mortem);
- Detection by FA on skin or corneal smear (collected ante mortem);
- FA positive after inoculation of brain tissue, saliva or CSF in cell culture, in mice or in suckling mice;
- Detectable rabies-neutralizing antibody titer in the CSF of an unvaccinated person;
- Identification of viral antigens by PCR on fixed tissue collected post mortem or in a clinical specimen (brain tissue or skin, cornea or saliva);
- Isolation of rabies virus from clinical specimens and confirmation of rabies viral antigens by direct fluorescent antibody testing.