MUNICIPAL HEALTH OFFICE

Republic of the Philippines

Province of Pangasinan

# MUNICIPALITY OF CALASIAO





### Case Investigation Form

**LEPTOSPIROSIS**

**(ICD 10 Code A27)**

|  |  |  |
| --- | --- | --- |
| PATIENT INFORMATION: | Patient’s Number: | Patient’s First Name Middle Name Last Name |
| Complete Address:  | Sex: □Male □Female | Date of Birth: | *MM* | *DD* | *YY* | Age: |  | DaysMonths Years |
|  |
|  |
| Occupation: | Date Reported: | *MM* | *DD* | *YY* |
| CLINICAL INFORMATION: |
| 1. Date Onset of Symptoms | *MM* | *DD* | *YY* | 4. Patient admitted to a hospital? □ Yes □ No □ Unknown |
| 2. Date patient first seek medical advice; | *MM* | *DD* | *YY* | 5. Name/Address of Hospital: |
| 3. Where did the patient first seek medical advice?□ government hospital □ private hospital□ health center □ private clinic□ others: specify- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 6. Date admitted: | *MM* | *DD* | *YY* |
| 7. Outcome of the case: □ Alive □ Died □ Unknown  |
| 8. Date of discharge/transfer or death | *MM* | *DD* | *YY* |
| CLINICAL DATA: | INFORMATION ON DISEASE TRANSMISSION: |
| *Case Definition - Acute febrile illness with headache, myalgia and prostration associated with any of the following symptoms: conjunctival suffusion, meningeal irritation, anuria or oliguria and/or proteinuria, jaundice, hemorrhages, cardiac arrhythmia or failure, skin rash AND a history of exposure to infected animals or an environment contaminated with animal urine* | History of other place/s visited the past week: prior to onset of symptoms □ Yes □ No If Yes, Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Possible sources of contamination:□ flood waters: □ paddy field □ livestock □ marshy/muddy land □ other water related sources (sewers, irrigation, fisheries)History of recent skin lesion/injury?□ Yes □ No □ UnknownDid any of the family members, companions, neighbors, or co-workers develop similar illness or manifestations? □ Yes □ No □ UnknownRemarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Symptoms and complications:□ acute fever: □ jaundice □ hemorrhage □ headache: □ conjunctival suffusion □ cardiac failure/ □ myalgia (muscle pain) □ meningeal irritation arrhythmia□ prostration □ anuria/oliguria □ skin rash □ other/s (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PROPHYLAXIS: |
| Was the patient on chemo-prophylactic treatment at the time of onset of illness? □ Yes □ No □ UnknownIf yes; what chemo-prophylactic drug and dosage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Source of chemo-prophylactic drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| LABORATORY FINDINGS: |
| Laboratory Tests done: □ Yes □ No □ Unknown |
| Tests | Blood | Urine | Other tissues:  |
| + | - | NA | + | - | NA | + | - | NA |
| Direct Microscopy |  |  |  |  |  |  |  |  |  |
| Culture |  |  |  |  |  |  |  |  |  |
| Proteinuria |  |  |  |  |  |  |  |  |  |
| Case Classification: □ Suspect □ Confirmed |

Date of Investigation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Informant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to the Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_