MINISTRY OF HEALTH & WELLNESS

NATIONAL SURVEILLANCE UNIT, NATIONAL EPIDEMIOLOGY BRANCH,
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NATIONAL EPIDEMIOLOGY BRANCH

LEPTOSPIROSIS CASE INVESTIGATION FORM

Date of Notification (DD/MM/YYYY):	Date Investigation Started: (DD/MM/YYYY)	

PATIENT'S DEMOGRAPHICS

Patient's ID Type: ☐ Driver's License ☐ TRN ☐ Passport ☐ NIN	Patient's ID Number:	
First Name:	Middle Name(s):	
Last Name:	Pet Name(s)	
Maiden Name (if applicable):		
Name of Facility Where Patient Seen:	Medical Record Number:	
Sex Assigned at Birth: ☐ Male ☐ Female	Date of Birth: (DD/MM/YYYY)	Age:
Country of Residence:	Parish of Residence (Jamaica):	
House Number, Street Name:	Community of Residence:	
Landmark or directions to address:		
Phone Number:	Email Address:	

NEXT OF KIN (NOK)

First Name:	Last Name:	
Phone Number:	Email address:	
Address: Lot/ Street/Community/Parish:		

Relationship to the Patient:

☐ Wife	☐ Father	☐ Sister	☐ Aunt	☐ Cousin
☐ Husband	☐ Son	☐ Brother	☐ Grandmother	☐ Friend
☐ Mother	☐ Daughter	☐ Uncle	☐ Grandfather	☐ Guardian

CLINICAL PROFILE

Symptom/Sign	Duration (Days)	Date of Onset (DD/MM/YYYY)	Symptom/Sign	Duration (Days)	Date of Onset (DD/MM/YYYY)
☐ Fever			☐ Conjunctival suffusion		
◦ History of fever			☐ Anuria or oliguria		
◦ Recorded temperature (°C):			☐ Jaundice		
☐ Headache			☐ Cough, haemoptysis and/or shortness of breath		
☐ Myalgia			☐ Haemorrhage (e.g., gastrointestinal bleed)		
◦ Calves and/or thighs			☐ Meningeal irritation		
◦ Other areas			☐ Skin rash		
☐ Weakness			☐ Cardiac arrhythmia/failure		
☐ Other (Specify):					

Clinical summary:

EPOSURE HISTORY

During the 3 weeks prior to onset:	Yes	No	Date(DD/MM/YYYY)	Details
Contact with animals (including pets) or their excreta at home or during travel	☐	☐		
Contact with known or possibly contaminated water	☐	☐		
Ingested possibly rodent-contaminated food/drink	☐	☐		
Contact with case of leptospirosis	☐	☐		

LEPTOSPIROSIS CASE INVESTIGATION

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

Travelled in the past six (6) weeks? ☐ Yes ☐ No ☐ Unknown **Country/Area Visited:**

MEDICAL HISTORY

Pre-existing Conditions:

☐ Asthma	☐ Diabetes mellitus	☐ HIV/AIDS	☐ Malignancy
☐ Autoimmune	☐ Heart disease	☐ Hypertension	☐ Sickle cell disease
☐ Chronic Obstructive Pulmonary Disease(COPD)	☐ Kidney disease	☐ Liver dysfunction	☐ Specify Other:

PREGNANCY

Is Patient Pregnant: ☐ Yes ☐ No ☐ Unsure ☐ Not applicable

Gestational Age: Trimester: ☐ First ☐ Second ☐ Third

HOSPITAL SUMMARY

Admitted to Hospital? ☐ Yes ☐ No	Date of Admission (DD/MM/YYYY):	Date of Discharge (DD/MM/YYYY):
Hospital:	Medical Record Number:	
Vital Status (Outcome): ☐ Alive ☐ Dead	Date of Death (DD/MM/YYYY):	Time of Death: ____ : ____ AM/PM

Place of Death: ☐ Home ☐ DOA ☐ Ward ☐ ICU

SAMPLE AND LAB INFORMATION

Was a specimen collected? ☐ Yes ☐ No Date Specimen Taken (DD/MM/YYYY):

Specimen Type: ☐ Blood, with anticoagulant (e.g., purple top tube) ☐ Blood, NO anticoagulant/clotted (e.g., red top tube)

☐ CSF ☐ Urine ☐ Other (Specify):

Which lab is the sample being sent to?

☐ National Public Health Laboratory ☐ Other (Specify):

Test Type	Date Test Done (DD/MM/YYYY)	Results	Interpretation
☐ PCR		☐ Positive ☐ Negative ☐ Indeterminate	
☐ IgM		☐ Positive ☐ Negative ☐ Indeterminate	
☐ Other (Specify):			

Classification

Initial Diagnosis:		Final Diagnosis:
☐ Laboratory Confirmed	☐ Probable	☐ Suspected
☐ Discarded	☐ Pending	

Reason for classification:

Aetiology Category: ☐ Imported case ☐ Endemic ☐ Unknown

Source country (If Imported or Import-Related:

DEATH CLASSIFICATION

Leptospirosis-related death: ☐ Confirmed ☐ Probable ☐ Suspected ☐ Discarded ☐ Under Investigation ☐ Cannot be classified

Investigator's Details

Date Investigation Completed (DD/MM/YYYY):

First Name:	Last Name
Professional Group:	
Phone number:	Email Address:
Name of Institution:	
Parish:	Community:
Office Number/Street Name:	
Health Region:	

Investigator's Signature:		Date signed by Investigator (DD/MM/YYYY):
Name of Parish MO(H):	Signature of MO(H)	Date signed by MO(H), (DD/MM/YYYY)