AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

# Rheumatic Fever (Acute) Register and Referral

**MUST ATTACH PATIENT LABEL HERE**

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

**Please ensure you attach the correct visit patient label**

RHEUMATIC FEVER REGISTER REFERRAL ACUTE

## WORKING DIAGNOSIS

☐ 1st Acute Rheumatic Fever (ARF) ☐ Recurrence of Acute Rheumatic Fever (ARF)

## PATIENT DETAILS

| | |
|---|---|
| **Family Name** | **DOB** / / |
| **Given Names** | **Gender** Male / Female |

**Ethnic Group:** *Tick as many boxes as you need to show which ethnic groups you belong to*

☐ NZ European ☐ Maori ☐ Tongan ☐ Chinese ☐ Other (such as Dutch, Japanese, Tokelauan)
☐ Samoan ☐ Niuean ☐ Indian ☐ Cook Island Maori Please State _____

**Country of Birth**

**Date of Arrival in New Zealand** / / **NZ Resident** ☐ Yes ☐ No

## REGISTRATION DETAILS

Attending school at time of diagnosis? ☐ Yes ☐ No ☐ Unknown

Attending a school with a throat swabbing programme ☐ Yes ☐ No ☐ Unknown ☐ Not at School

| School at diagnosis | School 1 month before diagnosis | School 2 months before diagnosis |
|---|---|---|
| | | |

Address at Registration:

Date of Registration: / /

Benzathine given prior to discharge: ☐ Yes ☐ No ☐ Unknown

If given date of most recent Benzathine Dose: / /

Estimated year for stopping of Benzathine penicillin:

Referred to register by:

**Referrer Role:**

☐ Resident Medical Officer (RMO)
☐ Senior Medical Officer (SMO)
☐ Nurse ☐ General Practitioner (G.P.)

Senior Consultant at time of registration:

**Consultant type:** ☐ Rheumatic Fever Physician
☐ Cardiologist ☐ Infectious Diseases Consultant
☐ Other (eg gen paed or gen med)

Diagnosis address same as registration address: ☐ Yes ☐ No ☐ Unknown

If no, Confirmed address at diagnosis:

DHB of Domicile at diagnosis

Previous Rheumatic Fever? ☐ Yes ☐ No ☐ Unknown

Previous RF Admissions? ☐ Yes ☐ No ☐ Unknown

**Details of RF Admissions if known**

| *Date of Admission* | *Hospital of RF admission* | *Details of RF admission* ARF | Recurrence | Surgery |
|---|---|---|---|---|
| | | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ |

Location of previous Prophylaxis treatment?

☐ DHB _____

☐ Overseas - specfiy country _____

Previous Carditis? ☐ Yes ☐ No ☐ Unknown

Has patient previously been on secondary prophylaxis ☐ Yes ☐ No ☐ Unknown

**Details of Prophylaxis Treatment being received when this episode occurred** (i.e. for patients previously been on secondary prophylaxis)

Prescribed frequency: ☐ 21 days ☐ 28 days ☐ Other

Regularity of prophylaxis: ☐ Regularly as prescribed ☐ Irregularly ☐ Uncertain

Specific type of prophylaxis (i.e. Drug prescribed)

Date of last prophylaxis / / ☐ Unknown

**PLEASE NOTE**

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- Please complete referral to nursing services, in addition to this form, as per your local DHB's policy
- Please send completed form to: Robyn Buchanan, Paediatric ID Secretary, 5th Floor, SSH
  Phone: **(09) 307 4949** ext. **22559** *or* email it to **RobynB@adhb.govt.nz**



CR2275

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## MAJOR CRITERIA

Carditis ☐ Yes ☐ No ☐ Unknown | Does patient require anti-coagulation therapy? ☐ Yes ☐ No ☐ Unknown

**Carditis details:** Select between: None, Trivial, Subclinical/Mild, Moderate, Severe

| Date | On Basis of | Mitral Regurgitation | Aortic Regurgitation | Tricuspid Regurgitation | Mitral Stenosis |
|---|---|---|---|---|---|
| / / | ☐ ECHO ☐ Auscultation | | | | |
| / / | ☐ ECHO ☐ Auscultation | | | | |

**Surgery for RHD:** ☐ Yes ☐ No ☐ Unknown **Surgery Type:** ☐ Mitral ☐ Aortic ☐ Tricuspid ☐ Mitral

Comments:

## JOINTS

| **Body Part** (i.e. Leg / Arm / Other) | **Joint** | **Left / Right** | **Arthritis / Arthralgia** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Migratory ☐ Yes ☐ No ☐ Unknown
Polyarthritis ☐ Yes ☐ No ☐ Unknown
Monoarthritis ☐ Yes ☐ No ☐ Unknown

Arthritis on history only ☐ Yes ☐ No ☐ Unknown
Alternative serology negative ☐ Yes ☐ No ☐ Unknown
Non-weight bearing ☐ Yes ☐ No ☐ Unknown

Major Criteria – Other

Chorea ☐ Yes ☐ No ☐ Unknown

Erythema Marginatum ☐ Yes ☐ No ☐ Unknown
Subcutaneous Nodules ☐ Yes ☐ No ☐ Unknown

## MINOR CRITERIA

Fever >= 38 degrees ☐ Yes ☐ No ☐ Unknown
Fever record ☐ By History ☐ Measured
Polyarthralgia ☐ Yes ☐ No ☐ Unknown

CRP Highest_____ ESR Highest_____

PR interval _____ Date of PR inteval / /

Other conductional disturbance ☐ Yes ☐ No

If other conductional distrubance = Yes

Conductional disturbance details
☐ Junctional Acceleration
☐ 2nd Degree AV block
☐ 3rd Degree AV block

## MINOR CRITERIA

| Date throat Swab taken | Positive for Group A Streptococcus Yes | No | Unknown | Date of Test | ASOT | Anti-DnaseB | Other | Need for further test Yes | No |
|---|---|---|---|---|---|---|---|---|---|
| / / | ☐ | ☐ | ☐ | / / | | | | ☐ | ☐ |
| / / | ☐ | ☐ | ☐ | / / | | | | ☐ | ☐ |
| / / | ☐ | ☐ | ☐ | / / | | | | ☐ | ☐ |

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## DENTAL

| Referral for dental review in hospital | Referral for dental care at school |
|---|---|
| ☐ Yes ☐ No ☐ Unknown | ☐ Yes ☐ No ☐ Unknown |

## MEDICAL REVIEW

Cardiac risk status at registration ☐ High ☐ Medium ☐ Low ☐ No carditis ☐ Unknown

**Anticipated date when clinic appointment required:** / /

| Medical review required by | Adult | Paeds | DHB location | Date last seen | Follow up (in months) |
|---|---|---|---|---|---|
| ☐ RF Physician ☐ Cardiologist ☐ Paediatrician ☐ ID Consultant | ☐ | ☐ | | / / | |
| ☐ RF Physician ☐ Cardiologist ☐ Paediatrician ☐ ID Consultant | ☐ | ☐ | | / / | |
| ☐ RF Physician ☐ Cardiologist ☐ Paediatrician ☐ ID Consultant | ☐ | ☐ | | / / | |
| | | | | | |

## AUCKLAND REGIONAL PUBLIC HEALTH (ARPHS) NOTIFICATION SENT

| ☐ Yes<br>Date form faxed to ARPHS / / | ☐ No - case already notified to another regional public health unit (i.e. transfer on active treatment or Northland patient and notification to NRPHU) |
|---|---|

Current Form available from here (Complete and Faxform to ARPHS)

http://www.arphs.govt.nz/Portals/0/Health%20Information/Communicable%20Disease/Rheumatic%20Fever/2014%209%2015%20ARF%20notification%20form.doc

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RHEUMATIC FEVER REGISTER REFERRAL NON-ACUTE

CR2275

AUCKLAND DISTRICT HEALTH BOARD
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**Rheumatic Fever (Acute) Register and Referral**

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**MEDICATION ORDER**

## $R_x$ Benzathine Penicillin Injections

900 mg (1.2 megaU) IM **OR** 450 mg (0.6 megaU) IM
(if less than 30 kgs)

## and **lignocaine** 2%

0.25 ml IM
(delete and initial if not required)

## every

21 / 28 days (circle and initial)

**Estimated year of cessation** _____

Signed: _____ Date: _____

Referring DR _____
(USE BLOCK LETTERS)

Medical Council #: _____

Address: _____

_____

_____

_____

_____

_____

Date of most recent Benzathine dose _____

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AUCKLAND
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# Rheumatic Fever
# Consent for Penicillin Treatment

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## CONSENT FOR PENICILLIN TREATMENT

| | | |
|---|---|---|
| I wish to have an interpreter | ☐ Yes | ☐ No |
| 'Oku ou fiemauke 'aia ha'aka fakatonulea | ☐ IO | ☐ IKAI |
| Oute maneo e I aise se fa'atonu | ☐ IOE | ☐ LEAI |
| E hiahia ana koe ki e Tangata Whaka - Maori | ☐ Yes | ☐ No |

**If yes:** Language _____

## CONSENT

The information on this form will be used to arrange Penicillin injections as prescribed by your doctor and to provide statistics on this disease. The information will be given only to health workers who are involved in your care, all of whom are bound to keep it confidential. The information will also be used to improve our treatment and prevention of Rheumatic Fever. No names or personal details will be used.

I, _____ hereby consent to treatment for rheumatic fever/rheumatic heart disease to prevent recurrent strep infections.

| | | |
|---|---|---|
| • Long acting Penicillin (Bicillin) by injection to be given by the Community Nurse. | ☐ Yes | ☐ No |
| • Lignocaine added to the Bicillin to numb the area around the injection. | ☐ Yes | ☐ No |
| • I understand the nature of the disease and the reasons for treatment. | ☐ Yes | ☐ No |

| | Name | Signature | Date |
|---|---|---|---|
| **Patient / Parent / Guardian** | | | |
| **Interpreter** *(if required)* | | | |
| **Staff Member** *Name:* <br> *Designation:* | | | |

**PLEASE NOTE**

- Scan completed medication order form and consent separately and upload into register
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RHEUMATIC FEVER CONSENT PENICILLIN TREATMENT

CR2274