

Meningococcal, invasive disease

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case

Reviewer initials: _____

Referred to another state: _____

CASE

Last name: _____
First and middle name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____

Maiden name: _____ Suffix: _____

Gender: Female Male Other _____

Address line: _____

Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____

Zip: _____ City: _____

Marital status: Single Married Divorced Parent with partner Separated Widowed

State: _____ County: _____

Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian

Long-term care resident: Yes No Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Facility name: _____

Parent/Guardian name: _____

Facility phone: (____) - ____ - ____ Type: _____

Parent/Guardian phone: (____) - ____ - ____ Type: _____

EVENT

Onset date: ____ / ____ / ____ Diagnosis date: ____ / ____ / ____

Last name: _____

Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown
Date of death: ____ / ____ / ____

First name: _____

Outbreak related: Yes No Unknown

Provider type: ARNP MD DO NP PA

Case could not be found
 Case could not be interviewed
 Case refused interview

Event exception Other – see notes

Outbreak name: _____

Facility name: _____

Exposure setting: _____

Address line 1: _____

Epi-linked: Yes No Unk To whom: _____

Address line 2: _____

Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown

Zip code: _____ City: _____

State: _____ Country: _____

State: _____ County: _____

Phone : (____) - ____ - ____ Type: _____

Healthcare provider information

LABORATORY FINDINGS

Laboratory: _____	Specimen source: _____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> No growth
Date received: ____ / ____ / ____	Test type: <input type="checkbox"/> PCR <input type="checkbox"/> Gram stain <input type="checkbox"/> Culture	Serogroup: <input type="checkbox"/> A <input type="checkbox"/> W-135 <input type="checkbox"/> B <input type="checkbox"/> Y <input type="checkbox"/> C
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Collection date: ____ / ____ / ____	Organism: Neisseria meningitidis
Accession #: _____	Result date: ____ / ____ / ____	

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OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____/____/____	Address: _____
Date worked to: ____/____/____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____/____/____	Phone: (____)____-____-____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____/____/____	Discharge date: ____/____/____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

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OTHER DEMOGRAPHIC INFO

Attending a college or university: Yes No Unk College/University name: _____

Student status: Active Inactive Year in college: Freshman Sophomore Junior Senior Grad student

Housing: Other Apartment Dormitory Single-family home with family Single-family home with students

CLINICAL INFO & DIAGNOSIS

Purpura fulminans present: Yes No Unk
Antibiotic resistance testing performed: Yes No Unk

Resistant to ampicillin: Yes No Unk
Resistant to chloramphenicol: Yes No Unk
Resistant to rifampin: Yes No Unk
Resistant to sulfa: Yes No Unk

Spinal tap Yes No Unk
Date: ____ / ____ / ____
Normal: Yes No Unk
Spinal fluid protein level: _____
Unit: mg/dL g/L μmol/L
Spinal fluid glucose level: _____
Unit: mg/dL μmol/L
White blood count: _____
Unit: cells/mm3 cells/mL

Infection type: Bacteremia Meningitis Pericarditis Peritonitis Pneumonia Other
Other infection type (specify): _____

TREATMENT

Antibiotics prescribed? Yes No Unknown

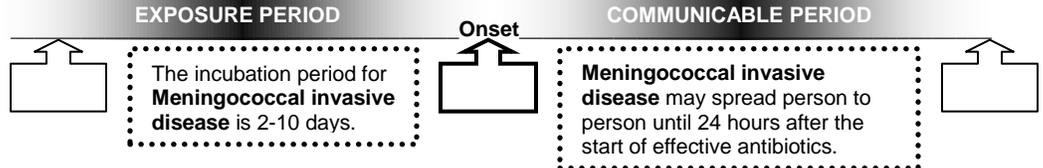
Antibiotic: _____
Date started: ____ / ____ / ____
Dose: _____
Unit: mg ml IU
of times a day: _____ Route: _____

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INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Vaccinated for meningococcal: Yes No Unknown

Date vaccinated: ____ / ____ / ____
Lot #: _____
Vaccine type: _____
Manufacturer: _____

Number of vaccinations: _____

CONTACTS

Number of people living in case's household: _____

Additional close contacts of the case: Yes No Unknown

Close contacts of the case

Table with columns: Name, DOB, Gender, Address/Phone, Relationship to case, List symptoms, Symptom onset date, Is contact a case? Includes post-exposure prophylaxis given? section.

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: ____-____-____
Relationship to case		List symptoms	Symptom onset date Is contact a case?
<input type="checkbox"/> Spouse	<input type="checkbox"/> Sexual contact		____/____/____ <input type="checkbox"/> Yes
<input type="checkbox"/> Child	<input type="checkbox"/> Family member (non-household)		<input type="checkbox"/> No
<input type="checkbox"/> Sibling	<input type="checkbox"/> Friend/acquaintance		
<input type="checkbox"/> Roommate	<input type="checkbox"/> Contact- work/school/etc		
<input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Unknown/Other		
Post exposure prophylaxis given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
Antibiotic: _____	Date started: ____/____/____	Dose: _____	Unit: _____ # of days: _____ # times/day: _____ Route: _____
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NOTES:
