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: ______
Maiden name: ______ Suffix: ______
Address line: ______
Zip: ______ City: ______
State: ______ County: ______
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name: ______
Facility phone: ( )- - Type: ______

Date of Birth: / / Estimated? ☐ Age: ______
Gender: ☐ Female ☐ Male ☐ Other ______
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name: ______
Parent/Guardian phone: ( )- - Type: ______

EVENT

Onset date: / / Diagnosis date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of death / /
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Event exception ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak name: ______
Exposure setting: ______
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom: ______
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: ______ Country: ______

Healthcare provider information

Last name: ______
First name: ______
Provider type: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name: ______
Address line 1: ______
Address line 2: ______
Zip code: ______ City: ______
State: ______ County: ______
Phone : ( )- - Type: ______

LABORATORY FINDINGS

Laboratory: ______
Date received: / /
Result type: ☐ Preliminary ☐ Final
Accession #:
Specimen source: ______
Test type: ☐ PCR ☐ Gram stain ☐ Culture
Collection date: / /
Result date: / /
Result: ☐ Positive ☐ Negative ☐ No growth
Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y
Organism: ***Neisseria meningitidis***

Laboratory: ______
Date received: / /
Result type: ☐ Preliminary ☐ Final
Accession #:
Specimen source: ______
Test type: ☐ PCR ☐ Gram stain ☐ Culture
Collection date: / /
Result date: / /
Result: ☐ Positive ☐ Negative ☐ No growth
Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y
Organism: ***Neisseria meningitidis***

Laboratory: ______________
Specimen source: ______________
Result: ☐ Positive ☐ Negative ☐ No growth

Date received: ___/___/___
Test type: ☐ PCR ☐ Gram stain ☐ Culture
Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y

Result type: ☐ Preliminary ☐ Final
Collection date: ___/___/___

Accession #:
Result date: ___/___/___
Organism: ***Neisseria meningitidis***

OCCUPATIONS

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

Occupation type: ______________ Job title: ______________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ______________
Date worked from: ___/___/___ Address: ______________
Date worked to: ___/___/___ Zip code: ______________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ______ State: ______ County: ______
Date removed: ___/___/___ Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: ______________ Job title: ______________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ______________
Date worked from: ___/___/___ Address: ______________
Date worked to: ___/___/___ Zip code: ______________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ______ State: ______ County: ______
Date removed: ___/___/___ Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ______________ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): ______
Admission date: ___/___/___ Discharge date: ___/___/___ Days hospitalized: ______
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

Hospital: ______________ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): ______
Admission date: ___/___/___ Discharge date: ___/___/___ Days hospitalized: ______
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

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
chloramphenicol:	☐ Yes	☐ No	☐ Unk
rifampin:	☐ Yes	☐ No	☐ Unk
sulfa:	☐ Yes	☐ No	☐ Unk

Symptoms:
☐ Fever ☐ Rash
☐ Headache ☐ Nausea
☐ Stiff Neck ☐ Vomiting
Other:______________________

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

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

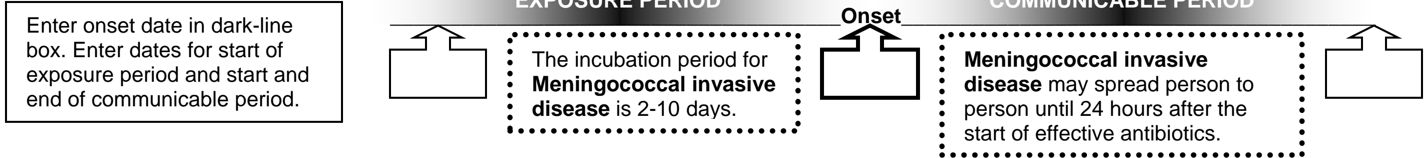
TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic: ____________	Antibiotic: ____________	Antibiotic: ____________
Date started: ___/___/___	Date started: ___/___/___	Date started: ___/___/___
Dose: ____________	Dose: ____________	Dose: ____________
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of times a day: ________ Route: ________	# of times a day: ________ Route: ________	# of times a day: ________ Route: ________

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

In the 10 days prior to onset of symptoms did the Case:

Travel within Iowa? ☐ Yes ☐ No ☐ Unk	City within Iowa: ____________	Departure date: ___/___/___	Return date: ___/___/___
Travel within U.S.? ☐ Yes ☐ No ☐ Unk	State: ______ City: ____________	Departure date: ___/___/___	Return date: ___/___/___
Travel outside U.S.? ☐ Yes ☐ No ☐ Unk	Country: ____________	Departure date: ___/___/___	Return date: ___/___/___

Is the case currently prescribed Soliris (Eculizumab)? ☐ Yes ☐ No ☐ Unk

Sexual Preference: ☐ Heterosexual ☐ Homosexual ☐ Other ☐ Unknown

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: ___/___/___	Date vaccinated: ___/___/___
Lot #: ____________	Lot #: ____________
Vaccine type: ____________	Vaccine type: ____________
Manufacturer:	Manufacturer:

Number of vaccinations: ____

CONTACTS

Number of people living in case's household: _____

Number of people living in case's home age 3 or less: _____

Additional close contacts of the case: ☐ Yes ☐ No ☐ Unknown

Close contacts of the case

Name	DOB	Gender	Address/Phone		
	/ /	☐ Male ☐ Female	________________________	Zip code:	Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	____________________ ____________________	/ /	☐ Yes ☐ No *If this contact is a case create a new event and/or case for this contact.*

Post exposure prophylaxis given? ☐ Yes ☐ No ☐ Unk

Antibiotic:	Date started:	Dose:	Unit:	# of days:	# times/day:	Route:
__________	/ /	______	☐ mg ☐ ml ☐ IU	________	________	__________

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown

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

Name	DOB	Gender	Address/Phone		
	/ /	☐ Male ☐ Female	________________________	Zip code:	Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	____________________ ____________________	/ /	☐ Yes ☐ No *If this contact is a case create a new event and/or case for this contact.*

Post exposure prophylaxis given? ☐ Yes ☐ No ☐ Unk

Antibiotic:	Date started:	Dose:	Unit:	# of days:	# times/day:	Route:
__________	/ /	______	☐ mg ☐ ml ☐ IU	________	________	__________

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown

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

Name	DOB	Gender	Address/Phone		
	/ /	☐ Male ☐ Female	________________________	Zip code:	Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	____________________ ____________________	/ /	☐ Yes ☐ No *If this contact is a case create a new event and/or case for this contact.*

Post exposure prophylaxis given? ☐ Yes ☐ No ☐ Unk

Antibiotic:	Date started:	Dose:	Unit:	# of days:	# times/day:	Route:
__________	/ /	______	☐ mg ☐ ml ☐ IU	________	________	__________

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown

Date vaccinated:	/ /	Date vaccinated:	/ /
Lot #:		Lot #:	
Vaccine type:		Vaccine type:	

	Manufacturer: ________		Manufacturer: ________

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	________ Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	________ ________	/ /	☐ Yes ☐ No *If this contact is a case create a new event and/or case for this contact.*

Post exposure prophylaxis given? ☐ Yes ☐ No ☐ Unk

Antibiotic:	Date started:	Dose:	Unit:	# of days:	# times/day:	Route:
________	/ /	______	☐ mg ☐ ml ☐ IU	______	______	________

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown

Date vaccinated:	/ /	Date vaccinated:	/ /
Lot #:	________	Lot #:	________
Vaccine type:	________	Vaccine type:	________
Manufacturer:	________	Manufacturer:	________

NOTES: