Meningococcal Disease

COUNTY

FOR STATE USE ONLY #

___/___/___ case report

___/___/___ interstate

☐ confirmed ☐ presumptive ☐ suspect

Date / time investigation initiated: ____ /____ /____ _____ :_____ ☐ am ☐ pm

CASE IDENTIFICATION

Name _____ (a.k.a.) Phone(s) _____
LAST, first, initials — indicate home (H); work (W); message (M)

Address _____
Street City County State Zip

_____ e-mail address _____

ALTERNATIVE CONTACT: ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

INITIAL SOURCE OF REPORT

Lab: ☐ ELR ☐ Phone call ☐ Fax ☐ ICP ☐ Physician ☐ _____

Name _____

Phone _____ Date ___/___/___ (first report) m d y

Primary M.D. _____ (if different)

Phone _____ OK to talk to patient? ☐

DEMOGRAPHICS

SEX
☐ female ☐ male

DATE OF BIRTH ___/___/___ m d y

or, if unknown, AGE _____

HISPANIC ☐ yes ☐ no ☐ unknown

RACE
☐ White ☐ American Indian
☐ Black ☐ Asian/Pacific Islander
☐ unknown ☐ refused to answer
☐ other _____

Worksites/school/day care center _____

_____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

ONSET date ___/___/___ m d y

Check all that apply:

bacteremia	☐ yes	☐ **no**	☐ unk
meningitis	☐ **yes**	☐ **no**	☐ unk
pneumonia	☐ yes	☐ **no**	☐ unk
conjunctivitis	☐ yes	☐ **no**	☐ unk

Hospitalized: ☐ **yes** ☐ **no** ☐ unk

if yes, name of hospital _____

date of admission ___/___/___ m d y

date of discharge ___/___/___ m d y

Transferred from another hospital:
☐ **yes** ☐ **no** ☐ unk

transfer hospital name _____

Outcome: ☐ **survived** ☐ **died** ☐ unk

if died, date of death ___/___/___ m d y

LABORATORY DATA

	Culture pos	*Culture* neg	*Gram stain* pos	*Gram stain* neg
CSF	☐	☐	☐	☐
Blood	☐	☐	☐	☐

Date of collection of first positive specimen ___/___/___ m d y

Culture confirmed: ☐ **yes** ☐ **no**

if yes, **Lab** _____

serogroup _____ ☐ **not groupable** ☐ **unknown**

Isolate sent to public health lab? ☐ **yes** ☐ **no**

PHL specimen # _____

RESULTS OF CSF EXAM (if available)

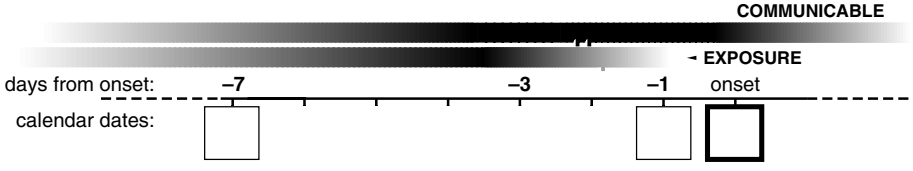
WBC count _____ **sugar** _____

RBC count _____ **protein** _____

% neutrophils _____

INFECTION TIMELINE

Enter onset date in box. Count back to figure probable exposure periods.



Persons are probably most infectious in the days before onset. Because asymptomatic carriage is so common, the exposure period is difficult to define. Infections are usually communicable until 48 h after antibiotic therapy aimed specifically at nasopharyngeal carriage has been started.

PATIENT'S NAME ▸

RISK FACTORS FOR DISEASE

Was the patient a contact of a confirmed or presumptive case in the 60 days before onset? ☐ yes ☐ no

if yes, was prophylaxis recommended? ☐ yes ☐ no

Was patient under 60-day surveillance? ☐ yes ☐ no

Did case have any respiratory disease in the 2 weeks before onset? ☐ yes ☐ no

Is case a smoker? ☐ yes ☐ no

if yes, cigarettes per day _______ (number)

years of smoking _______ (number)

If case is a child, does primary caretaker or person who spends most time with case smoke? ☐ yes ☐ no

Was patient out of the U.S. in the 60 days prior to onset? ☐ yes ☐ no

if yes, was vaccine recommended prior to travel? ☐ yes ☐ no

If yes,patient was a contact, provide relevant details.

Was patient ever immunized against *Neisseria meningitidis*? ☐ yes ☐ no

Did patient have a cochlear implant? ☐ yes ☐ no

If yes, date of implant ____/____/____ (m d y)

CASE-CONTACT MANAGEMENT AND FOLLOW UP

Case education provided? ☐ yes ☐ no ☐ unknown *if yes*, date _____/_____/_____

Was the **case** treated for nasopharyngeal carriage? ☐ yes ☐ no

Was it recommended? ☐ yes ☐ no

Identify persons with ***significant*** exposure in the 7 days prior to onset of symptoms to 24 hours after initiation of treatment. Consider household members, roomates in institutions, daycare contacts, playmates, other children, other patients, medical personnel, EMTs, co-workers as significant contacts.

If EMTs were exposed, was their supervisor notified? ☐ yes ☐ no

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	PROPHYLAXIS Prophylaxis Recommended?
____________________	______	______________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy	☐ yes ☐ no ☐ insignificant exposure ☐ NA If yes, date recommended: ____/____/____ (m d y)
Prophylaxis given: ☐ Yes ☐ No ☐ Refused ☐ Referred to HCP ☐ Unknown		Type of prophylaxis (if avail): ____________				Comments: ____________

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	PROPHYLAXIS Prophylaxis Recommended?
____________________	______	______________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy	☐ yes ☐ no ☐ insignificant exposure ☐ NA If yes, date recommended: ____/____/____ (m d y)
Prophylaxis given: ☐ Yes ☐ No ☐ Refused ☐ Referred to HCP ☐ Unknown		Type of prophylaxis (if avail): ____________				Comments: ____________

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	PROPHYLAXIS Prophylaxis Recommended?
____________________	______	______________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy	☐ yes ☐ no ☐ insignificant exposure ☐ NA If yes, date recommended: ____/____/____ (m d y)
Prophylaxis given: ☐ Yes ☐ No ☐ Refused ☐ Referred to HCP ☐ Unknown		Type of prophylaxis (if avail): ____________				Comments: ____________

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	PROPHYLAXIS Prophylaxis Recommended?
____________________	______	______________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy	☐ yes ☐ no ☐ insignificant exposure ☐ NA If yes, date recommended: ____/____/____ (m d y)
Prophylaxis given: ☐ Yes ☐ No ☐ Refused ☐ Referred to HCP ☐ Unknown		Type of prophylaxis (if avail): ____________				Comments: ____________

Notes:

C

ADMINISTRATION

Remember to copy patient's name to the top of this page.

Date and time case report sent to OHS: ____/____/____ ____ ☐am ☐pm

Completed by ______________________ Date __________ Phone ______________ Investigation sent to OHS on ____/____/____