Meningococcal, invasive disease

Agency: _____

Investigator: _____ Phone number: _____

CASE

Last name: _____ Date of Birth: ___/___/___ Estimated? ☐ Age: _____

First and middle name: _____ Gender: ☐ Female ☐ Male ☐ Other _____

Maiden name: _____ Suffix: _____

Alias: _____

Address line: _____ Does patient speak English: ☐ Yes ☐ No If no, what language? _____

Zip: _____ City: _____ Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ Asian

State: _____ County: _____

Phone: (___)___-____ Type: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Long-term care resident: ☐ Yes ☐ No ☐ Unknown Parent/Guardian name: _____

Corrections facility ☐ Yes ☐ No ☐ Unknown

Homeless ☐ Yes ☐ No ☐ Unknown Parent/Guardian Phone: (___)___-____ Type: _____

Facility name: _____ Is patient aware of diagnosis: ☐ Yes ☐ No ☐ Unknown

EVENT

Diagnosis date: ___/___/___ Onset date: ___/___/___

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown

Outbreak related: ☐ Yes ☐ No ☐ Unknown

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 title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA

Facility name: _____

Address line 1: _____

Address line 2: _____

Zip code: _____ City: _____

State: _____ County: _____

Phone : (___)___-____ Type: _____

LABORATORY FINDINGS

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***

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***

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 or teach 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 in lab or health care setting: ☐ 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 or teach 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 in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Attending a college or university: ☐ Yes ☐ No ☐ Unk College/University name: Student status: ☐ Active ☐ Inactive

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

Attend childcare: ☐ Yes ☐ No ☐ Unk Childcare name and location:

HOSPITALIZATIONS

Was the case hospitalized at least overnight for this illness? ☐ Yes ☐ No ☐ Unknown

Hospital: Admission date: / / Discharge date: / /

Days hospitalized:

CLINICAL INFO & DIAGNOSIS

Symptoms: ☐ Headache ☐ Fever ☐ Stiff neck ☐ Rash ☐ Photophobia ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Sore throat ☐ Other:

Purpura fulminans present: ☐ Yes ☐ No ☐ Unk

Infection type:

☐ Bacteremia ☐ Meningitis

☐ Epiglottitis ☐ Peritonitis

☐ Pericarditis ☐ Pneumonia

Other infection type (specify):

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

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 cell count:	Unit: ☐ cells/mm3 ☐ cells/mL

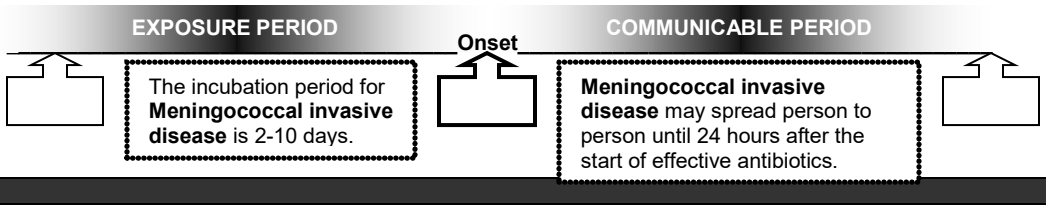
TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

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

Travel Information – *In the 10 days prior to onset of symptoms did the case:*

Travel				
Travel within Iowa? ☐ Yes ☐ No ☐ Unk	City in 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 a complement inhibitor such as eculizumab (Soliris)? ☐ **Yes** ☐ **No** ☐ **Unk**

Does the case have sex with males, females, or both: ☐ Males ☐ Females ☐ Both ☐ Unknown

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown

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

Number of vaccinations: ____

Reason not vaccinated (check only one):
☐ Religious exemption
☐ Medical contraindication
☐ Previous disease confirmed by culture or MD
☐ Parent refusal
☐ Age less than 11 years
☐ Unknown
☐ Other _____

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?**

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

PROPHYLAXIS

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown **Antibiotics:** ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /	Date vaccinated: / /	Antibiotic:			
Lot #:	Lot #:	Date started:			
Vaccine type:	Vaccine type:	Dose:	☐ mg ☐ ml ☐ IU		
Manufacturer:	Manufacturer:	# of times a day:	Number of days:	Route:	

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 ☐ Unknown/Other:	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Childcare attendee		/ /	☐ Yes ☐ No *If this contact is a case create a new event and/or case for this contact.*

PROPHYLAXIS

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown **Antibiotics:** ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /	Date vaccinated: / /	Antibiotic:			
Lot #:	Lot #:	Date started:			
Vaccine type:	Vaccine type:	Dose:	☐ mg ☐ ml ☐ IU		
Manufacturer:	Manufacturer:	# of times a day:	Number of days:	Route:	

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 ☐ Unknown/Other:	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Childcare attendee		/ /	☐ Yes ☐ No *If this contact is a case create a new event and/or case for this contact.*

PROPHYLAXIS

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown **Antibiotics:** ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /	Date vaccinated: / /	Antibiotic:			
Lot #:	Lot #:	Date started:			
Vaccine type:	Vaccine type:	Dose:	☐ mg ☐ ml ☐ IU		
Manufacturer:	Manufacturer:	# of times a day:	Number of days:	Route:	

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 ☐ Unknown/Other:	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Childcare attendee		/ /	☐ Yes ☐ No *If this contact is a case create a new event and/or case for this contact.*

PROPHYLAXIS

Vaccinated for meningococcal: ☐ Yes ☐ No ☐ Unknown

Antibiotics: ☐ Yes ☐ No ☐ Unknown

Date vaccinated:	/ /	Date vaccinated:	/ /	Antibiotic:	
Lot #:		Lot #:		Date started:	
Vaccine type:		Vaccine type:		Dose:	☐ mg ☐ ml ☐ IU
Manufacturer:		Manufacturer:		# of times a day:	Number of days: Route:

NOTES: