

MENINGOCOCCAL DISEASE CASE REPORT

Patient name—last		first	middle initial	Date of birth	Age	Sex
Address—number, street			City	State	County	ZIP code
Telephone number Home () Work ()				Occupation		
RACE (check one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other: _____				ETHNICITY (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
If Asian/Pacific Islander, please check one: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____						

PRESENT ILLNESS

Onset date	Attending physician				Telephone number ()
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Admit date	Discharge date	Hospital name	Medical record number	Telephone number ()

SYMPTOMS/SIGNS

	Yes	No	Unk		Yes	No	Unk
Date history obtained: _____							
Fever ≥ 38°C/100.4 °F (highest recorded: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Altered consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maculopapular rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Petechial rash (distribution: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Purpuric rash (distribution: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other relevant symptoms (list): _____				Clinical purpura fulminans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYNDROME

	Yes	No	Unk		Yes	No	Unk
Pneumonia/ARDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ICU admission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis/meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intubated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Septic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were antibiotics taken prior to collection of blood for microbial testing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sepsis/multi-organ failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were antibiotics taken prior to collection of CSF for microbial testing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disseminated intravascular coagulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date antibiotics started: _____			
Prior medical history:				Antibiotic/s prescribed: _____			
				Died (if yes, date: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LABORATORY TESTING FOR *N. meningitidis*

	Pos	Neg	Unk	Not Done		Pos	Neg	Unk	Not Done
Blood culture (date collected: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood PCR (date collected: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSF gram stain (for gram negative diplococci)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CSF PCR (date collected: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSF antigen test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other PCR (specimen= _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSF culture (date collected: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(date collected: _____)				
Other culture (specimen= _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
(date collected: _____)									
Was specimen(s) or isolate(s) submitted to MDL for additional testing	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____								
MDL Accession # _____	Was PFGE performed? Yes <input type="checkbox"/> No <input type="checkbox"/>								
	PFGE pattern # _____								

Please submit copies of supporting lab reports and antimicrobial susceptibility patterns (if done) with Case Report Form

SEROGROUP IDENTIFICATION (Choose one)

A B C Y W135 Not Groupable Other: _____
 Not done Unknown Pending

EXPOSURES	Yes	No	Unk		Yes	No	Unk
Day care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is patient known MSM?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kindergarten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Military	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grades 1–5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did patient reside in a dormitory while ill?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grades 6–8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did patient reside in another congregate setting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did travel while infectious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
College	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did patient fly while infectious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes to any , describe: _____							

SOURCE CASE INFORMATION

Was this case part of a recognized cluster or outbreak? Yes No Unk
 If yes, please list the name(s) of other associated case(s): _____
 Notes: _____

VACCINE INFORMATION

Had patient received meningococcal vaccine prior to symptom onset? Yes No Unk
 Was the vaccine: Menomune – polysaccharide
 Menactra – conjugate (licensed 1/2005)
 Menveo – conjugate (licensed 2/2010)
 Date of vaccination: _____ Lot #: _____ *Please attach vaccination records to case report form*

CONTACTS/CHEMOPROPHYLAXIS

Were household contacts or other close contacts of this case provided chemoprophylaxis? Yes No Unk
 If yes, how many: _____ What antibiotic was used: _____
 Was vaccine offered to any close contacts? Yes No
 Was prophylaxis offered in any large settings? Yes No If yes, describe: _____

REMARKS

MENINGOCOCCAL DISEASE CASE DEFINITION

CDC. Prevention and Control of Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2013; 62(RR027) at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm>

Case Classification (<http://www.cdc.gov/NNDSS/script/casedef.aspx?CondYrID=774&DatePub=1/1/2010 12:00:00 AM>)

- Suspect: 1) Clinical purpura fulminans in the absence of a positive blood culture **OR**
 2) Gram negative diplococci from a normally sterile body site (e.g., blood or CSF)
- Probable: 1) Detection of *N. meningitidis*-specific nucleic acid in a specimen obtained from a normally sterile body site (e.g., blood or CSF), using a validated polymerase chain reaction (PCR) assay, **OR**
 2) Evidence of *N. meningitidis* antigen by immunohistochemistry (IHC) on formalin-fixed tissue or latex agglutination of CSF*
- Confirmed: 1) Isolation of *Neisseria meningitidis* from a normally sterile body site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, synovial, pleural, or pericardial fluid) or from purpuric lesions

*Positive antigen test results from urine or serum samples are unreliable for diagnosing meningococcal disease.

Investigator name (print)	Date	Telephone number
Agency name		()