Local Use Only

Meningococcal Disease Surveillance Worksheet (Expanded Worksheet Option)

Appendix 9

NAME (Last, First)				Hospital Record No.
Address (Street and No.)	City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/LabPhone	Address			Phone

DETACH HERE and transmit only lower portion if sent to CDC

DEMOGRAPHIC INFORMATION

1. Patient Date of Birth ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

2. Reported Age: ☐☐☐
☐ YEARS ☐ DAYS
☐ HOURS ☐ MONTHS
☐ WEEKS ☐ UNKNOWN

3. Sex ☐ MALE ☐ FEMALE ☐ UNKNOWN

4. Ethnicity ☐ HISPANIC ☐ NOT HISPANIC ☐ UNKNOWN

5. Race:
☐ American Indian or Alaska Native ☐ White
☐ Asian ☐ Other _____
☐ Black or African-American ☐ Unknown
☐ Native Hawaiian or Other Pacific Islander

6. Identification Information as of ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

Type _____ Assigning Authority _____

ID Value _____

INVESTIGATION

INVESTIGATION SUMMARY

7. Jurisdiction: _____

8. Program Area (state assigned): _____

9. State class ID number: _____

10. Investigation start date ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

11. Investigation status ☐ Open ☐ Closed

12. Share record with guests of this jurisdiction and program area? ☐ Yes ☐ No

INVESTIGATOR

13. Last Name: _____

14. First Name: _____

15. E-mail: _____

16. Investigation status ☐☐☐ ☐☐☐ ☐☐☐☐

17. Date assigned to investigation ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

18. Type of insurance

☐ MEDICARE
☐ INDIAN HEALTH SERVICE (IHS)
☐ NO HEALTHCARE COVERAGE
☐ MILITARY/ VA
☐ PRIVATE/ HMO/PPO/MANAGED CARE PLAN
☐ UNKNOWN
☐ MEDICAID/ STATE ASSISTANCE PROGRAM
☐ OTHER (SPECIFY) _____

19a. WEIGHT

_____lbs _____oz OR _____ kg ☐ unknown

19b. HEIGHT

_____Ft _____in OR _____ cm ☐ unknown

REPORTING SOURCE

20. Date of report ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

21. Source name: _____

22. City: _____

23. State: _____ Zip +4_____

24. County: _____

EARLIEST DATE REPORTED TO:

25. County: ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

26. State: ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

REPORTER

27. Last name: _____

28. First name: _____

29. Person ID: _____

30. E-mail: _____

31. Telephone: ☐☐☐ ☐☐☐ ☐☐☐☐

Extension: ☐☐☐☐

CLINICAL

PHYSICIAN

32. Last name: _____ **33. First name:** _____

34. E-mail: _____ **35. Telephone:** ☐☐☐ ☐☐☐ ☐☐☐☐ **Extension:** ☐☐☐☐

HOSPITAL

36. Was the patient hospitalized for this illness?

☐ Yes ☐ No ☐ UNKNOWN

37. Hospital name: _____

38. Hospital ID: _____

39. Hospital ID Type: _____

40. Admission Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

41. Discharge Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

42.Total duration of stay within hospital: ☐☐☐ Days

43a. Hospital/lab iD where culture identified: ☐☐☐☐☐

43b. Hospital iD where patient treated: ☐☐☐☐☐

44a. Was patient transferred from another hospital?

☐ Yes ☐ No ☐ Unknown

44b. If Yes, hospital iD ☐☐☐☐☐

45. Illness Onset Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

46. Illness End Date: ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

47. Types of infection caused by organism (CHECK ALL THAT APPLY)

- ☐ Bacteremia without focus
- ☐ Abscess (not skin)
- ☐ Empyema
- ☐ Meningitis
- ☐ Peritonitis
- ☐ Endocarditis
- ☐ Otitis media
- ☐ Pericarditis
- ☐ Endometritis
- ☐ Pneumonia
- ☐ Septic abortion
- ☐ STSS
- ☐ Cellulitis
- ☐ Chorioamnionitis
- ☐ Necrotizing fasciitis
- ☐ Epiglotitis
- ☐ Septic arthritis
- ☐ Puerperal sepsis
- ☐ Hemolytic uremic syndrome (HUS)
- ☐ Osteomyelitis
- ☐ Other infection _____

48a. Bacterial species isolated from any normally sterile site (CHECK ALL THAT APPLY)

- ☐ *Neisseria meningitidis*
- ☐ Abscess (not skin)
- ☐ *Haemophilus influenzae*
- ☐ Group A streptococcus
- ☐ Group B streptococcus
- ☐ *Streptococcus pneumoniae*

48b. Other bacterial species isolated from any normally sterile site

_____

_____

_____

49. Sterile sites from which organism isolated: (CHECK ALL THAT APPLY)

- ☐ Blood
- ☐ Peritoneal fluid
- ☐ Bone
- ☐ CSF
- ☐ Pericardial fluid
- ☐ Muscle
- ☐ Pleural fluid
- ☐ Joint

Specify

- ☐ Internal body site _____
- ☐ Other normally sterile site _____

50. Date first positive culture obtained: (date specimen drawn)

☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

51. Other nonsterile sites from which organism isolated: (CHECK ALL THAT APPLY)

- ☐ Placenta
- ☐ Middle ear
- ☐ Amniotic fluid
- ☐ Sinus
- ☐ Wound
- ☐ Other nonsterile site _____

52. Underlying causes or prior illness: (CHECK ALL THAT APPLY)

- ☐ Current smoker
- ☐ Hodgkin disease
- ☐ HIV infection
- ☐ Heart failure / CHF
- ☐ Multiple myeloma
- ☐ Asthma
- ☐ AIDS or CD4 count <200
- ☐ Obesity
- ☐ Sickle cell anemia
- ☐ Emphysema / COPD
- ☐ Cochlear implant
- ☐ CSF leak
- ☐ Splenectomy / asplenia
- ☐ Systemic lupus erythematosus (SLE)
- ☐ Deaf / profound hearing loss
- ☐ IVDU
- ☐ Immunoglobulin deficiency
- ☐ Diabetes mellitus
- ☐ Cirrhosis / Liver failure
- ☐ Cerebral vascular accident (CVA) / Stroke
- ☐ Immunosupressive therapy (Steroids, Chemotherapy, Radiation)
- ☐ Nephrotic syndrome
- ☐ Alcohol Abuse
- ☐ Complement deficiency
- ☐ Leukemia
- ☐ Renal failure/Dialysis
- ☐ Atherosclerotic Cardiovascular Disease (ASCVD) / (CAD)

Specify

- ☐ Other malignancy _____
- ☐ Organ transplant _____
- ☐ Other prior illness _____

53. Was patient pregnant / post partum at time of first positive culture? ☐ Yes ☐ No ☐ Unknown

If yes, outcome of fetus

- ☐ Survived, no apparent illness
- ☐ Live birth / neonatal death
- ☐ Induced abortion
- ☐ Survived, clinical infection
- ☐ Abortion / stillbirth
- ☐ Unknown

54. Is the patient <1 month of age? ☐ Yes ☐ No ☐ Unknown If yes, time of birth: _____:_____

Gestational age: ☐☐ (wks) Birth weight: ☐☐☐☐ (gms)

55. Did the patient die from this illness? ☐ Yes ☐ No

56. What was the serogroup?

1 ☐ A 3 ☐ C 5 ☐ W135 9 ☐ Unknown

2 ☐ B 4 ☐ Y 6 ☐ Not groupable 8 ☐ Other (Specify)_____

58. Is patient currently attending college (15-24 years only)**?**

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Year of School: _____ Full-time or Part-time:

☐ Full-time ☐ Part-time

Name of College/University:_____

Housing:_____ Other Housing:_____

59. Did the patient ever receive a meningococcal (conjugate or polysaccharide) vaccine?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

57. How was the case identified?

Specify IHC Specimen 1: BMD309_____

Specify IHC Specimen 2: BMD310_____

Specify IHC Specimen 3: BMD311_____

Specify PCR Source: BMD308_____

Other Sterile Site: BMD162_____

Other Identification Method: BMD163_____

If case identified by non-culture method, date sample collected for diagnostic testing: BMD307____/____/____ mm/dd/yy

Is this a secondary case? BMD271_____

Specify Type: BMD272_____

Specify Other: BMD273_____

If *N. meningitidis* was isolated from blood or CSF, was it resitstent to:

Sulfa (58) 1 ☐ Yes 2 ☐ No 9 ☐ Not tested or unknown

Rifampin (59) 1 ☐ Yes 2 ☐ No 9 ☐ Not tested or unknown

VACCINATION RECORD

Vaccine	Administered (mm/dd/yyyy)	Given by: Last Name /First Name Provider ID	Organization Name / ID	Lot Number	Expiration Date (mm/dd/yyyy)
Menomune, tetravalent meningococcal polysaccharide vaccine					
Menactra, tetravalent meningococcal conjugate vaccine					
Other (specify)_____					
Not Known					

EPIDEMIOLOGIC

60. Does this patient: (CHECK ALL THAT APPLY)

Attend a day care* facility ☐ Yes ☐ No ☐ Unknown **Facility name** _____

*DAY CARE IS DEFINED AS A SUPERVISED GROUP OF 2 OR MORE UNRELATED CHILDREN FOR >4 HOURS PER WEEK.

Reside in a long term care facility? ☐ Yes ☐ No ☐ Unknown **Facility name** _____

61. Is this case part of an outbreak? ☐ Yes ☐ No ☐ Unknown **Outbreak name** _____

Where was this disease acquired? _____

Imported Country: _____ Imported City: _____

Imported State: _____ Imported County: _____

CONFIRMATION METHOD

62. Case status:

☐ Confirmed ☐ Not a case

☐ Probable ☐ Unknown

☐ Suspect

63. Does this patient have recurrent disease with the same pathogen?

☐ Yes ☐ No ☐ Unknown

If yes, previous (1st) state I.D. ☐☐☐☐☐☐☐

64. CRF Status:

☐ Complete ☐ Chart unavailable after 3 requests

☐ Incomplete

☐ Edited & Correct

General Comments: _____