West Virginia Bureau for Public Health — Your Health Your Safety Our Purpose
Department of Health & Human Resources

Neisseria Meningitidis

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade:_____ Employer/School:_____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:*_____ *Phone:* _____

Birth date: __ / __ / ____ Age: _____
Gender: ☐Male ☐Female ☐Unk

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unk

REPORTING SOURCE

Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐Other
Report Source Name: _____ Address: _____ _____ Phone: _____
Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____
Reporter Name: _____ ____ Address: _____ Phone: _____

CLINICAL

Physician Name: _____ Physician Facility : _____
Physician Address: _____ Phone: _____

Hospital Y N U
☐ ☐ ☐ Hospitalized for this illness? If yes: Hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Condition Illness onset date: __ / __ / ____ Diagnosis date: __ / __ / ____ Illness end date: __ / __ / ____

Types of infection caused by organism:

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

Date first positive culture obtained: __/__/____

Sterile sites from which organism was isolated: ☐ Blood ☐ Bone ☐ Cerebral Spinal Fluid ☐ Internal body site ☐ Joint ☐ Muscle ☐ Pericardial Fluid ☐ Peritoneal Fluid ☐ Pleural Fluid ☐ Other normally sterile site (specify) _____
Nonsterile sites from which organism isolated:☐Amniotic fluid ☐Middle ear ☐Placenta ☐Sinus ☐Wound ☐Other (specify) _____

Did patient have any underlying medical conditions? ☐ **Y** ☐ **N** ☐ **U** If yes, specify:

☐ AIDS	☐ Alcohol abuse	☐ Asthma
☐ Atherosclerotic Cardiovascular Disease	☐ Burns	☐ Cerebral vascular accident (CVA)/Stroke
☐ Cirrhosis/liver failure	☐ Cochlear implant	☐ Complement deficiency
☐ CSF leak (2 deg trauma/surgery)	☐ Current smoker	☐ Deaf/profound hearing loss
☐ Diabetes mellitus	☐ Emphysema/COPD	☐ Heart failure/CHF
☐ HIV	☐ Hodgkin's disease	☐ Immunoglobulin deficiency
☐ Immunosuppressive therapy (steroids, chemo)	☐ IVDU	☐ Leukemia
☐ Multiple myeloma	☐ Nephrotic syndrome	☐ Obesity
☐ Renal failure/dialysis	☐ Sickle cell anemia	☐ Splenectomy/Asplenia
☐ Systemic lupus erythematosus (SLE)	☐ Unknown	☐ Other prior illness (specify)_____
☐ Other malignancy (specify) _____	☐ Organ transplant (specify)_____	

Did patient die from this illness? ☐ **Y** ☐ **N** ☐ **U** If yes, date of death: __/__/____

Condition (cont.)

What was the serogroup? ☐ A ☐ B ☐ C ☐ W135 ☐ Y ☐ Not groupable ☐ Unknown ☐ Other (specify) ___________________

Is this a secondary case? ☐ **Y** ☐ **N** ☐**U** If yes, specify type: ☐ Daycare center contact ☐ Family contact ☐ Hospital acquired ☐ Laboratory acquired ☐ Other (specify) ____________________

How was the case identified?

☐ Clinical purpura fulminans
☐ Gram negative diplococcic (sterile site)
☐ Isolation of N meningitidis from blood
☐ Isolation of N meningitidis from CSF
☐ Positive meningococcal antigen test (CSF)
☐ Other (specify) ____________________
☐ Culture from other sterile site (specify) ___________________________________
☐ N meningitidis antigen by IHC (specify)
IHC Specimen 1:_____________________
IHC Specimen 2:_____________________
☐ N meningitidis DNA by PCR (specify source): ☐ Blood ☐ CSF ☐ Other site

If *N. meningitidis* was isolated from blood or CSF, was it resistant to: Sulfa: ☐ **Y** ☐ **N** ☐ **U** Rifampin: ☐ **Y** ☐ **N** ☐ **U**

Is patient currently attending college? (15-24 year olds only) ☐ **Y** ☐ **N** ☐ **U**

If yes: Name of college: ________________________________ Address: ____

Year in school: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate student ☐ Unknown

Full/part-time: ☐ Full-time ☐ Part-time ☐ Unknown

Housing type: ☐ Apartment/Dorm ☐ Dormitory ☐ Communal living (college house) ☐ Other (specify) _______________ ☐ Single family home with family ☐ Single family home with students ☐ Unknown

VACCINE INFORMATION

☐ **Y** ☐ **N** ☐ **U** Has patient received the polysaccharide meningococcal vaccine? If yes, enter dosage in Vaccination Record

☐ **Y** ☐ **N** ☐ **U** Has patient received the conjugate meningococcal vaccine? If yes, enter dosage in Vaccination Record

VACCINATION RECORD

Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ _ Organization Name: _____________________________________ Organization ID: _________________
Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ _ Organization Name: _____________________________________ Organization ID: _________________
Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ _ Organization Name: _____________________________________ Organization ID: _________________

EPIDEMIOLOGIC

☐ **Y** ☐ **N** ☐ **U** If <6 years of age, is the patient in daycare? If yes, name of day care facility: ______________________________

☐ **Y** ☐ **N** ☐ **U** Was the patient a resident of a nursing home or other chronic care facility at time of first positive culture? If yes, name of chronic care facility: ____________________________

☐ **Y** ☐ **N** ☐ **U** Is this case part of an outbreak? If yes, name of outbreak? _____________________________________

Where was the disease acquired?

☐ Indigenous, within jurisdiction ☐ Out of country ☐ Out of jurisdiction, from another jurisdiction ☐ Out of state ☐ Unknown

Confirmation method:

☐ Active surveillance ☐ Case/Outbreak management ☐ Clinical diagnosis (not lab confirmed) ☐ Epidemiologically linked
☐ Lab confirmed ☐ Lab report ☐ Local/State specified ☐ Medical record review
☐ No information given ☐ Occupational disease surveillance ☐ Provider certified ☐ Other (specify): ______________________

Was patient pregnant or post-partum at time of first culture? ☐ **Y** ☐ **N** ☐ **U**

If yes, outcome of fetus: ☐ Survived, no apparent illness ☐ Survived, clinical infection ☐ Live birth, neonatal death ☐ Abortion or stillbirth ☐ Induced abortion ☐ Unknown

If patient < 1 month of age: Gestational age (in weeks)_____ Birth weight (in grams)_____

PUBLIC HEALTH ACTIONS/NOTES

Y N U ☐ Lost to follow-up

☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian
If yes, date: __/__/____

Y=Yes N=No U=Unknown

Contact Tracing Sheet									
Name/Contact Information (including guardian information for minors)	Household Contact (Y/N)	Age	Relationship to case?	Exposure date (mm/dd/yyyy)	Exposure setting	Exposure Mode	PEP given? (Y/N)	Date PEP given (mm/dd/yyyy)	PEP given by whom?

* PEP = Post-exposure prophylaxis

Number of contacts in any setting recommended PEP: _____