THIS FORM SHOULD BE USED FOR CASE INVESTIGATION PURPOSES ONLY AND DOES NOT REPLACE THE MENINGITIS CASE REPORT FORM.

SUSPECT INVASIVE MENINGOCOCCAL DISEASE INTAKE FORM

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF EPIDEMIOLOGY AND IMMUNIZATION (617) 983-6800

Person Completing the Form: _____ **Date/Time:**_____

Name of Person Reporting: _____ **Phone:** _____

Affiliation of Person Reporting: _____

Case Information

Suspect case: _____ **(date)**
Confirmed case: _____ **(date)**

General Onset Date: _____
(for symptom-specific onset date, see page 3)

Name	Date of birth/age	Sex	Race
Address	City		
Parents' names (if applicable)	Phone number ( )		
OCCUPATION (if student, specify grade or daycare)	Name and Address of Place of Employment/School/Daycare		
Contact name and phone for place of employment/school/daycare	Medical Record Number		
Was Local Board of Health Notified? Y N BOH Contact Name and Phone Number:			

Hospital Information

Was the case hospitalized? If yes, please complete the following hospital information. **Y** **N**

Hospital #1		Hospital #2 (if patient was transferred for intensive care)	
Hospital Name		Hospital Name	
Hospital Phone Number ( )		Hospital Phone Number ( )	
Date Admitted	Date Discharged	Date Admitted	Date Discharged
Physician's Name / Phone Number		Physician's Name / Phone Number	
Hospital Infection Control Contact Name / Phone Number		Hospital Infection Control Contact Name / Phone Number	
Has Infection Control been notified? Y N		Has Infection Control been notified? Y N	
Lab Contact Name / Phone Number		Lab Contact Name / Phone Number	

Laboratory Diagnosis

NOTE: A positive culture from a non-sterile site (sputum, urine) is not considered invasive disease and follow-up is not necessary. If the practitioner has a high level of suspicion for invasive meningococcal disease, he or she should be encouraged to collect appropriate clinical specimens (i.e., blood, CSF).

If a positive culture was obtained from a sterile site (blood, CSF, synovial fluid, bronchial or pleural fluid, or a petechial scraping), or a presumptive diagnosis was made based on clinical presentation, follow-up is necessary. Continue to complete this intake form.

CSF Analysis: Hospital (circle) #1 #2 Contact:

Date sample collected:	**Appearance of CSF: (Circle)** **Clear Cloudy Bloody***	**Gram stain: Gram Pos Gram Neg** **Diplococci: Y N No orgs seen**

Culture Results: (Circle)

_____ **hours**	**No Growth**	**Presumptive *N. meningitidis***	**Confirmed *N. meningitidis***
_____ **hours**	**No Growth**	**Presumptive *N. meningitidis***	**Confirmed *N. meningitidis***
_____ **hours**	**No Growth**	**Presumptive *N. meningitidis***	**Confirmed *N. meningitidis***

Glucose: **Normal Range:**	**Serum glucose:**	**Protein:**** **Normal range:**	**Total serum protein:**	**RBC:***

Bacterial Antigen Screen: Pos Neg Group _____	**WBC (total) :** % **Polys*** % Lymphs*** % Monos**

*Blood in CSF may be an indication of a poorly performed spinal tap and test results should be carefully evaluated.
**High protein levels and low glucose levels are indicative of bacterial meningitis.
***In CSF, a high percentage of polys generally indicates a bacterial infection; whereas, a high percentage of lymphs generally indicates a viral infection.

Blood or other sterile fluid: Hospital (circle) #1 #2 Contact:

Date sample collected:	**Type of specimen: Blood** **Other (synovial fluid, bronchial/pleural fluid):** _____	**Gram stain: Gram Pos Gram Neg** **Diplococci: Y N Unknown**

Culture Results: (Circle)

_____ **hours**	**No Growth**	**Presumptive *N. meningitidis***	**Confirmed *N. meningitidis***
_____ **hours**	**No Growth**	**Presumptive *N. meningitidis***	**Confirmed *N. meningitidis***
_____ **hours**	**No Growth**	**Presumptive *N. meningitidis***	**Confirmed *N. meningitidis***

Bacterial Antigen Screen: **Pos Neg Group** _____	**Other Tests (specify):**

NOTES:_____

_____

_____

_____

_____

REMINDER: Please request submission of the isolate to the SLI for serogrouping.

Date isolate requested: _____ **Date isolate typed:** _____

Clinical Manifestations

Diagnosis: (Circle) **Meningococcemia** **Meningitis** **Pneumonia** **Other** _____

Treatment initiated? **Date:** _____/_____/_____ **Medication type:** _____

Patient status: (Circle) **Alive** **Deceased**

Sign/Symptom	Onset Date	Other Symptoms	Onset Date
Fever (Specify highest temp.)			
Stiff Neck **Yes No Unknown**			
Headache **Yes No Unknown**			
Rash (describe including body location, i.e., petechial, lower limbs)			
Disseminated Intravascular Coagulation **Yes No**			

NOTES:_____

Control Measures and Evaluation of Close Contacts

Control measures are implemented through the administration of prophylactic antibiotics to individuals who have been in "close contact" (see definition below) with a case during the **2 weeks** prior to symptoms onset. Antibiotics should be initiated as soon as possible after exposure (**up to two weeks after exposure**). Contacts of a case should consult their health care provider for evaluation and prophylaxis options.

How to Define a "Close Contact"
"Close contacts" include **household members** and individuals who have had intimate contact with the case's oral secretions through kissing or sharing eating or drinking utensils, water bottles, cigarettes, food or drink. Also consider shared office space, car pools, or other shared, enclosed spaces because of potential spread by coughing, sneezing, etc.
Medical personnel: prophylaxis is not routinely recommended for medical personnel attending a case except for those who have had intimate exposure to the case (mouth-to-mouth resuscitation, intubation, or suctioning) prior to or 24 hours after the initiation of antibiotic prophylaxis.

Symptom onset date: _____/_____/_____

Prophylaxis necessary for close contacts starting (date): _____/_____/_____
(two weeks prior)

When attempting to identify close contacts to the case the following categories of individuals should be evaluated:

***(PEP): Please indicate the number of close contacts for whom post-exposure prophylaxis was recommended.**

Children	**PEP***		**PEP***
Household members		Friends	
Day Care		Parties	
School		Visitors	
After-School Programs		Baby-sitters	
Sports Teams		Relatives	
Clubs/Organizations (i.e., girl scouts, boy scouts)			
Adults	**PEP***		**PEP***
Household members		Clubs/Organizations	
Spouse/Partner		Parties	
Close friends		Friends	
Work place (shared office)		Relatives	
Sports Teams		Car Pool	
Health care workers (including dentist/orthodontist)	**PEP***		**PEP***

If the case attends college, collect the following information:

Year in college: Freshman Sophomore Junior Senior Graduate

Full or Part-Time Student: Full-time Part-Time Unknown

Housing: **Dormitory** **Apartment** **Single-family house with family** **Single-family house with students**
Other (specify):

Vaccination: Has the case received meningococcal vaccine? Y N U
If yes: Name of vaccine and date administered: _____ / /

SURVEILLANCE FOR SECONDARY CASES SHOULD CONTINUE.

NOTES: