

CASE REPORT FORM

Meningococcal Disease

Meningococcal disease _____	EpiSurv No. EpiSurvNumber _____
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Reporting Authority

Name of Public Health Officer responsible for case **OfficerName** _____

Notifier Identification

Reporting source* **ReportSrc** General Practitioner Hospital-based Practitioner Laboratory
 Self-notification Outbreak Investigation Other

Name of reporting source **ReportName** _____ **Organisation** **ReportOrganisation** _____

Date reported* **ReportDate** _____ **Contact phone** **ReportPhone** _____

Usual GP **UsualGP** _____ **Practice** **GPPracticeName** _____ **GP phone** **GPPhone** _____

GP/Practice address Number **houzenumber** Street **streetname** Suburb **suburb**
Town/City **towncity** Post Code **postcode** GeoCode **geocode** **addressmatchaccuracy**

Case Identification

Name of case* Surname **Surname** _____ Given Name(s) **GivenName** _____

NHI number* **NHINumber** _____ **Email** **Email** _____

Current address* Number **houzenumber** Street **streetname** Suburb **suburb**
Town/City **towncity** Post Code **postcode** GeoCode **geocode** **addressmatchaccuracy**

Phone (home) **PhoneHome** _____ **Phone (work)** **PhoneWork** _____ **Phone (other)** **PhoneOther** _____

Case Demography

Location **TA*** **TA** _____ **DHB*** **DHB** _____

Date of birth* **DateOfBirth** _____ **OR** **Age** **Age** _____ Days Months Years **AgeUnits**

Sex* **Sex** Male Female Indeterminate Unknown

Occupation* **Occupation** _____

Occupation location **occupation_place_type** Place of Work School Pre-school

Name **occupation_place_name** _____

Address Number **houzenumber** Street **streetname** Suburb **suburb**
Town/City **towncity** Post Code **postcode** GeoCode **geocode** **addressmatchaccuracy**

Alternative location **occupation_place_type** Place of Work School Pre-school

Name **occupation_place_name** _____

Address Number **houzenumber** Street **streetname** Suburb **suburb**
Town/City **towncity** Post Code **postcode** GeoCode **geocode** **addressmatchaccuracy**

Ethnic group case belongs to* (tick all that apply)

NZ European **EthNZEuroean** Maori **EthMaori** Samoan **EthSamoa** Cook Island Maori **EthCookIslandMaori**
 Niuean **EthNiuean** Chinese **EthChinese** Indian **EthIndian** Tongan **EthTongan**
 Other (such as Dutch, Japanese, Tokelauan) *(specify) **EthOther** **EthSpecify1** _____ **EthSpecify2** _____

Basis of Diagnosis**CLINICAL CRITERIA**Fits Clinical Description* **FitClinDes** Yes No Unknown

Clinical features

Meningitis* **Meningitis** Yes No Unknown *Septicaemia* **Septicaemia** Yes No UnknownPetechial or purpuric rash* **PretRash** Yes No Unknown **Other invasive illness* (specify)** **OthInvIll** _____**LABORATORY CRITERIA**Isolation of *N.meningitidis* from CSF* **IsolCSF** Yes No Not Done Awaiting ResultsIsolation of *N.meningitidis* from blood* **IsolBlood** Yes No Not Done Awaiting ResultsIsolation of *N.meningitidis* from nasopharynx* **IsolNaso** Yes No Not Done Awaiting ResultsIsolation of *N.meningitidis* from other site* **IsolSite** Yes No Not Done Awaiting Results(specify site*) **IsolSpec** _____Detection of Gram-negative intracellular diplococci* **GramNeg** Yes No Not Done Awaiting Results(specify site*) **GramNegSite** _____Detection of meningococcal antigen in CSF (latex test)* **Latex** Yes No Not Done Awaiting ResultsDetection of *N.meningitidis* DNA by PCR in blood* **PCRBlood** Yes No Not Done Awaiting ResultsDetection of *N.meningitidis* DNA by PCR in CSF* **PCRCSF** Yes No Not Done Awaiting ResultsOther positive test* (specify) **OthPosTest** _____**STATUS*** **Status** Under investigation Probable Confirmed Not a case**ADDITIONAL LABORATORY DETAILS**Group* **Serogroup** A B C Y Not groupable Other (*specify) **SeroGOther** _____Type (Serotype)* **SeroType** _____ **PorA (Subtype)* SubType** _____ESR Updated **AutoUpdated** **Laboratory Laboratory** _____Date result updated **DateResultUpdated** _____ **Sample number** **SampleNumber** _____Other laboratory details* **OthLab** _____**Clinical Course and Outcome**Date of onset* **OnsetDt** _____ Approximate **OnsetDtApprox** Unknown **OnsetDtUnknown**Time of onset* **OnsetTime** _____ Unknown **OnsetTimeUnknown**Hospitalised* **Hosp** Yes No UnknownDate hospitalised* **HospDt** _____ Unknown **HospDtUnknown**Time Hospitalised* **HospTime** _____ Unknown **HospTimeUnknown**Hospital* **HospName** _____Died* **Died** Yes No UnknownDate died* **DiedDt** _____ Unknown **DiedDtUnknown**Was this disease the primary cause of death?* **DiedPrimary** Yes No UnknownIf no, specify the primary cause of death* **DiedOther** _____

Outbreak Details

Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*

 Yes **Outbrk**If yes, specify Outbreak No.* **OutbrkNo** _____**Risk Factors**Contact with a presumptive case of meningococcal disease in 60 days before onset* **ContCase** Yes No UnknownIf yes, was prophylaxis offered?* **ProphOffer** Yes No UnknownIf yes, was prophylaxis taken?* **ProphTake** Yes No UnknownIf yes, specify type of prophylaxis* **ContName** Antibiotic VaccineName of presumptive case* **ContName** _____Nature of contact with presumptive case* **NatuContCase** _____ (see contact management categories below)Attendance at school, preschool or childcare* **AttendSch** Yes No UnknownWas the case overseas during the incubation period (range = 2 - 60 days) for meningococcal disease?* **Overseas** Yes No UnknownOther risk factors for meningococcal disease, specify* **RiskOthSpecify** _____**Protective Factors**At any time prior to onset, had the case been immunised with meningococcal vaccine?* **Immunised** Yes No Unknown

If yes, specify which vaccine*

No. of Doses*

Date of Last Dose*

Source of Information*

 C conjugate **CConjugate****CCNumDoses****DtCCVGiven** Patient/caregiver recall **SceCConjugate** Documented Quadrivalent (A,C,Y,W135) **Quadrivalent****QVNumDoses****DtQuadVGiven** Patient/caregiver recall **SceQuadV** Documented MeNZB (record details below) **MeNZB** Other (*specify) **OthMen****OthMenSpec****OMNumDoses****DtOthMenGiven** Patient/caregiver recall **SceOthMen** Documented

If MeNZB, record each dose and the date given*

First dose MeNZB administered* **Dose1MeNZB** Yes No No documented evidenceDate given* **DtFirstDose** _____ Or age when first dose given **AgeFirstDose** Weeks Months Years **YMWFirstDose**Documented source of information* (tick all that apply) National Immunisation Register (NIR) **Sce1stDNIR** GP record **Sce1stDGP**
 Well-child (Plunket) book **Sce1stDWellChild** MeNZB card **Sce1stDMeNZBCard**Second dose MeNZB administered* **Dose2MeNZB** Yes No No documented evidenceDate given* **DtSecondDose** _____ Or age when second dose given **AgeSecondDose** Weeks Months Years **YMWSecondDose**Documented source of information* (tick all that apply) National Immunisation Register (NIR) **Sce2ndDNIR** GP record **Sce2ndDGP**
 Well-child (Plunket) book **Sce2ndDWellChild** MeNZB card **Sce2ndDMeNZBCard**Third dose MeNZB administered* **Dose3MeNZB** Yes No No documented evidenceDate given* **DtThirdDose** _____ Or age when third dose given **AgeThirdDose** Weeks Months Years **YMWThirdDose**Documented source of information* (tick all that apply) National Immunisation Register (NIR) **Sce3rdDNIR** GP record **Sce3rdDGP**
 Well-child (Plunket) book **Sce3rdDWellChild** MeNZB card **Sce3rdDMeNZBCard**Fourth dose MeNZB administered* **Dose4MeNZB** Yes No No documented evidenceDate given* **DtFourthDose** _____ Or age when fourth dose given **AgeFourthDose** Weeks Months Years **YMWFourthDose**Documented source of information* (tick all that apply) National Immunisation Register (NIR) **Sce4thDNIR** GP record **Sce4thDGP**
 Well-child (Plunket) book **Sce4thDWellChild** MeNZB card **Sce4thDMeNZBCard**

Protective Factors continued

If there is no documented evidence of MeNZB, how many doses does the parent/caregiver or case think they've had? ***NumNonDocDoses** _____

*month/year of last dose _____ **MthLastNonDocDose** / _____ **YrLastNonDocDose**

Management**CASE MANAGEMENT**

Was case seen by a doctor prior to hospital admission? ***SeenDoc** Yes No Unknown

If yes, date seen ***DateSeen** _____

Unknown

Time seen* _____

Unknown

_____ **DateSeenUnknown** **TimeSeen** _____ **TimeSeenUnknown**

Were IV/IM antibiotics given prior to hospital admission? ***AbxGiven** Yes No Unknown

If yes, date given ***DateAbx** _____

Unknown

Time given* _____

Unknown

_____ **DateAbxUnknown** **TimeAbx** _____ **TimeAbxUnknown**

CONTACT MANAGEMENT

Type of contact

Number identified

Number counselled

Number offered antibiotics

Number offered vaccination

Household contacts

_____ **NoHhold**

_____ **NoHholdCou**

_____ **NoHholdAbx**

_____ **NoHholdVac**

Childcare/pre-school contacts

_____ **NoCCare**

_____ **NoCCareCou**

_____ **NoCCareAbx**

_____ **NoCCareVac**

Close institutional contacts

_____ **NoInstute**

_____ **NoInstCou**

_____ **NoInstAbx**

_____ **NoInstVac**

Contacts exposed to oral secretions

_____ **NoExpOral**

_____ **NoExpCou**

_____ **NoExpAbx**

_____ **NoInstVac**

Other close contacts

_____ **NoOthr**

_____ **NoOthrCou**

_____ **NoOthrAbx**

_____ **NoOthrVac**

(specify) **ContOtherSpec** _____

Comments*

Comments