CASE REPORT FORM

Meningococcal Disease

EpiSurv No.

D											
Reporting	Autho	rity									
Name of Pub	lic Healt	h Officer	responsible	for case							
Notifier Id	entific	ation									i
Reporting so	urce*	○ Gene	eral Practition	er	Hospita	-based Practiti	ioner		Laborato	ry	
		O Self-	notification		Outbrea	k Investigatior	n		Other		
Name of repo	orting so	ource				Organisatio	on 📗				
Date reporte	d* dd,	/mm/yyyy	∰ La	boratory samp	le date	dd/mm/yyyy	У	Contact	phone		
Usual GP				Practice				GF	phone		
GP/Practice	address	Number		Street			9	Suburb			
		Town/City						Post Code		GeoCode	
Case Ident	tificati	on									i
Name of case	* Sun	name				Given Name(s)					
NHI number	k		Email								
Current addr	ess* 1	Number		Street				Suburb			
	7	Town/City						Post Code		GeoCode	
Phone (home	e)			Phone (work)			Pho	one (oth	er)		
Case Demo	ograph	ıy									
Location T	A*					DHB*					
Date of birth	* dd	l/mm/yyyy	<u> </u>	OR	Age		Days	0	Months	O Years	
Sex*										O Tears	
		Male	Fem	nale	Indetermir	nate	Unkn			O Tedis	
Occupation*		Male	○ Fem	nale	Indetermin	nate	Unkn				i)
		Male Place		School		-school	Unkn				i
Occupation*							Unkn				i)
Occupation* Occupation lo											i)
Occupation* Occupation lo Name Address	Jumber Town/City	O Place	of Work	School	O Pre	-school		own			i
Occupation* Occupation lo Name Address	Jumber Town/City	O Place	of Work		O Pre			Suburb			i)
Occupation* Occupation lo Name Address	Jumber Town/City	O Place	of Work	School	O Pre	-school		Suburb			i)
Occupation* Occupation lo Name Address Alternative lo	Jumber Town/City	O Place	of Work	School	O Pre	-school		Suburb Post Code Suburb		GeoCode	
Occupation* Occupation le Name Address Alternative le Name Address	Jumber Jown/City Decation	O Place	of Work Street of Work Street	School School	O Pre	-school		Suburb Post Code		GeoCode	
Occupation* Occupation lo Name Address Alternative lo Name Address Address Ethnic group	Jumber Jumber Jumber Jumber Jumber Jumber Jumber Jumber Jumber	Place Place	of Work Street of Work Street (tick all that	School School	○ Pre	-school		Suburb Post Code Suburb Post Code		GeoCode	
Occupation* Occupation le Name Address Alternative le Name Address T Ethnic group	Jumber Jumber Jumber Jumber Jumber Jumber Jumber Jumber Jumber	Place Place Mac	of Work Street of Work Street (tick all that	School School	O Pre	-school	ook Islar	Suburb Post Code Suburb		GeoCode	
Occupation* Occupation lo Name Address Alternative lo Name Address Address Ethnic group	Jumber Ju	Place Place Ilongs to*	of Work Street of Work Street (tick all that orinese	School School apply) India	O Pre	-school	ook Islar	Suburb Post Code Suburb Post Code		GeoCode	

				EpiSurv No.					
Basis of Diagnosis									
CLINICAL CRITERIA									
Fits clinical description	ts clinical description*						Unknown	i	
Clinical features									
Meningitis*	Yes	O No	Unknown	*Septi	caemia*	O Yes	O No O Unkno	wn	
Petechial or purpuric ra	ash* Yes	O No	Unknown	Other	invasive i	illness* (specify	<i>ı</i>)		
Other clinical features	r clinical features								
Gastrointestinal sympt	oms Yes	O No	Unknown	If yes, specify					
Respiratory symptoms	O Yes	O No	Unknown	If yes, specify					
LABORATORY CRITERI	.A								
Isolation of <i>N.meningi</i>	tidis from CSF	*		O Yes	O No	Not Done	Awaiting Results		
Isolation of N.meningi	<i>tidis</i> from bloo	d*		O Yes	O No	Not Done	Not Done Awaiting Result		
Isolation of <i>N.meningi</i>	<i>tidis</i> from othe	r site*		O Yes	O No	Not Done	Awaiting Results		
(sp	ecify site*)								
Detection of Gram-neg	ative intracell	ular dipl	ococci*	O Yes	O No	Not Done	 Awaiting Results 		
(sp	ecify site*)								
Detection of meningoc	occal antigen	in CSF (l	atex test)*	O Yes	O No	O Not Done	Awaiting Results		
Detection of N.mening	lood*		O Yes	○ No	Not Done	Awaiting Results			
Detection of N.mening	<i>itidis</i> DNA in C	SF*		O Yes	O No	Not Done	 Awaiting Results 		
Detection of N.mening	<i>itidis</i> DNA in o	ther site	*	O Yes	O No	Not Done	Awaiting Results		
(s	pecify site*)								
Other positive test* (sp	pecify)								
CLASSIFICATION*		Under inv	estigation	Proba	able	Confirmed	O Not a case	(i)	
ADDITIONAL LABORAT	ORY DETAILS								
Group				PorA	type				
Multi locus sequence ty	ype (MLST)								
ESR Updated La	boratory								
Da	ate result upda	ted	dd/mm/yyyy		Sample	number			
Other laboratory detail	ls*								
Clinical Course and	l Outcome								
Date of onset*	dd/mm/yyyy		☐ Approxima	ate	Unknown	ı			
Time of onset*			Unknown						
Hospitalised*	Yes	No	Unknown						
Date hospitalised*	dd/mm/yyyy		Unknown						
Time Hospitalised*			Unknown						
Hospital*									

						Epis	Surv No.	li		
Clinical Course and Outo	come continued									
ed* Yes No						Unknown				
Date died*	dd/mm/yyyy		Unknown							
Was this disease the primary	cause of death?*	O Yes		No		\circ	Jnknown			
If no, specify the primar										
Outbreak Details										
Is this case part of an outbre	ak (i.e. known to be	linked to a	one or more o	other o	cases of	the sam	e disease)?*		
	Yes	If yes, s	specify Outbr	eak N	o.*					
Risk Factors										
Contact with a confirmed or p		ningococca	ıl disease duı	ring th	ne	O Yes	O No	Unknown		
incubation period for this disc If yes, was prophylaxis offered?						O Yes	○ No	Unknown		
If yes, was prophylaxis	taken?*					O Yes	○ No	Unknown		
If yes, specify typ	pe of prophylaxis* (tick	call that app	oly)			Antibi	otic	☐ Vaccine		
EpiSurv number of confirmed or	probable case*									
Nature of contact with confirmed	or probable case*									
		(see conta	ct managemer	nt cate	gories be	elow)				
Attendance at school, presch	ool or childcare*		Yes		○ No)	O Uni	known		
Was the case overseas during period for meningococcal disc			Yes		O No	0	O Unl	known		
Other risk factors for mening	ococcal disease, spe	cify*								
Protective Factors										
At any time prior to onset, ha with meningococcal vaccine?		nunised		\bigcirc_{Y}	'es	O No	Unkn	nown		
If yes, specify which vaccine*		No. of Doses*	Date of Last Dose*	So	urce of Ir	nformation	ı*			
Meningococcal B four-compor	nent recombinant		dd/mm/yyyy		Patie	nt/caregiv	er recall	Documented		
Meningococcal ACWY conjuga	ate		dd/mm/yyyy	<u> </u>	O Patie	ent/caregiv	ver recall	Documented		
Meningococcal group C conju	gate		dd/mm/yyyy		O Patie	ent/caregiv	ver recall	Documented		
Other (*specify)			dd/mm/yyyy		Patie	ent/caregiv	ver recall	Documented		
Management										
CASE MANAGEMENT										
Were IV/IM antibiotics given	prior to hospital ad	mission?*		O Yes	5	No	\circ	Jnknown		
If yes, specify antibiotic and re	oute				O In	travenous	;	Intramuscular		
If yes, date given*	n/vvvv 🛗 🗆 [Date unknov	vn Time o	iiven*				Time unknown		

				EpiSurv No.	le
Management continued					
CONTACT MANAGEMENT					
Type of contact	Number identified	Number offered abx	Number given abx	Number offered vaccination	Number vaccinated
Household contacts					
Childcare/pre-school contacts					
Close institutional contacts					
Contacts exposed to oral secretions					
Other close contacts					
(specify)					
If contacts were vaccinated, name of the vaccine	e(s) given				
Comments*					
					,