Washington State Department of Health

Meningococcal Disease

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____

LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification ☐ Classification pending ☐ Confirmed
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status
☐ In progress
☐ Complete
☐ Complete – not reportable to DOH
☐ Unable to complete Reason _____

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

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

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

Employed ☐ Yes ☐ No ☐ Unk Occupation _____
Industry _____ Employer _____
Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk
Type of school ☐ Preschool/day care ☐ K-12 ☐ College
☐ Graduate School ☐ Vocational ☐ Online ☐ Other
School name _____
School address _____
City/State/County _____ Zip _____
Phone number _____ Teacher's name _____

REPORT SOURCE

Initial report source _____
LHJ _____
Reporter organization _____
Reporter name _____
Reporter phone _____

All reporting sources (list all that apply)
_____
_____
_____

COMMUNICATIONS

Primary HCP name _____
Phone _____

OK to talk to patient (If Later, provide date)
☐ Yes ☐ Later ___/___/___ ☐ Never

Date of interview attempt ___/___/___
☐ Complete ☐ Partial ☐ Unable to reach
☐ Patient could not be interviewed

Alternate contact ☐ Parent/Guardian ☐ Spouse/Partner
☐ Friend ☐ Other _____
Name _____ Phone _____

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___
Illness duration _____ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk

Clinical Features

Type of infection/complication caused by organism (check all that apply) ☐ **Primary bacteremia** ☐ **Meningitis** ☐ Conjunctivitis
☐ **Septic arthritis** ☐ **Pneumonia** ☐ Cellulitis ☐ Epiglottitis ☐ Peritonitis ☐ Pericarditis
☐ Other _____

Y	N	Unk	
☐	☐	☐	Any fever, subjective or measured Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	Altered mental status
☐	☐	☐	Cough Onset date ___/___/___
☐	☐	☐	Headache
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Nuchal rigidity (stiff neck)
☐	☐	☐	Photophobia (eyes sensitive to light)
☐	☐	☐	**Purpura fulminans**

Case Name ________________________________ LHJ Case ID ________________________________

Y N Unk
☐ ☐ ☐ **Rash (i.e., maculopapular or petechial)**
☐ ☐ ☐ Other symptoms consistent with this illness ________________________________
☐ ☐ ☐ Amputations
☐ ☐ ☐ Disseminated intravascular coagulopathy (DIC)
☐ ☐ ☐ Permanent neurological impairment
☐ ☐ ☐ Any other complication ________________________________

Predisposing Conditions

Y N Unk
☐ ☐ ☐ Current tobacco smoker
☐ ☐ ☐ HIV positive/AIDS
☐ ☐ ☐ Respiratory disease in 2 weeks before onset
☐ ☐ ☐ Spend prolonged time in an indoor environment where people smoke

Vaccination

Y N Unk
☐ ☐ ☐ Ever received Meningococcal containing vaccine
Number of Meningococcal doses prior to illness _______

Vaccine information available ☐ Yes ☐ No

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ________________________________ Administering provider ________________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ________________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ________________________________ Administering provider ________________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ________________________
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Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ________________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Y N Unk
☐ ☐ ☐ Meningococcal vaccination up to date for age per ACIP
Vaccine series not up to date reason
☐ Religious exemption ☐ Medical contraindication ☐ Philosophical exemption
☐ Laboratory confirmation of previous disease ☐ MD diagnosis of previous disease
☐ Underage for vaccine ☐ Parental refusal ☐ Other ☐ Unknown

Supplemental Culture Information

Y N Unk
☐ ☐ ☐ Antibiotic use prior to specimen collection Date initiated ___/___/___ Time of first administration _______

Hospitalization

Y N Unk
☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name ________________________________
Hospital admission date ___/___/___ Discharge ___/___/___ HRN ____________________
Disposition ☐ Another acute care hospital Facility name ________________________________
☐ Died in hospital
☐ Long term acute care facility Facility name ________________________________
☐ Long term care facility Facility name ________________________________
☐ Non-healthcare (home) ☐ Unk ☐ Other ________________________________
☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ Mechanical ventilation or intubation required
☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk
☐ ☐ ☐ Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
☐ ☐ ☐ Autopsy performed
☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition
Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital) ☐ Emergency department (ED)
☐ Inpatient ward ☐ ICU ☐ Other ________________________________

Case Name _____ LHJ Case ID _____

RISK AND RESPONSE (Ask about exposures 2-10 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____

☐ ☐ ☐ Contact with recent foreign arrival Country _____ Date(s) of contact ___/___/___

☐ ☐ ☐ Exposure to human saliva (e.g., water bottle, cigarettes, lipstick, shared utensils)

☐ ☐ ☐ Congregate living

☐ Barracks ☐ Corrections ☐ Long term care ☐ Dormitory ☐ Boarding school ☐ Camp ☐ Shelter

☐ Other _____

☐ ☐ ☐ Injected drugs not prescribed by a doctor, even if only once or a few times Describe _____

Assess MSM status

During the last 12 months, have you had sex with

☐ Males only ☐ Females only ☐ Both males and females ☐ Unk ☐ Refused ☐ Other _____

Do you consider yourself to be

☐ Heterosexual/straight ☐ Gay/lesbian/homosexual ☐ Bisexual ☐ Refused ☐ Other _____

Thinking back to the 3 months before you became ill with meningococcal disease, how many MEN did you have sex with during that time _____

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ **Epidemiologically linked to a lab positive case classified as confirmed**

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____

☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Person to person ☐ Unk ☐ Other _____

Describe _____

Suspected exposure setting ☐ Daycare/Childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER

☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Place of worship

☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Transit

☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other _____

Describe _____

Exposure summary

Suspected transmission type (check all that apply) ☐ Person to person ☐ Unk ☐ Other _____

Describe _____

Suspected transmission setting (check all that apply) ☐ Daycare/Childcare ☐ School (not college) ☐ Doctor's office

☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military

☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter

☐ International Travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant

☐ Hotel/motel/hostel ☐ Other _____

Describe _____

Case Name _____ LHJ Case ID _____

Public Health Issues

Evaluate immune status of close contacts ☐ Yes Date initiated ___/___/___
Number of close contacts evaluated for immune status _____
Number of susceptible contacts identified _____
☐ No, close contacts not evaluated
☐ No, case had no close contacts
☐ Unk

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Prophylaxis of appropriate contacts recommended Date initiated ___/___/___
Number of contacts recommended prophylaxis _____
Number of contacts receiving prophylaxis _____
Number of contacts completing prophylaxis _____

Type of contact(s) (check all that apply)

Y N Unk

☐ ☐ ☐ Household members
☐ ☐ ☐ Roommates
☐ ☐ ☐ Carpools
☐ ☐ ☐ Coworkers
☐ ☐ ☐ Teammates
☐ ☐ ☐ Child care contacts
☐ ☐ ☐ Playmates
☐ ☐ ☐ Other children
☐ ☐ ☐ EMTs
☐ ☐ ☐ Medical personnel
☐ ☐ ☐ Other patients
☐ ☐ ☐ Other close contacts _____

Y N Unk

☐ ☐ ☐ Was vaccine offered to any close contacts
Number of contacts recommended vaccine _____
Number of contacts receiving vaccine _____
☐ ☐ ☐ Was vaccine or prophylaxis offered in any large settings
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING

Contagious period: ~1 week prior to symptom onset, 24 hours after initiation of treatment with appropriate antibiotic

Visited, attended, employed, or volunteered at any public settings while contagious ☐ Yes ☐ No ☐ Unk

Settings and details (check all that apply)

☐ Day care ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Health care ☐ Home ☐ Work ☐ College
☐ Military ☐ Correctional facility ☐ Place of worship ☐ International travel ☐ Out of state travel ☐ LTCF
☐ Homeless/shelter ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

TREATMENT

Y N Unk

☐ ☐ ☐ Did patient receive prophylaxis/treatment
Specify antibiotic _____
Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___
Prescribed dose _____ ☐ g ☐ mg ☐ ml Frequency _____ Duration _____ ☐ Days ☐ Weeks ☐ Months
Did patient take medication as prescribed ☐ Yes ☐ No - Why not _____ ☐ Unk
Prescribing provider _____

NOTES

LAB RESULTS

Lab report information
Lab report reviewed – LHJ ☐
WDRS user-entered lab report note

Submitter _____
Performing lab for entire report _____
Referring lab _____

Specimen
Specimen identifier/accession number _____
Specimen collection date ___/___/___ Specimen received date ___/___/___
WDRS specimen type _____
WDRS specimen source site _____
WDRS specimen reject reason _____

Test performed and result
WDRS test performed _____
WDRS test result, coded _____
WDRS test result, comparator _____
WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____
WDRS unit of measure _____
Test method _____
WDRS interpretation code _____
Test result – Other, specify _____
WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending
Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending
Result date ___/___/___
Upload document

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____