



| Meningococcal Infection Investigation Form | | NBS Patient ID: _____ | NBS Investigation ID _____ | | | | | | | | | | | | | | | | | | | | |
|--|--|---|------------------------------------|----------------------------|------------------------|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Patient's name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First MI </div> Address: _____ City: _____ County: _____ Zip: _____ Phone 1: () _____ Phone 2: () _____ Date of birth: ___/___/___ Age: ____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Patient occupation: _____ Parent/guardian's name: _____ | | Reported by: _____ Agency: _____ Phone: () _____ Date reported: ___/___/___ <hr/> Investigated by: _____ Agency: _____ Phone: () _____ Email: _____ Investigation start date: ___/___/___ | | | | | | | | | | | | | | | | | | | | | |
| CLINICAL DATA Date of symptom onset: ___/___/___ Illness end date: ___/___/___ Did patient die? <input type="checkbox"/> Yes, date of death: ___/___/___ <input type="checkbox"/> No <input type="checkbox"/> Unk Signs and symptoms (Check all that apply): <input type="checkbox"/> Fever <input type="checkbox"/> Sensitivity to light <input type="checkbox"/> Stiff neck <input type="checkbox"/> Headache <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Confusion <input type="checkbox"/> Other: _____ Clinical infection presentation (Check all that apply): <input type="checkbox"/> Bacteremia <input type="checkbox"/> Meningitis <input type="checkbox"/> Septic arthritis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Cellulitis <input type="checkbox"/> Pericarditis <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Other: _____ Physician's name: _____ Physician's phone: () _____ | | UNDERLYING CONDITIONS Does the patient have any underlying health conditions? <input type="checkbox"/> Yes (check all that apply) <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Cancer <input type="checkbox"/> Cochlear implant <input type="checkbox"/> Diabetes <input type="checkbox"/> End stage renal disease <input type="checkbox"/> HIV <input type="checkbox"/> Other: _____ Other prior illness within two weeks of onset? <input type="checkbox"/> Yes, specify _____ <input type="checkbox"/> No <input type="checkbox"/> Unk Does the patient have high risk behaviors? <input type="checkbox"/> Yes (check behaviors below) <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Current smoker <input type="checkbox"/> Intravenous drug user (IVDU) <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Other: _____ | | | | | | | | | | | | | | | | | | | | | |
| HOSPITALIZATION INFORMATION Was the patient hospitalized? <input type="checkbox"/> Yes, name of hospital: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Date of admission: ___/___/___ Date of discharge: ___/___/___ How was the patient transported to the hospital? _____ How many people were in the vehicle that transported the patient to the hospital? ____ Was the patient seen at multiple hospitals? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, complete the following table | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Hospital / Clinic name</th> <th style="width: 30%;">Mode of transportation to facility</th> <th style="width: 15%;">Date/time of visit/arrival</th> <th style="width: 15%;">Date/time of discharge</th> <th style="width: 10%;">Discharged to*</th> </tr> </thead> <tbody> <tr> <td> </td> <td> <input type="checkbox"/> drove self <input type="checkbox"/> driven by friend/family <input type="checkbox"/> ambulance <input type="checkbox"/> other: _____ </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> <input type="checkbox"/> drove self <input type="checkbox"/> driven by friend/family <input type="checkbox"/> ambulance <input type="checkbox"/> other: _____ </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> <input type="checkbox"/> drove self <input type="checkbox"/> driven by friend/family <input type="checkbox"/> ambulance <input type="checkbox"/> other: _____ </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> | | Hospital / Clinic name | Mode of transportation to facility | Date/time of visit/arrival | Date/time of discharge | Discharged to* | | <input type="checkbox"/> drove self <input type="checkbox"/> driven by friend/family <input type="checkbox"/> ambulance <input type="checkbox"/> other: _____ | | | | | <input type="checkbox"/> drove self <input type="checkbox"/> driven by friend/family <input type="checkbox"/> ambulance <input type="checkbox"/> other: _____ | | | | | <input type="checkbox"/> drove self <input type="checkbox"/> driven by friend/family <input type="checkbox"/> ambulance <input type="checkbox"/> other: _____ | | | | | |
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| <small>* discharged to home, another facility, or left against medical advice (AMA)</small> | | | | | | | | | | | | | | | | | | | | | | | |
| TREATMENT HISTORY Did the patient receive antibiotics? <input type="checkbox"/> Yes, start date ___/___/___ end date ___/___/___ <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, name or type of antibiotic(s) given: _____ Were any antibiotics given prior to specimen collection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, antibiotic name: _____ given on ___/___/___ at ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM If yes, antibiotic name: _____ given on ___/___/___ at ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM | | | | | | | | | | | | | | | | | | | | | | | |
| VACCINATION HISTORY Did the patient receive the polysaccharide meningococcal vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of vaccine ___/___/___ Manufacturer: _____ Did the patient receive the conjugate meningococcal vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of vaccine ___/___/___ Manufacturer: _____ Vaccination history was obtained from? <input type="checkbox"/> Patient <input type="checkbox"/> Parent/guardian <input type="checkbox"/> Primary care physician <input type="checkbox"/> Reporting physician/facility <input type="checkbox"/> Imtrak | | | | | | | | | | | | | | | | | | | | | | | |

CONTACTS

Use the contact tracking sheet to record information on anyone determined to be a close contact as defined by the Red Book.

Was the patient associated with an outbreak? Yes, outbreak name: _____ No Unknown

How many people live in the patient's household? _____

During the two weeks before onset, how many people did the patient

kiss: _____ share a sleeping area with: _____ share a toothbrush with: _____ share food or utensils with: _____ share drinks with: _____

share (brass or wind) band instruments with: _____ share cigarettes with: _____ share drugs with: _____

Did the patient perform mouth to mouth resuscitation on anyone? Yes No Unknown

If yes, name of person: _____ Date performed: ____/____/____

Did any member of the patient's household have a similar illness during the two weeks prior to onset? Yes No Unknown

If yes, name of person: _____ Date of onset ____/____/____

Did the patient attend, visit or work at a school? Yes, student Yes, faculty/staff Yes, visitor No UnknownIf a college student, college year: Fr So Jr Sr Live in a dorm? Yes No UnknownDid the patient attend, visit or work at a child care center / home during the two weeks prior to illness? Yes No UnknownDid the patient stay at, visit or work at a nursing home / long term care facility during the two weeks prior to illness? Yes No Unk

If yes to school, child care or long term care facility, please complete the following:

School / facility name: _____ Date last attended/worked/visited before onset: ____/____/____

Total contacts: _____ students/residents _____ staff Total close contacts: _____ students/residents _____ staff

Did anyone associated with the facility have a similar illness during the two weeks prior to onset? Yes No Unknown

If yes, name of person: _____ Date of onset ____/____/____ if needed, attach list to this report

ADDITIONAL EXPOSURE HISTORYDid the patient travel anywhere during the two weeks prior to onset? Yes No Unknown

If yes, location traveled to: _____ Dates of travel: ____/____/____ to ____/____/____

Did the patient spend 8 or more hours on a plane (or bus or train)? Yes No Unknown

If yes, airline: _____ flight number: _____ Flight date: ____/____/____ time: ____:____ Departure city: _____

Did the patient attend any public gatherings / parties during the two weeks prior to onset? Yes No Unknown

If yes, complete the following table

| Event | Location | # of people present | Date of event |
|-------|----------|---------------------|----------------|
| | | | ____/____/____ |
| | | | ____/____/____ |

PROPHYLAXIS

Date prophylaxis recommendations were first made: ____/____/____

Prophylaxis provided by (check all that apply): DSHS or LHD Hospital Private physician Other: _____ None given

| Number of people | Household | Students at school &/or daycare | Staff at school &/or daycare | Residents at long term care facility | Staff at long term care facility | Healthcare workers including EMS | Other close contacts* |
|-----------------------------------|-----------|---------------------------------|------------------------------|--------------------------------------|----------------------------------|----------------------------------|-----------------------|
| Prophylaxis recommended for: | | | | | | | |
| Declined recommended prophylaxis: | | | | | | | |
| Received prophylaxis: | | | | | | | |

* friends, colleagues, extended family, etc.

LABORATORY DATA Isolate sent to DSHS (required)? Yes, on ___/___/___ No Unknown If no, reason: _____

Was *Neisseria meningitidis* testing done : Yes No, diagnosis based on clinical purpura fulminans Other: _____

Gram stain: Date collected: ___/___/___ Time collected: ___:___ AM PM
Specimen Source: CSF Blood Other: _____
Result: Gram negative diplococci Negative Inconclusive Unknown Other: _____

CSF Profile: Date collected: ___/___/___ Appearance: _____ Pressure: _____ mm
Glucose: _____ mg/dl Protein: _____ mg/dl RBCs: _____ mm³ WBCs: _____ mm³ Lymphs: _____ % Polys: _____ % Mono: _____ %

Culture: Date collected: ___/___/___ Time collected: ___:___ AM PM
Specimen Source: CSF Blood Other: _____
Result: Positive Negative Inconclusive Unknown Other: _____

Other test: Test name: Latex agglutination Immunohistochemistry (HIC) PCR Other: _____
Date collected: ___/___/___ Time collected: ___:___ AM PM
Specimen Source: CSF Blood Other: _____
Result: Positive Negative Inconclusive Unknown Pending

Serogroup results : A B C Y W135 Other: _____ Not groupable Unknown Pending

Antibiotic resistance (please attach lab report if you need to record more than three antibiotic resistance results):
Name 1: _____ Resistant Intermediate Susceptible Not tested Unknown MIC values : _____
Name 2: _____ Resistant Intermediate Susceptible Not tested Unknown MIC values : _____
Name 3: _____ Resistant Intermediate Susceptible Not tested Unknown MIC values : _____

ADDITIONAL HEALTH DEPARTMENT ACTIONS AND CONTROL MEASURES IMPLEMENTED (check all that apply and indicate date initiated)

- Confirmed that symptomatic individuals are placed on droplet precautions until 24 hours after effective antibiotic treatment on ___/___/___
- Reviewed high risk exposures with medical provider on ___/___/___
- Contact tracing (identifying close contacts through patient or surrogate interview) initiated on ___/___/___
- Education (risk, transmission, symptoms) provided to contacts starting on ___/___/___
- Requested the hospital or laboratory forward the isolate to the DSHS lab on ___/___/___
- Worked with school, daycare or long term care facility to identify and notify close contacts starting on ___/___/___
- Other (specify): _____ ___/___/___
- Other (specify) _____ ___/___/___

COMMENTS

PROPHYLAXIS RECOMMENDATIONS

The following groups of individuals should receive prophylaxis after exposure to meningococcal disease

- All family contacts or household members who spend at least 8 hours a day with the case.
- Classroom contacts in the childcare center or childcare home attended by the case.
- Persons directly exposed to infectious oral secretions without personal protective equipment (PPE) including through kissing, sharing utensils, sharing toothbrushes or unprotected mouth to mouth resuscitation.

It is important that antimicrobial chemoprophylaxis be administered as soon as possible, ideally within 24 hours. The incubation period is 1 to 10 days. Chemoprophylaxis given more than 14 days after exposure is of limited value. When prophylaxis is indicated, it should be administered to all eligible contacts at the same time to eliminate the organism from the population. Prophylaxis should begin within 24 hours of diagnosis or strong suspicion of case. Culturing of contacts is not recommended. Prophylaxis should not substitute for close observation of case contacts for symptoms. Refer to the current American Academy of Pediatrics Red Book for prophylaxis dosages.

Prophylaxis is not recommended for casual contacts without direct exposure to the patient's oral secretions (e.g. school or work). All contacts should be provided education on risk, transmission and symptoms.