Massachusetts Department of Public Health
Bureau of Communicable Disease Control
Office of Integrated Surveillance and Informatics Services
305 South Street, Jamaica Plain MA 02130
*Phone: **617-983-6801*** *Confidential Fax: **617-983-6813***

Received in ISIS:

INVASIVE MENINGOCOCCAL DISEASE

For assistance filling out this form, call (617) 983-6800

CONFIDENTIAL CASE REPORT

(leave this section blank for state health department use) Report Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Revoked

DEMOGRAPHIC INFORMATION

Last Name: First Name: MI:

Address: Apt. #:

City: State: Zip:

Unique Address Condition: ☐ Homeless ☐ Incarcerated

Contact phone: (____) _____-_____ Occupation:

Birth date: _____/_____/_____ Place of birth (e.g. specific country):

Age: _____ ☐ Years ☐ Months ☐ Weeks ☐ Days ☐ Unk

Sex: ☐ Female ☐ Male ☐ Transgender ☐ Unk

Race *(check all that apply):*
☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unk

Hispanic: ☐ Yes ☐ No ☐ Unk

CLINICAL INFORMATION

Diagnosis date: _____/_____/_____

Did case have any symptoms? ☐ Yes ☐ No ☐ Unk Symptom onset date: _____/_____/_____

Chest tightness ☐ Yes ☐ No ☐ Unk Difficulty breathing ☐ Yes ☐ No ☐ Unk
Disseminated Intravascular Coagulation (DIC) ☐ Yes ☐ No ☐ Unk
Fatigue ☐ Yes ☐ No ☐ Unk Fever ☐ Yes (highest temp._____°F/°C) ☐ No ☐ Unk
Headache ☐ Yes ☐ No ☐ Unk Lethargy ☐ Yes ☐ No ☐ Unk
Mental status change ☐ Yes ☐ No ☐ Unk Nausea ☐ Yes ☐ No ☐ Unk
Rash ☐ Yes ☐ No ☐ Unk *If yes, describe*: ☐ Petechial ☐ Purpuric ☐ Other
Stiff neck ☐ Yes ☐ No ☐ Unk Vomiting ☐ Yes ☐ No ☐ Unk
Other (*specify*): _____

Type of infection*(check all that apply)*:
☐ Bacteremia (meningococcemia) with focus ☐ Bacteremia (meningococcemia) without focus
☐ Epiglottitis ☐ Meningitis ☐ Pericarditis ☐ Peritonitis
☐ Pneumonia ☐ Purpura Fulminans ☐ Septic Arthritis ☐ Other (*specify*): _____

If case is ≤ 7 years of age and had meningitis, did the case have cochlear implants? ☐ Yes ☐ No ☐ Unk

Was case pregnant during illness? ☐ Yes ☐ No ☐ Unk

Case hospitalized? ☐ Yes ☐ No ☐ Unk Date hospitalized: _____/_____/_____

Hospital name: Date discharged: _____/_____/_____

Outcome: ☐ Died ☐ Recovered ☐ Unk Date of death: _____/_____/_____

Clinician name and address:

Clinician phone: (_____) _____-_____ Patient record/ chart #:

Please complete page 2. Include additional lab information if available.

DIAGNOSTIC LABORATORY TEST INFORMATION

Was laboratory testing done? ☐ Yes ☐ No ☐ Unk

Date specimen collected: _____/_____/_____ Name of Laboratory:_____

Source: ☐ Blood ☐ CSF ☐ Joint fluid ☐ Pericardial fluid
☐ Peritoneal fluid ☐ Pleural fluid ☐ Skin scraping ☐ Other (*specify*): _____

Type of test: ☐ Bacterial antigen screen ☐ Chest X-ray ☐Culture ☐ Other (*specify*): _____

Serogroup: ☐ Group A ☐ Group B ☐ Group C
☐ Group W 135 ☐ Group Y ☐ Group Z
☐ Not groupable ☐ Unk ☐ Other (*specify*): _____

INFORMATION RELEVANT TO EXPOSURE, CONTROL AND PREVENTION

Is the case enrolled or employed in a supervised care setting (daycare)? ☐ Yes ☐ No ☐ Unk

If yes, name and location of daycare: _____

Is the case enrolled or employed at a school? ☐ Yes ☐ No ☐ Unk

If yes, Name and location of school: _____

Contact name and phone: _____ (_____) _____/_____

Does the case board at this school? ☐ Yes ☐ No ☐ Unk

Does case attend college/university? ☐ Yes ☐ No ☐ Unk

If **yes**, name and location of college/university: _____

Contact name and phone: _____ (_____) _____/_____

Full- or part-time student: ☐ Full-time ☐ Part-time ☐ Unk

Year in college: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Other

Housing ☐ Dormitory ☐ Apartment ☐ Single-family home with family
☐ Single family home with students ☐ Fraternity/Sorority house
☐ Other (*specify*): _____

VACCINE AND IG INFORMATION

If the case was vaccinated for meningococcal disease, please complete the following information:

	Dose 1	**Dose 2**
Vaccine:	_____	_____
Date:	_____/_____/_____	_____/_____/_____
Type/Manuf:	_____	_____
Lot #:	_____	_____

Reason for immunization: ☐ Boarding school entrance ☐ College entrance ☐ Medical risk factor
☐ Military Service ☐ Travel ☐ Other (*specify*): _____

ADMINISTRATIVE INFORMATION

Comments:_____

_____

Investigator's name: _____ Phone: (____) _____ - _____

Agency: _____ Fax: (____) _____ - _____

Date first reported to you: ____/____/____ Date investigation started: ____/____/____ Date form completed: ____/____/____

(Leave this section blank for state health department use)

Case report reviewed by epidemiologist? ☐ Yes Name: _____ Date reviewed: ___/___/_____

Is case part of a current outbreak? ☐ Yes ☐ No ☐ Unk Outbreak name:_____