

CASE REPORT FORM

Meningococcal Disease

	EpiSurv No. <input style="width: 20px;" type="text"/>
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Reporting Authority

Name of Public Health Officer responsible for case

Notifier Identification (i)

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

Name of reporting source Organisation

Date reported* Laboratory sample date Contact phone

Usual GP Practice GP phone

GP/Practice address Number Street Suburb
Town/City Post Code GeoCode

Case Identification (i)

Name of case* Surname Given Name(s)

NHI number* Email

Current address* Number Street Suburb
Town/City Post Code GeoCode

Phone (home) Phone (work) Phone (other)

Case Demography

Location TA* DHB*

Date of birth* OR Age Days Months Years

Sex* Male Female Indeterminate Unknown

Occupation* (i)

Occupation location Place of Work School Pre-school

Name

Address Number Street Suburb
Town/City Post Code GeoCode

Alternative location Place of Work School Pre-school

Name

Address Number Street Suburb
Town/City Post Code GeoCode

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

NZ European Maori Samoan Cook Island Maori
 Niuean Chinese Indian Tongan
 Other (such as Dutch, Japanese, Tokelauan) *(specify)

Basis of Diagnosis**CLINICAL CRITERIA**Fits clinical description* Yes No Unknown (i)**Clinical features**Meningitis* Yes No Unknown ***Septicaemia*** Yes No UnknownPetechial or purpuric rash* Yes No Unknown **Other invasive illness* (specify)** **Other clinical features**Gastrointestinal symptoms Yes No Unknown If yes, specify Respiratory symptoms Yes No Unknown If yes, specify **LABORATORY CRITERIA**Isolation of *N.meningitidis* from CSF* Yes No Not Done Awaiting ResultsIsolation of *N.meningitidis* from blood* Yes No Not Done Awaiting ResultsIsolation of *N.meningitidis* from other site* Yes No Not Done Awaiting Results(specify site*) Detection of Gram-negative intracellular diplococci* Yes No Not Done Awaiting Results(specify site*) Detection of meningococcal antigen in CSF (latex test)* Yes No Not Done Awaiting ResultsDetection of *N.meningitidis* DNA in blood* Yes No Not Done Awaiting ResultsDetection of *N.meningitidis* DNA in CSF* Yes No Not Done Awaiting ResultsDetection of *N.meningitidis* DNA in other site* Yes No Not Done Awaiting Results(specify site*) Other positive test* (specify) **CLASSIFICATION*** Under investigation Probable Confirmed Not a case (i)**ADDITIONAL LABORATORY DETAILS**Group PorA type Multi locus sequence type (MLST) ESR Updated Laboratory Date result updated dd/mm/yyyy Sample number Other laboratory details* **Clinical Course and Outcome**Date of onset* dd/mm/yyyy Approximate UnknownTime of onset* UnknownHospitalised* Yes No UnknownDate hospitalised* dd/mm/yyyy UnknownTime Hospitalised* UnknownHospital*

Management continued**CONTACT MANAGEMENT**

Type of contact	Number identified	Number offered abx	Number given abx	Number offered vaccination	Number vaccinated
Household contacts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Childcare/pre-school contacts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Close institutional contacts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Contacts exposed to oral secretions	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other close contacts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(specify)	<input type="text"/>				
If contacts were vaccinated, name of the vaccine(s) given	<input type="text"/>				

Comments*