

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**MENINGOCOCCAL DISEASE, INVASIVE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 27**

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name— City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U
 If yes, symptom onset date (mm/dd/yyyy): ___/___/___
 CHECK ALL THAT APPLY:
 Meningitis Y N U
 Purpura fulminans Y N U
 Septicemia/sepsis Y N U
 Was patient hospitalized for this illness >24 hours? Y N U
 Hospital name: _____
 City, State: _____
 Hospital contact name: _____
 Telephone: (____) _____ - _____
 Admit date (mm/dd/yyyy): ___/___/___
 Discharge date (mm/dd/yyyy): ___/___/___
 Discharge/Final diagnosis: _____
 Notes:

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U
 Specify _____

 Did the patient have a respiratory illness in the two weeks before illness onset? Y N U

TREATMENT

Were antibiotics taken before culture specimen collected? Y N U
 Specify culture site _____
 Notes:

CLINICAL FINDINGS

Arthritis Y N U
 Extent
 One joint
 Multiple joints
 Note location: _____
 Type
 Septic
 Other, specify: _____
 Skin rash Y N U
 If yes, onset date (mm/dd/yyyy): _____
 Observed by health care provider? Y N U
 Location
 All over the body (Generalized)
 Localized/Focal
 If yes, specify location: _____
 Unknown
 Appearance of rash (choose all that apply)
 Macular Petechial
 Papular Unknown
 Osteomyelitis Y N U
 Cellulitis Y N U
 Gangrene Y N U
 Amputation Y N U
 Conjunctivitis Y N U
 Did the patient have a chest X ray? Y N U
 Was the X ray abnormal? Y N U
 If yes, specify: _____
 Pneumonia Y N U
 Pericarditis Y N U
 Bacteremia Y N U
 If yes, date of positive blood culture (mm/dd/yyyy): _____
 Other, specify: _____
 Other symptoms, signs, clinical findings, or complications consistent with this illness? Y N U
 If yes, specify: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

TRAVEL/IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 None of the above

Did patient have a travel history during the 10 days prior to onset of symptoms until 24 hours after start of antibiotics? Y N U
 List travel dates and destinations _____

Additional travel/residency information:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 10 days prior to onset of symptoms until 24 hours after start of antibiotics did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U
 Name of facility: _____
 Dates of contact: _____

During the 10 days prior to onset of symptoms until 24 hours after start of antibiotics, did the patient attend social gatherings or crowded settings? Y N U
 If yes, specify: _____

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

Does the patient smoke? Y N U
Does the patient spend prolonged time indoors where people smoke? Y N U

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 Specify _____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: _____

Patient a child care worker or volunteer in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: _____

Patient a parent or primary caregiver of a child in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: _____

Is patient a student? Y N U
 Type of school:
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)
 Name: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: _____
 Specify grade: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U
 Type of school:
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)
 Name: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Telephone: _____

CLINICAL OUTCOMES

Survived? Y N U
Died? Y N U
Died from this illness? Y N U
 Date of death (mm/dd/yyyy): ____/____/____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ____/____/____
Were interviews conducted with others? Y N U
 Who was interviewed? _____

Were health care providers consulted? Y N U
 Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U
Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
 Specify location:
 In NC
 City _____
 County _____

Outside NC, but within US
 City _____
 State _____
 County _____

Outside US
 City _____
 Country _____

Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

VACCINE

Has the patient ever received meningococcal vaccine in the past? Y N U
 If yes, type:
 Meningococcal polysaccharide vaccine (e.g., Menomune)
 Number of doses: _____
 Date of last vaccination (mm/dd/yyyy): ____/____/____
 Vaccination date unknown
 Meningococcal conjugate vaccine (e.g., Menactra)
 Number of doses: _____
 Date of last vaccination (mm/dd/yyyy): ____/____/____
 Vaccination date unknown
 Vaccine type unknown
 Number of doses: _____
 Date of last vaccination (mm/dd/yyyy): ____/____/____
 Vaccination date unknown

Vaccination confirmed in:
 medical record
 NCIR
 patient/parent copy of immunization record
 verbal report only

Meningococcal Disease (*Neisseria meningitidis*), invasive

2005 CDC Case Definition

Clinical description

Meningococcal disease manifests most commonly as meningitis and/or meningococemia that may progress rapidly to purpura fulminans, shock, and death. However, other manifestations might be observed.

Case classification

Suspect:

- Clinical purpura fulminans in the absence of a positive blood culture
- A clinically compatible case with gram negative diplococci from a normally sterile site (e.g., blood or CSF)

Probable: A clinically compatible case that has either:

- Evidence of *N. meningitidis* DNA using a validated polymerase chain reaction (PCR), obtained from a normally sterile site (e.g., blood or CSF) ¹,

OR

- Evidence of *N. meningitidis* antigen by immunohistochemistry (IHC) on formalin-fixed tissue or latex agglutination of CSF ^{2,3}

Confirmed: A clinically compatible case **AND** isolation of *Neisseria meningitidis* from a normally sterile site (e.g., blood or cerebrospinal fluid {CSF} or, less commonly, synovial, pleural, or pericardial fluid) or skin scrapings of purpuric lesions.

¹ EA Mothershed, et al., "Use of Real-Time PCR to Resolve Slide Agglutination Discrepancies in Serogroup Identification of *Neisseria meningitidis*," *J Clin Microbiol* 42 (2004): 320-328.

² J. Guarner, et al., "Pathogenesis and Diagnosis of Human Meningococcal Disease Using Immunohistochemical and PCR Assays," *American Journal of Clinical Pathology* 122, no. 5 (2004): 754-64.

³ Positive antigen test results from urine or serum samples are unreliable for diagnosing meningococcal disease.