Meningococcal, invasive disease  Agency:									
Investigator:	Phon	ne number:							
CASE									
CAGE									
First and middle			irth: / / der: ☐ Female ☐	Estimate  ☐ Other	<b>v</b>				
Maiden name:	Suffix:	<u></u>							
Alias:		_							
		Does pat		o If no, what lang	uage?				
	City:			☐ American Indian or Alaskan Native ☐ Unknown					
	County:			can American Pacific Islander	☐ White ☐ Asian				
		– Ethnic	city: 🔲 Hispanic or I	Latino 🔲 Not Hisp	anic or Latino 🔲 Unknown				
Long-term care resident:	☐ Yes ☐ No ☐ Unknown	Parent/Guard							
Corrections facility	☐ Yes ☐ No ☐ Unknown	110							
Homeless		Parent/Guard	dian ( )		Type:				
		Is patient aw	/are	o ☐ Unknown	туре.				
EVENT		of diagno	osis.	O D OHKHOWH					
EVENI									
Diagnosis date:	Onset / / date: /	1	Last name:						
Event outcome:	☐ Survived this illness ☐ Died from this ☐ Died unrelated to this illness ☐ Unknown								
Outbreak	☐ Yes ☐ No ☐ Unknown	atio		ARNP ME					
related:		ıform	<b>□</b> '		<u>—</u>				
Outbreak name: Exposure		Marian Provider information							
setting:	DV DN- DH T		Address line 1:						
·	☐ Yes ☐ No ☐ Unk To whom:		Address line 2:						
Location acquired:	☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA	Healthca	Zip code:		City:				
	Unknown	_	State:		County:				
	State: Country:		Phone : (	)	Туре:				
LABORATORY F									
	Speci	men			☐ Positive				
Laboratory:	sou	ırce:	☐ Gram stain	Result:	☐ Negative ☐ No growth				
Date received:	/ Test t	type: PCR	Culture	Serogroup:	□ A □ W-135 □ B □ Y				
Result type:	☐ Preliminary ☐ Final Collection of	date:/	1	_	□C □ ¹				
Accession #:	Result o	date: /	1	Organism:	Neisseria meningitidis				
l ahoraton/	Speci sou	men urce:		Result:	☐ Positive ☐ No growth				
	 Test t	type: PCR	☐ Gram stain	Caracratic	□ A □ W 135				
	/ / Final Collection of	date: /	Culture /	Serogroup:	B W-135				
Accession #:	Result of			Organism:	Neisseria meningitidis				

PATIENT NAME: CONFIDENTIAL Iowa Department of Public Health ☐ Positive Specimen Result: ☐ Negative ☐ No growth Laboratory: source: ☐ Gram stain □ PCR Test type: ☐ Culture Serogroup: ☐ W-135 Date received: ☐ Preliminary ☐ Collection  $\square$  Y Result type: Final date: Accession #: Organism: Result date: Neisseria meningitidis **OCCUPATIONS** Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'. Occupation type: Job title: Worked after symptom onset: Yes No Unknown Facility name: Date worked from: / / Address: Date worked to: Zip code: Removed from City: \_\_\_\_\_ State: \_\_\_\_ County: Date removed: Phone: ( )-Type: ☐ Yes ☐ No ☐ Yes ☐ No Work in a health care setting: Handle food: Unknown ☐ Yes ☐ No ☐ Unknown Unknown Attend or provide child care: Direct patient care duties in □ No Attend or teach school: ☐ Yes Unknown lab or health care setting: ☐ Yes ☐ No ☐ Unknown Unknown Work in a lab setting: ☐ Yes Health care worker type: Occupation type: Job title: Worked after symptom onset: Yes No Unknown Facility name: Date worked from: / / Address: Date worked to: Zip code: Removed from State: County: duties: ☐ Yes ☐ No ☐ Unknown City: \_)-\_\_\_\_\_ Phone: ( Date removed: Type: Unknown Handle food: ☐ Yes ☐ No Work in a health care setting: ☐ Yes ☐ No ☐ Unknown Attend or provide child care: ☐ Yes □ No Unknown Direct patient care duties in Attend or teach school: ☐ Yes ☐ No Unknown lab or health care setting: ☐ Yes ☐ No Unknown Work in a lab setting: ☐ Yes П № Unknown Health care worker type: Attending a college ☐ Yes ☐ No ☐ Unk Student status: ☐ Active ☐ Inactive or university: College/University name: ☐ Apartment ☐ Dormitory ☐ Single-family home with family ☐ Single-family home with students ☐ Other Housing: Childcare name and Attend childcare: ☐ Yes ☐ No ☐ Unk location: **HOSPITALIZATIONS** Was the case hospitalized at least overnight for this illness? ☐ Yes ☐ No ☐ Unknown Admission date: / / Discharge date: / / Hospital: Days hospitalized: **CLINICAL INFO & DIAGNOSIS** ☐ Headache ☐ Stiff neck ☐ Photophobia ☐ Vomiting ☐ Sore throat Symptoms: ☐ Fever ☐ Rash ☐ Nausea □ Diarrhea Other: Infection type: ☐ Bacteremia Purpura fulminans ☐ Yes ☐ No ☐ Unk ☐ Epiglottitis ☐ Peritonitis present: Other infection ☐ Pericarditis ☐ Pneumonia type (specify): Resistant to: Antibiotic resistance ampicillin: ☐ Yes ☐ No ☐ Unk ☐ Yes ☐ No ☐ Unk testing performed: chloramphenicol: ☐ Yes ☐ No ☐ Unk Yes No Unk rifampin: sulfa:

CONFIDENTIAL PATIENT NAME:		Iowa Department o	f Public Health						
Spinal tap: ☐Yes ☐No ☐ Unk	Date: // / Normal: ☐Yes ☐No	o							
Spinal fluid protein level: Unit:									
Spinal fluid glucose level: Unit: \( \propto mg/dL \) \( \propto \propto \propto mol/L \)									
White blood cell count: Unit: ☐ cells/mL									
TREATMENT									
Antibiotics prescribed? ☐ Yes ☐ No ☐ Unkno	own								
Antibiotic: Date started: / /  Dose: mg Unit:	Antibiotic: Date started: / /  Dose:	Antibiotic: Date started: /  Dose:	# of days:						
INFECTION TIMELINE									
Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.	The incubation period for Meningococcal invasive disease is 2-10 days.	Meningococcal invasive disease may spread person to person until 24 hours after the start of effective antibiotics.							
RISK FACTORS/TRAVEL			<b>.</b>						
Travel Information – In the 10 days prior to c	onset of symptoms did the case:								
Travel within lowa? City in   Yes No Unk lowa:  Travel within U.S.?   Yes No Unk State:  Travel outside U.S.?   Yes No Unk Country:	Departure date:  City:  Departure date:  Departure date:	/ / Return date:  Return / / date:  / / Return date:	/ / / /						
Is the case currently prescribed a complement in	hibitor queb es soulizumen (Solirio)?	Vac 🗆 No 🗆 Unk							
,	· · · · —								
Does the case have sex with males, females, or be Vaccinated for meningococcal: ☐ Yes ☐ No ☐		VN							
Date vaccinated: / /	Date vaccinated: / /								
Lot #:	Lot #:								
Vaccine type:	Vaccine type:								
Manufacturer:	Manufacturer:								
Number of vaccinations:									
Reason not vaccinated (check only one):  Religious exemption Medical contraindication Parent refusal Age less than 11 years Unknown Other									
CONTACTS									
Number of people living in case's household: Number of people living in case's home age 3 or less:									
Additional close contacts of the case:  Yes  Unknown									
Close contacts of the case  Name  DOB	Gender Address/Phone								
1 1									
D. Letters about	Zip code:	Phone: Symptom	Is contact a						
Relationship to case	List symptoms	onset date	case?						

CONFIDENTIAL	PATIENT NAM	IE:		-	Iowa Depa	rtment of Public Health			
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian ☐ Unknown/Other:	☐ Friend/acqu ☐ Contact- wo	nber (non-household) uaintance ork/school/etc			I	/ Yes   No   If this contact is a case create a new event and/or case for this contact.			
			PROPHYLAXIS						
Vaccinated for mer	ningococcal: 🗌 Yes 📗	No Unknown			Antibiotics:	∕es □ No □ Unknown			
Date vaccinated:	1 1	Date vaccinated:	1 1	Antibiotic:					
Lot #:		Lot #:		Date started:					
Vaccine type:		Vaccine type:		Dose:		☐ mg ☐ ml ☐ IU			
Manufacturer:		Manufacturer:		# of times a day:	Number of days:	Route:			
Name	DOB	Gender	Address/Phone						
Hame	БОВ		Address/i fione						
	1 1		Zip code:		Phone: -				
Polotionship to oo	•		•		Symptom	Is contact a			
Relationship to cas		tt	List symptoms		onset date	case?			
☐ Spouse ☐ Child	☐ Sexual con ☐ Family mer	เลcเ nber (non-household)			1	☐ Yes / ☐ No			
☐ Sibling	☐ Friend/acqu	uaintance				If this contact is a case create a new			
☐ Roommate ☐ Parent/ guardian		ork/school/etc attendee				event and/or case			
Unknown/Other:						for this contact.			
			PROPHYLAXIS						
Vaccinated for mer	ningococcal:  Yes	No Unknown			Antibiotics:	res ☐ No ☐ Unknown			
Date vaccinated:	1 1	Date vaccinated:	1 1	Antibiotic:					
Lot #: _		Lot #:		Date started:					
Vaccine type:		Vaccine type:		Dose:	Number	□mg □ml □IU			
Manufacturer:		Manufacturer:		# of times a day:	of days:	Route:			
Name	DOB	Gender	Address/Phone						
	1 1	☐ Male							
		☐ Female			Dhono				
Deletie webie to see			Zip code:		Phone: - Symptom	Is contact a			
Relationship to cas			List symptoms		onset date	case?			
☐ Spouse ☐ Child	☐ Sexual con ☐ Familv mer	tact nber (non-household)			1	☐ Yes / ☐ No			
☐ Sibling	☐ Friend/acqu	uaintance				If this contact is a			
☐ Roommate ☐ Parent/ guardian		ork/school/etc ottendee				case create a new event and/or case			
Unknown/Other:						for this contact.			
PROPHYLAXIS PROPHYLAXIS									
Vaccinated for mer	ningococcal:  Yes	」No □ Unknown			Antibiotics:	∕es ☐ No ☐ Unknown			
Date vaccinated:	1 1	Date vaccinated:	1 1	Antibiotic:					
Lot #: _		Lot #:		Date started:					
Vaccine type:		Vaccine type:		Dose:	Number	□mg □ml □IU			
Manufacturer:		Manufacturer:		# of times a day:	of days:	Route:			
Name	DOB	Gender	Address/Phone						
	/ /	☐ Male ☐ Female							

**PATIENT NAME:** CONFIDENTIAL Iowa Department of Public Health Zip code: Phone: Symptom Is contact a List symptoms Relationship to case onset date case? Spouse Child Sibling ☐ Sexual contact ☐ Yes Family member (non-household) ☐ No ☐ Friend/acquaintance If this contact is a case create a new Roommate Contact- work/school/etc event and/or case ☐ Parent/ guardian ☐ Childcare attendee for this contact. Unknown/Other: **PROPHYLAXIS** Vaccinated for meningococcal: 

Yes 

No 

Unknown Antibiotics: Yes No Unknown Antibiotic: Date vaccinated: Date vaccinated: Date Lot #: Lot #: started: Dose: Vaccine type: Vaccine type: Number # of times Route: Manufacturer: Manufacturer: of days: a day: NOTES: