New Jersey Department of Health
Vaccine Preventable Disease Program
PO Box 369
Trenton, NJ 08625-0369

MENINGOCOCCAL DISEASE CASE REPORT

Report Status	
☐ Confirmed ☐ Probable ☐ Not a Case	
CDRSS#	E#

REPORTING INFORMATION

Reported By	Date Reported to LHD/State	Telephone No.
	_ _ / _ _ / _ _ _ _	(_ _ _) _ _ _ - _ _ _ _

Reporting Site/Clinic	Town/City	County

Type of Reporting Site

☐ College/University ☐ Healthcare Provider ☐ Correctional Facility
☐ School/Day Care ☐ Health Department ☐ Other:

PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth	Age
	_ _ / _ _ / _ _ _ _	

Address	Telephone Number	Secondary Telephone Number
	(_ _ _) _ _ _ - _ _ _ _	(_ _ _) _ _ _ - _ _ _ _

City	Zip Code	County

Race	Ethnicity	Sex
☐ White ☐ Asian/Pacific Islander ☐ Black ☐ Alaskan/Native American ☐ Unknown ☐ Other:	☐ Hispanic ☐ Non-Hispanic ☐ Unknown	☐ Male ☐ Female

Alternate Address *(If applicable, e.g., school, dormitory)*	Telephone Number
	(_ _ _) _ _ _ - _ _ _ _

City	State	Zip Code	County

Emergency Contact (Last, First)	Telephone Number
	(_ _ _) _ _ _ - _ _ _ _

Relationship

☐ Parent/Guardian ☐ Spouse ☐ Sibling ☐ Other (specify):

CLINICAL INFORMATION

Illness Onset Date	Date of Initial Healthcare Evaluation
_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _

Medical Facility	Telephone Number
	(_ _ _) _ _ _ - _ _ _ _

Treating Physician	Telephone Number
	(_ _ _) _ _ _ - _ _ _ _

Primary Care Physician	Telephone Number
	(_ _ _) _ _ _ - _ _ _ _

Symptoms

☐ Altered Mental Status ☐ Fever (highest recorded: ____) ☐ Nausea ☐ Shock
☐ Chills ☐ Headache ☐ Petechial Rash ☐ Stiff Neck
☐ Coma ☐ Malaise ☐ Photophobia ☐ Vascular Disease
☐ Fatigue ☐ Meningitis ☐ Purpuric Rash ☐ Vomiting
☐ Other:

MENINGOCOCCAL DISEASE CASE REPORT
(Continued)

CLINICAL INFORMATION, CONTINUED

Admission Date: _ _ / _ _ / _ _ _ _
Discharge Date: _ _ / _ _ / _ _ _ _
Was Patient Admitted through ED? ☐ Yes ☐ No
Was Patient Admitted to ICU? ☐ Yes ☐ No
Was Patient on a Mechanical Ventilator? ☐ Yes ☐ No
Is Patient Deceased? ☐ Yes ☐ No
If Yes, Date of Death: _ _ / _ _ / _ _ _ _

Medical Record Number:

Treatment

Medication: _____ Dose:
Date(s): _ _ / _ _ / _ _ _ _ - _ _ / _ _ / _ _ _ _
Medication: _____ Dose:
Date(s): _ _ / _ _ / _ _ _ _ - _ _ / _ _ / _ _ _ _
Medication: _____ Dose:
Date(s): _ _ / _ _ / _ _ _ _ - _ _ / _ _ / _ _ _ _

Is Patient Pregnant?
☐ Yes ☐ No ☐ Unknown If Yes, Estimated Delivery Date: _ _ / _ _ / _ _ _ _

Risk Factors
- ☐ Active or Passive Smoking
- ☐ Recent Respiratory Illness
- ☐ Underlying Condition/Immunosuppressed (specify):
- ☐ Known Exposure to Other Case
- ☐ Lives in College Dorm/Military Barracks
- ☐ Recent Travel
- ☐ Other (specify):

Previous History of Vaccination?
☐ Yes ☐ No ☐ Unknown
If Yes:
☐ MCV4 ☐ MPSV4 ☐ Other (specify):
Date of First Dose: _ _ / _ _ / _ _ _ _
Brand:
Date of Second Dose: _ _ / _ _ / _ _ _ _
Brand:

Is Patient part of a Cluster/Outbreak?
☐ Yes (Name of Outbreak): _____ ☐ No ☐ Unknown

Is Patient a Known MSM?
☐ Yes ☐ No ☐ Unknown

LABORATORY INFORMATION

Date of Blood Specimen Collection: _ _ / _ _ / _ _ _ _
Gram Stain: ☐ Gram-negative Diplococci ☐ No Organism
Culture Result: ☐ *N. meningitidis* ☐ No Growth
Was Specimen Collected Prior to Treatment?
☐ Yes ☐ No ☐ Unknown

Date of CSF Specimen Collection: _ _ / _ _ / _ _ _ _
Gram Stain: ☐ Gram-negative Diplococci ☐ No Organism
Culture Result: ☐ *N. meningitidis* ☐ No Growth
Was Specimen Collected Prior to Treatment?
☐ Yes ☐ No ☐ Unknown

	CSF Characteristics	Serum Characteristics
Color/Clarity:		**N/A**
Pressure:		**N/A**
Protein:		**N/A**
Glucose:		
RBC Count:		
WBC Count:		
Predominate Cell Type:		

Other Laboratory Test (specify): _____ Result: _____
Collection Date: _ _ / _ _ / _ _ _ _
Specimen: _____
Was Specimen Collected Prior to Treatment?
☐ Yes ☐ No ☐ Unknown

ADDITIONAL COMMENTS

MENINGOCOCCAL DISEASE CASE REPORT
CONTACT FOLLOW-UP

Record information of close contacts below. All household members (including roommates), and any person who may have had contact with oral secretions should be included.

Name of Contact	Nature of Contact* (List # of all that apply)	Date(s) of Exposure	Date of Birth	Sex	Phone	Previous Immunization? (Provide dates if known)	Recommended Prophylaxis? (Y/N)	Taken Prophylaxis (Y/N/Unknown)?	Prophylaxis Type(s) and Dates

*Nature of Contact:

(1) Household (includes roommates in dormitories)
(2) Intimate contact (including kissing)
(3) Shared food, drink, cigarettes, lipstick, or any articles put in/on mouth
(4) Overnight stay
(5) Preschool/Day Care (younger than kindergarten)
(6) Healthcare/EMS worker exposed to patient's oral/nasal secretions through unprotected mouth-to-mouth resuscitation, intubation, or suctioning
(7) Other (explain)