Invasive Bacterial Disease

Neisseria meningitidis, Haemophilus influenzae, and Group B Streptococcus (Streptococcus agalactiae) Case Report Form

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control
Infectious Disease Epidemiology Program
Phone: 304-558-5358 or 800-423-1271 in West Virginia
Fax: 304-558-8736

Disease Under Investigation

(Bacterial species isolated from any normally sterile site)

* indicates required fields

*Report should be filed within 24 hours electronically and by phone for these diseases.

○ *Neisseria meningitidis ('Meningococcus')** ○ *Haemophilus influenzae ('H.flu')** ○ *Group B Streptococcus (Streptococcus agalactiae)*

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	First Name*	Middle Initial

Street Address

City	County	State	Zip
		West Virginia	

Is the patient's residence a:

○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____

○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.	Report Date mm/dd/yyyy

Parent / Guardian Information

Last Name	First Name	Middle Initial	Relationship to Patient

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	County	State	Zip
		West Virginia	

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	**Age**	**Age Units** ○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native* ☐ *Asian*
☐ *Black or African American* ☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White* ☐ *Unknown*
☐ *Failure to report race/missing race* ☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms mm/dd/yyyy	**Date of diagnosis** mm/dd/yyyy

Was the patient hospitalized for the disease? ○ *Yes* ○ *No* ○ *Unknown*	**Name of Hospital**	**Date of Admission** mm/dd/yyyy

Patient outcome from this disease: ○ *Died* ○ *Survived* ○ *Unknown*	**Date of Death** mm/dd/yyyy

Data for Pregnant / Post-partum Women and/or Infants

Was patient pregnant or post-partum at time of first culture?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, outcome of fetus: ○ *Survived, no apparent illness* ○ *Survived, clinical infection* ○ *Live birth/neonatal death* ○ *Abortion/stillbirth* ○ *Induced abortion* ○ *Unknown*	**If patient < 1 month of age:** Gestational Age (wks)	**Birthweight** (gms)

Types of infection caused by organism

(Check all that apply)

☐ *Abscess (not skin)* ☐ *Bacteremia without focus* ☐ *Cellulitis* ☐ *Chorioamnionitis* ☐ *Endometritis*
☐ *Epiglottitis* ☐ *Hemolytic Uremic Syndrome (HUS)* ☐ *Meningitis* ☐ *Necrotizing fasciitis* ☐ *Osteomyelitis*
☐ *Otitis media* ☐ *Pericarditis* ☐ *Peritonitis* ☐ *Pneumonia* ☐ *Puerperal sepsis*
☐ *Septic abortion* ☐ *Septic arthritis* ☐ *STSS* ☐ *Other (specify)*_____

Laboratory Results

Sterile sites from which the organism was isolated:

(Check all that apply)

☐ *Blood* ☐ *Bone* ☐ *CSF* ☐ *Internal body site:* ☐ *Joint*
☐ *Muscle* ☐ *Pericardial fluid* ☐ *Peritoneal fluid* ☐ *Pleural fluid* ☐ *Other normally sterile site:*_____

Date first positive culture obtained

mm/dd/yyyy

Other sites from which organism isolated:

(Check all that apply)

☐ *Amniotic fluid* ☐ *Middle ear* ☐ *Placenta* ☐ *Sinus* ☐ *Wound* ☐ *Other:*_____

Reporting Source

Last Name	**First Name**

Reporting Source cont.

Phone	Ext.	Fax
###-###-####		###-###-####

Facility

Address

City	State	Zip
	West Virginia	

E-mail

Provider with Further Patient Information

Last Name	First Name

Phone	Ext.	Fax
###-###-####		###-###-####

Address

City	State	Zip
	West Virginia	

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date of Interview
		mm/dd/yyyy

Investigator	Date	Health Department	Phone	Ext.
	mm/dd/yyyy		###-###-####	

Investigation ID	Part of an Outbreak?	Outbreak Name	Lost to follow-up?
	○ *Yes* ○ *No* ○ *Unknown*		○ *Yes* ○ *No*

○ *Check if epi-linked to another case and complete information below*

Last Name of Epi-linked Case	First Name	DOB	County
		mm/dd/yyyy	

Onset Date	If less than 6 years of age, is patient in daycare?
mm/dd/yyyy	○ *Yes* ○ *No* ○ *Unknown*

Indicate underlying causes or prior illness

If none or information not available, check here:

○ *None* ○ *Unknown*

Indicate underlying causes or prior illness cont.

(Check all that apply)

- ☐ *AIDS or CD4 count < 200*
- ☐ *Alcohol abuse*
- ☐ *Asthma*
- ☐ *Atherosclerotic cardiovascular disease (ASCVD)/CAD*
- ☐ *Burns*
- ☐ *Cerebral Vascular Accident (CVA)/Stroke*
- ☐ *Cirrhosis/Liver failure*
- ☐ *Cochlear implant*
- ☐ *CSF leak (2 deg trauma/surgery)*
- ☐ *Current smoker*
- ☐ *Deaf/Profound hearing loss*
- ☐ *Diabetes mellitus*
- ☐ *Emphysema/COPD*
- ☐ *Heart failure/CHF*
- ☐ *HIV infection*
- ☐ *Hodgkin's disease*
- ☐ *Immunoglobulin deficiency*
- ☐ *Immunosuppressive therapy (steroids, chemotherapy, radiation)*
- ☐ *IVDU*
- ☐ *Leukemia*
- ☐ *Multiple myeloma*
- ☐ *Nephrotic syndrome*
- ☐ *Renal failure / renal dialysis*
- ☐ *Sickle cell anemia*
- ☐ *Splenectomy / asplenia*
- ☐ *Systemic lupus erythematosus (SLE)*
- ☐ *Transplant (specify):*_____
- ☐ *Other malignancy (specify):*_____
- ☐ *Other prior illness (specify):*_____

Complete the immunization history for persons with invasive Haemophilus influenzae infection

If < 15 years of age and serotype 'b' or 'unknown' did patient receive Haemophilius influenzae b vaccine?

○ *Yes* ○ *No* ○ *Unknown*

If YES, complete below:

Dose	Date given	Vaccine name	Vaccine manufacturer	Lot number
	mm/dd/yyyy			
1.				
2.				
3.				
4.				

What was the serotype?

○ *b* ○ *Not Typeable* ○ *a* ○ *c* ○ *d* ○ *e* ○ *f* ○ *Not tested/Unknown* ○ *Other*_____

Complete the immunization history for persons with invasive Neisseria meningitidis infection

Did patient recieve Meningococcal vaccine?

○ *Yes* ○ *No* ○ *Unknown*

If YES, Complete Vaccine History

Dose	Date given	Vaccine name	Vaccine manufacturer	Lot number
	mm/dd/yyyy			
1.				
2.				
3.				
4.				

What was the serogroup?

○ *Group A* ○ *Group B* ○ *Group C* ○ *Group W135*
○ *Group Y* ○ *Not groupable* ○ *Unknown* ○ *Other (specify):*_____

Is the patient currently attending college?

(15-24 yrs only)

○ *Yes* ○ *No* ○ *Unknown*

H. Influenza Disease and Meningococcal Disease Contact List

Household Contacts

Name of Contact	Age	Relationship to case	Exposure date*	Exposure setting*	Exposure Mode*	Prophylaxis Yes/No	Prophylaxis Date given	Prophylaxis By whom
			mm/dd/yyyy			(select one)	mm/dd/yyyy	

Out-of-Household Contacts

Name of Contact	Age	Relationship to case	Exposure date*	Exposure setting*	Exposure Mode*	Prophylaxis Yes/No	Prophylaxis Date given	Prophylaxis By whom
(name,address,phone)			mm/dd/yyyy			(select one)	mm/dd/yyyy	

Public Health Action Taken

Describe public health action taken