TEXAS Health and Human Services | Texas Department of State Health Services

Submit all completed forms
Texas Department of State Health Services
Phone: (512) 776-7676 Fax: (512) 776-7616
VPDTexas@dshs.texas.gov

Invasive Meningococcal Disease (*Neisseria meningitidis*) Case Investigation Form

FINAL CASE STATUS:
- ☐ CONFIRMED
- ☐ PROBABLE
- ☐ SUSPECT
- ☐ RULED OUT/ NOT A CASE

NBS PATIENT ID#: _____

NBS CASE INVESTIGATION ID#: _____

Patient's Name: _____ (last) (first)
Address: _____
City: _____ County: _____ Zip: _____
Region: _____ Phone: ( ) _____
Parent/Guardian: _____

Physician: _____ Phone: ( ) _____
Address: _____
_____

☐ Check box if history of homelessness in last 6 months

Reported by: _____
Agency: _____
Phone: ( )_____
Date reported: ____/____/____

Investigated by: _____
Agency: _____
Phone: ( ) _____
Email: _____
Investigation start date: ____/____/____
Date investigation completed: ____/____/____

DEMOGRAPHICS: DATE OF BIRTH: _____/_____/_____ AGE: _____ PLACE OF BIRTH: ☐ USA ☐ Other: _____ ☐ Unknown
SEX: ☐ Male ☐ Female ☐ Unknown
RACE: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pac. Islander ☐ Am. Indian or Alaska Native ☐ Unknown ☐ Other: _____
ETHNICITY: Hispanic ☐ Yes ☐ No ☐ Unknown
If female, is patient currently pregnant? ☐ Yes ☐ No ☐ Unknown Obstetrician's name, address, and phone #: _____
If yes, estimated date and location of delivery: ____/____/____ _____

CLINICAL INFORMATION: **Symptom onset date**: ____/____/____ **Illness end date**: ____/____/____

Did patient die? ☐ Yes, died on: ____/____/_____ ☐ No, but still ill as of: ____/____/____ ☐ No, recovered ☐ Unknown

Signs and symptoms: *(Select all that apply)*

Fever ☐Yes, ____°F or ☐Subjective fever / ☐No / ☐Unk

Rash ☐Yes, petechiae /☐Yes, purpura /☐Yes, type unknown /☐Yes, other type / ☐No / ☐Unk

Headache	☐Yes / ☐No/ ☐Unk	Cough	☐Yes / ☐No/ ☐ Unk	Shortness of breath	☐Yes / ☐No/ ☐Unk
Stiff neck	☐Yes / ☐No/ ☐ Unk	Seizures	☐Yes / ☐No/ ☐ Unk	Photophobia (sensitivity to light)	☐Yes / ☐No/ ☐Unk
Sore throat	☐Yes / ☐No/ ☐ Unk	Joint pain	☐Yes / ☐No/ ☐ Unk	Nausea	☐Yes / ☐No/ ☐Unk
Chills	☐Yes / ☐No/ ☐ Unk	Cold	☐Yes / ☐No/ ☐ Unk	Vomiting	☐Yes / ☐No/ ☐Unk
Fatigue	☐Yes / ☐No/ ☐ Unk	hand/feet	☐Yes / ☐No/ ☐ Unk	Diarrhea	☐Yes / ☐No/ ☐Unk
Muscle pain	☐Yes / ☐No/ ☐Unk	Confusion	☐Yes / ☐No/ ☐ Unk	Abdominal pain	☐Yes / ☐No/ ☐Unk
Chest pain	☐Yes / ☐No/ ☐ Unk				

Clinical presentation (select all that apply)

☐ Bacteremia ☐Meningitis ☐ Pneumonia ☐ Septic arthritis ☐ Cellulitis ☐ Pericarditis ☐Osteomyelitis ☐ Purpura fulminans
☐ Other: _____

COMPLEMENT INHIBITOR INFORMATION

Does the patient have complement component deficiency/inhibition (or is taking Soliris/eculizumab) ☐Yes ☐ No ☐ Unknown

Has the patient taken Eculizumab/Soliris at time of disease onset or up to 3 months prior to disease onset? ☐Yes ☐ No ☐ Unknown

Has the patient taken Ravulizumab/ultomiris at the time of disease onset or up to 8 months prior to disease onset? ☐Yes ☐ No ☐ Unknown

(Complete rest of section if yes indicated for question above)

Indication for eculizumab treatment ☐ Paroxysmal nocturnal hemoglobinuria (PNH) ☐Generalized myasthenia gravis (gMG)

☐Atypical hemolytic uremic syndrome (aHUS) ☐ Other: _____ ☐ Unknown

Date eculizumab treatment started: ____/____/____ ☐ Unknown

Date eculizumab treatment ended: ____/____/____ ☐ Ongoing ☐ Unknown

Was the patient taking antibiotics at the time of disease onset? ☐ Yes ☐ No ☐ Unknown
If yes, antibiotic name: _____ **Date antibiotic started**: ____/____/____ **Daily dose:** _____

UNDERLYING CONDITIONS*

Does the patient have any underlying health conditions? ☐ Yes *(check all that apply)* ☐ No ☐ Unknown

☐ HIV/AIDS ☐ Diabetes ☐ Renal failure/Dialysis ☐ Cancer, specify:_____ ☐ Heart failure/CHF ☐ CVA/Stroke ☐Cirrhosis / Liver failure

☐ Asthma ☐ Other chronic lung disease ☐ Asplenia (functional or anatomic)/ Splenectomy ☐ Cochlear implant ☐ Immunosupressive therapy (Steroids, Chemotherapy, Radiation) ☐Atherosclerotic Cardiovascular Disease (ASCVD) / (CAD ☐ Other: _____

Other prior illness within two weeks of onset? ☐ Yes, specify: _____ ☐ No ☐ Unknown

HEALTH BEHAVIORS (record underlying conditions in NBS) **Do any of the following apply to the patient?**
☐ Yes *(check behaviors below)* ☐ No ☐ Unknown ☐ Refused to answer

☐ Current smoker ☐ Alcohol, drinks per week: _____ ☐ Intravenous drug use (IVDU), current ☐ Other; specify: _____

**Record all underlying conditions and health behaviors in NBS*

TREATMENT HISTORY

Did the patient receive antibiotics? ☐ Yes, one ☐ Yes, multiple ☐ No ☐ Unknown

If yes, name or type of antibiotic given: _____ Start date: ____/____/____ End date: ____/____/____

If yes, name or type of antibiotic given: _____ Start date: ____/____/____ End date: ____/____/____

If yes, name or type of antibiotic given: _____ Start date: ____/____/____ End date: ____/____/____

Were any antibiotics given prior to specimen collection? ☐ Yes ☐ No ☐ Unknown

If yes, antibiotic name:_____ given on ____/____/____ at ____:____ ☐ AM ☐ PM

If yes, antibiotic name:_____ given on ____/____/____ at ____:____ ☐ AM ☐ PM

HOSPITALIZATION INFORMATION

Was the patient hospitalized? ☐ Yes, name of hospital: _____ ☐ No ☐ Unknown

Date of admission: ____/____/____ Date of discharge: ____/____/_____

How many people were in the vehicle that transported the patient to the hospital? _____ ☐Date transport persons contacted ___/___/____

Was the patient seen at multiple hospitals? ☐ Yes ☐ No ☐ Unknown *If yes, complete the following table:*

Hospital / Clinic name	Mode of transportation to facility	Date/time of visit/arrival	Date/time of discharge	Discharged to*
	☐ Drove self ☐ Driven by friend/family ☐ Ambulance ☐ Other:_____			
	☐ Drove self ☐ Driven by friend/family ☐ Ambulance ☐ Other:_____			

*Discharged to home, another facility, or left against medical advice (AMA)

VACCINATION HISTORY **Has the patient ever received any meningococcal vaccine?** ☐ Yes, *fill in table below* ☐ No* ☐ Unknown**

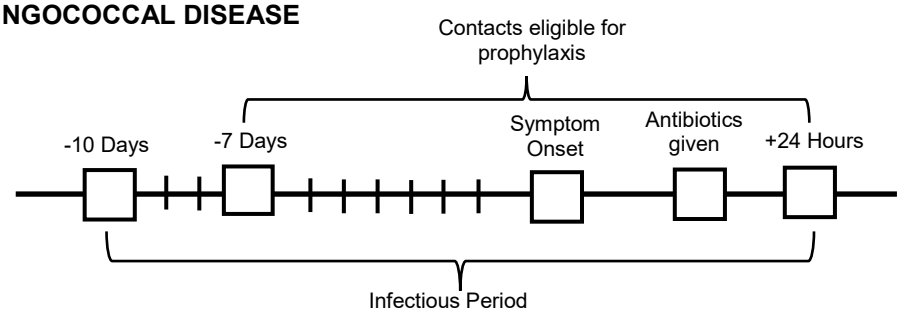
History obtained from: ☐ Patient/Parent ☐ Primary care physician ☐ Reporting physician/facility ☐ School ☐ ImmTrac ☐ Other: _____

***If no, indicate reason**: ☐Religious Exemption ☐Medical Contraindication ☐Under Age ☐Parental Refusal ☐Unknown ☐Other: _____

Dose #	Date dose received	Type of Vaccine	Vaccine Manufacturer	Vaccine Brand/Name	Vaccine Lot Number
1	____/____/_____				
2	____/____/_____				
3	____/____/_____				

***Note: All possible sources of vaccination history above should be exhausted before deciding that vaccination status is "unknown". If "unknown", mark boxes for all sources checked.*

TIMELINE FOR MENINGOCOCCAL DISEASE



ADDITIONAL EXPOSURE HISTORY

Did the patient travel anywhere during the two weeks prior to onset and up until the patient was diagnosed/treated? ☐ Yes ☐ No ☐ Unk

Travel location:_____ Dates of travel: ____/____/_____ to ____/____/_____

Travel location:_____ Dates of travel: ____/____/_____ to ____/____/_____

Did the patient spend 8 or more hours on an airplane (or bus, train, etc.)? ☐ Yes, *complete line(s) below* ☐ No ☐ Unknown

Airline:_____ Flight number:_____ Flight date: ____/____/____ Time:___:___ Departure city:_____

Airline:_____ Flight number:_____ Flight date: ____/____/____ Time:___:___ Departure city:_____

Did the patient attend any gatherings (e.g., public, church/religious, family, etc.), conventions, meetings, parties, dinners, sporting events, festivals, or other group events during the two weeks prior to onset? ☐ Yes, *complete the following table* ☐ No ☐ Unknown

Event	Location	# of people present	Date of event
			____/____/_____
			____/____/_____
			____/____/_____

CONTACTS *(Refer to Investigation Guidance for a description of close contacts)*

For the following questions, please ask about the two weeks prior to symptom onset and up until the patient was appropriately treated.

Where was the patient living (select all that apply)? ☐ Single-family dwelling ☐ Duplex, triplex, etc. ☐ Apartment/Condo/Townhome ☐ Dormitory ☐Military barracks ☐ Hospital or rehab facility ☐ Nursing home or similar ☐ Retirement home ☐ Camp ☐ Other:_____ ☐ Unknown **Name of location**:_____

Was the patient in a detention center, correctional facility, halfway house, or shelter (e.g., jail, prison, etc.)? ☐ Yes ☐ No ☐ Unknown

If yes, name/location of facility: _____

How many people live in the patient's household? _____

During the two weeks prior to onset, did any member of the patient's household have a similar illness? ☐ Yes ☐No ☐ Unknown

If yes, name of person:_____ Date of onset ____/____/_____ Symptoms: _____

If yes, name of person:_____ Date of onset ____/____/_____ Symptoms: _____

Did the patient attend, visit, or work at a school? ☐ Yes, student ☐ Yes, faculty/staff ☐ Yes, visitor ☐ No ☐ Unknown

If a college student, college year: ☐ Fr ☐ So ☐ Jr ☐ Sr ☐ Other **Name/location of school**: _____

Does the college student live on or off campus? ☐ On campus ☐ Off campus Name/location of residence:_____

Does the college student participate in Greek life? ☐ Yes ☐ No Name/location of Greek organization: _____

How many people did the patient… (Indicate a number for all of the following:)

Kiss: ____ Share a sleeping area:_____ Share a toothbrush:_____ Share food or utensils:_____ Share drinks:_____ Share drugs: _____

Share (brass or wind) band instruments: _____ Share cigarettes: _____

Did the patient perform mouth to mouth resuscitation on anyone? ☐ Yes ☐ No ☐ Unknown

If yes, name of person: _____ Date performed:____/____/_____

Did the patient attend, stay, visit, or work at a childcare center, home daycare, nursing home, or similar facility? ☐ Yes ☐ No ☐ Unknown

If yes, school/facility name: _____ Date last attended/worked/visited before onset: ____/____/_____

Total contacts (#): _____students/residents _____staff Total close contacts (#): _____students/residents _____staff

Did anyone associated with the facility have a similar illness during the two weeks prior to onset? ☐Yes ☐ No ☐Unknown

If yes, name of person: _____ Date of onset: ____/____/____ Symptoms:_____ (*If needed, attach list to this report*)

Is the patient employed? ☐Yes ☐ No ☐ Unknown Occupation: _____

Name/location of employer: _____ Date last worked before treatment: ____/____/_____

Description of job duties: _____

SEXUAL CONTACTS *(Please ask the patient all of the following questions)*

During the past 12 months, have you had sex with only males, only females, or with both males and females?

☐Males only ☐Females only ☐Both males and females ☐Unknown ☐Not Sexually active ☐Refused to answer

Do you consider yourself to be: ☐Heterosexual/Straight ☐ Gay/Lesbian/Homosexual ☐Bisexual ☐Other: _____ ☐ Refused

MSM not otherwise specified: ☐Yes ☐ No ☐ Unknown

Thinking back to the 3 months before you were diagnosed with meningococcal disease, how many MEN did you have sex with during that time?

☐Number of men: _____ (☐Known ☐ Estimated) ☐Unknown (no number given) ☐Refused to answer

PROPHYLAXIS – Please refer to the Meningococcal Disease Investigation Guidance for prophylaxis guidelines and recommendations

Were control activities initiated? ☐*Yes* ☐No ☐Unknown *If no or unk, explain:* _____ *Date* ____/____/____

Date prophylaxis recommendations were first made: ____/____/____

Prophylaxis provided by *(check all that apply)*: ☐ DSHS or LHD ☐ Hospital ☐ Private physician ☐ Other:_____ ☐ None given

Number of people	Household	Students/ Staff at school &/or daycare	Residents/ Staff at long term care facility	Residents/ Staff at correctional facility	Healthcare workers including EMS	Other close contacts*
Prophylaxis recommended for:						
Declined recommended prophylaxis:						
Received prophylaxis:						
Type of prophylaxis:						

** Friends, colleagues, extended family, etc.*

LABORATORY DATA

Isolate sent to DSHS? (required) ☐ Yes, date____/____/____; DSHS Lab#: _____

☐ No, reason: _____ ☐If no, Hospital/Laboratory contacted and education provided, date ____/____/____

☐ Unknown ☐If unknown, Hospital/Laboratory contacted and education provided, date ____/____/____

Was *Neisseria meningitidis* testing done?

☐ Yes, *complete sections below* ☐ No, diagnosis based on clinical purpura fulminans ☐ Other:_____

Gram stain: Date and time collected: ____/____/_____; ____:____ ☐AM ☐PM Specimen Source: ☐ CSF ☐ Blood ☐Other:_____

Result: ☐ Gram-negative diplococci ☐ Negative ☐ Inconclusive ☐ Unknown ☐ Other:_____

CSF Profile: Date collected: ____/____/_____ Appearance:_____ Pressure:_____ mm H_2O

Glucose: _____mg/dL Protein: _____ mg/dL RBCs: _____mm^3 WBCs: _____mm^3 Lymphs: _____% Polys: _____% Mono: _____%

Culture: Date and time collected: ____/____/_____; ____: ____ ☐AM ☐ PM Specimen Source: ☐ CSF ☐ Blood ☐ Other:_____

Result: ☐ Positive for: _____ ☐ Negative ☐ Inconclusive ☐ Unknown ☐ Other:_____

Other test:

Test type: ☐ Latex agglutination ☐ Immunohistochemistry (IHC) ☐ PCR ☐ Other:_____

Date and time collected: ____/____/_____; ____:____ ☐AM ☐PM Specimen Source: ☐ CSF ☐ Blood ☐ Other:_____

Result: ☐ Positive for: _____ ☐ Negative ☐ Inconclusive ☐ Unknown ☐ Other:_____

Serogroup results: ☐ A ☐ B ☐ C ☐ Y ☐ W135 ☐ Z ☐ Other: _____ ☐ Not groupable ☐ Unknown ☐ Pending

ADDITIONAL HEALTH DEPARTMENT ACTIONS AND CONTROL MEASURES IMPLEMENTED

(check all that apply and indicate date initiated)

☐ Confirmed that symptomatic individuals are placed on droplet precautions until 24 hours after effective antibiotic treatment on ____/____/____

☐ Reviewed high risk exposures with medical provider on ____/____/____

☐ Contact tracing (identifying close contacts through patient or surrogate interview) initiated on____/____/____

☐ Education (risk, transmission, symptoms) provided to contacts starting on ____/____/____

☐ Requested the hospital or laboratory forward the isolate to the DSHS lab on ____/____/____

☐ Worked with school, daycare or long term care facility to identify and notify close contacts starting on ___/____/____

☐ Other (specify):_____ on ____/____/____

☐ Other (specify) _____ on ____/____/____

COMMENTS: