Appendix 3: Sample Meningococcal Disease case questionnaire

*(This page contains form/s that are intended to be paper based that you can download and complete. If you are using any assistive technology and are unable to use the form please contact us using the* [*Online form*](http://www.health.gov.au/internet/main/publishing.nsf/Content/health-comments.htm) *and feedback)*

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| **Sample Meningococcal Disease Case Questionnaire**  |
| Unique identifier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Final classifications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Confirmed – serogroup:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Probable (i.e. clinically compatible):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Rejected:\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /Interviewer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Person interviewed (if not case):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Section 1: Demographic Data**Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Given names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suburb/Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: H: W: Mob: Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of parent / guardian / care-giver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: / / or Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: Male / Female \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Interpreter required: Yes /No. If yes, state language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Aboriginal: or
* Torres Strait Islander: (Tick as appropriate)
* Aboriginal & TSI
* Not A/TSI
* Not Stated/Unknown/Question unable to be asked

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name / Address of Employer or School or Child Care Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facsimile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Last Attended: / /  |
| **Section 2: Treating Doctor/Hospital**Name of Treating Doctor or Hospital (if admitted):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient UR No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ward: Suburb Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facsimile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Admission: / / Date of Discharge / / Death / /Was the patient brought to hospital by ambulance? no yes (circle option)General practitioner details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number: Fixed ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Section 3: Illness Summary**Onset Date (first symptom): / / Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Incubation period from: / / (7 days before onset)Symptom Checklist

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| Fever / Chills  | Headache  | Rash  | Photophobia  | Neck stiffness  |
| Arthralgia/ Myalgia  | Abdominal Pain  | Vomiting  | Diarrhoea  | Ataxia  |
| Confusion | Drowsiness |  |  |  |

Syndrome:Meningitis\_\_\_\_\_\_\_\_ Septicaemia:\_\_\_\_\_\_\_\_\_\_ Conjunctivitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_Laboratory Results:WCC:\_\_\_\_\_\_\_\_\_ Neutrophils:\_\_\_\_\_\_\_\_\_\_\_ CRP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| Blood  |  Date of collection: / / | PCR: Positive / Negative | Culture: Growth / No Growth | Gram stain result: |
| CSF  |  Date of collection: / / | PCR: Positive / Negative | Culture: Growth / No Growth | Gram stain result: |
| Conjunctival swab |  Date of collection: / / | PCR: Positive / Negative | Culture: Growth / No Growth | Gram stain result: |

Details (onset, description and location of rash etc) and other symptoms, treatment details. Date of commencement of antibiotic treatment:Has the case received appropriate clearance antibiotics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the patient have functional or anatomical asplenia? Yes no (circle)Smoking risk? Smoker \_\_\_\_\_\_ Smoker in household \_\_\_\_\_ Non-smoker\_\_\_\_\_\_\_\_\_ |
| **Section 4: Epidemiological Contact Questions**Previous meningococcal vaccination? Yes No Date: / /Verified by: ACIR Vaccine or medical record Recall only \_\_\_\_\_\_If yes, details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Conjugate/Polysaccharide (A/C/Y/W135) / /Previous contact with a family member, a friend, school contact or work colleagues with a compatible illness? Yes No If yes, details: Attended childcare in the 7 days prior to onset? Yes No Not applicable (circle)If yes, details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Attended any special functions / parties in the 7 days prior to onset? Yes No (circle)If yes, details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Has the case travelled in the 7 days prior to onset? Yes No (circle)If yes, details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Section 5: Clearance antibiotics log sheet for contacts**Prescribing doctor to complete and return via email or fax within 24 hours. Record the names of all contacts given clearance antibiotics

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| Name | Tel no | Date of birth/ Age | Antibiotic | Dose | Weight (kg) | Date | Signature |
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|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Name of prescribing Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital and ward/unit name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_On completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please email or fax to Communicable Disease Branch or equivalentFax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Section 6: Comments or Conclusions** Epidemiological classification: sporadic cluster co-primary outbreak secondary Related cases reference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Creche or School notified Name: date: / /Workplace notified Name: date: / /Ambulance service notified Name: date: / /Information provided to contacts: Yes No (circle) date: / /Officer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: / / (Also print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |