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   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  |  |  |  | | --- | --- | --- | --- | --- | | 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   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Name | Tel no | Date of birth/ Age | Antibiotic | Dose | Weight (kg) | Date | Signature | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |   Name of prescribing Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hospital and ward/unit name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  On completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please email or fax to Communicable Disease Branch or equivalent  Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |