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 and feedback)

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 clusterco-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) _____