

Enhanced Meningococcal Disease Surveillance Data Collection Guidance Worksheet

NNDSS Case ID: _____		State ID: _____		Laboratory ID: _____																																																	
DOB: / / OR Age: _____ years old			Case Status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable																																																		
Event date: / /			Source: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Other (specify): _____																																																		
Lab confirmation method: <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> Latex <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Test used to serogroup: <input type="checkbox"/> Slide agglutination (SASG) <input type="checkbox"/> PCR <input type="checkbox"/> WGS <input type="checkbox"/> Other																																																		
Serogroup: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> E <input type="checkbox"/> W <input type="checkbox"/> X <input type="checkbox"/> Y <input type="checkbox"/> Not groupable <input type="checkbox"/> Other (specify) _____			<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Symptoms:</th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">Unknown</th> </tr> </thead> <tbody> <tr><td>Headache</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Fever</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Stiff neck</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Photophobia</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Nausea</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Vomiting</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Diarrhea</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Sore throat</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Rash</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr> <td></td> <td colspan="3" style="text-align: right;">Rash type: <input type="checkbox"/> Petechiae <input type="checkbox"/> Purpura <input type="checkbox"/> Other <input type="checkbox"/> Unknown</td> </tr> <tr> <td></td> <td colspan="3" style="text-align: right;"><input type="checkbox"/> Other (specify) _____</td> </tr> </tbody> </table>			Symptoms:	Yes	No	Unknown	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Photophobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rash type: <input type="checkbox"/> Petechiae <input type="checkbox"/> Purpura <input type="checkbox"/> Other <input type="checkbox"/> Unknown				<input type="checkbox"/> Other (specify) _____		
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Outcome: <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown																																																					
\ # k : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																																																					
Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																																																					
College Student: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>If yes, please complete the following questions</i> Year in School: <input type="checkbox"/> Freshman <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> Graduate Student <input type="checkbox"/> Other <input type="checkbox"/> Unknown Residence Type: <input type="checkbox"/> On Campus <input type="checkbox"/> Off Campus <input type="checkbox"/> Unknown Greek Life: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			HIV Status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown																																																		
MSM (men who have sex with men)- Complete these variables for any male cases 16 years of age and older.																																																					
During the past 12 months, have you had sex with only males, only females, or with both males and females? <input type="checkbox"/> Males only <input type="checkbox"/> Females only <input type="checkbox"/> Both males and females <input type="checkbox"/> Not sexually active <input type="checkbox"/> Unknown <input type="checkbox"/> Refused																																																					
MSM not otherwise specified: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																																																					
Taking complement inhibitor: <input type="checkbox"/> Yes, eculizumab/Soliris <input type="checkbox"/> Yes, ravulizumab/Ultomiris <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>If yes, please complete the complement inhibitor case information table below</i>																																																					
COMPLEMENT INHIBITOR CASE INFORMATION*																																																					
Indication for complement inhibitor treatment: <input type="checkbox"/> Paroxysmal nocturnal hemoglobinuria (PNH) <input type="checkbox"/> Unknown <input type="checkbox"/> Generalized myasthenia gravis (gMG) <input type="checkbox"/> Atypical hemolytic uremic syndrome (aHUS) <input type="checkbox"/> Other: _____																																																					
Date complement inhibitor treatment started: / / <input type="checkbox"/> Unknown																																																					
Date complement inhibitor treatment ended: / / <input type="checkbox"/> Ongoing <input type="checkbox"/> Unknown																																																					
Hospitalized? <input type="checkbox"/> Yes () days <input type="checkbox"/> No <input type="checkbox"/> Unknown			Sequelae: <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown																																																		
Was the patient taking antibiotics at the time of disease onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown ➤ If yes: Antibiotic: _____ Date antibiotic started: / / Daily dose: _____																																																					

*These variables are part of a supplemental data collection activity that is NOT part of NNDSS meningococcal disease surveillance. This is included as a convenience for jurisdictions who choose to participate in this supplemental data collection.

VACCINATION INFORMATION

Did the patient receive quadrivalent meningococcal vaccine? Yes No Unknown *If yes to either, please complete the table below for each dose*

Did the patient receive serogroup B meningococcal vaccine? Yes No Unknown

Date	Vaccine		
	Type	Name	Lot Number
MM/DD/YY <input type="checkbox"/> Unknown	<input type="checkbox"/> MenACWY <input type="checkbox"/> MenB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
MM/DD/YY <input type="checkbox"/> Unknown	<input type="checkbox"/> MenACWY <input type="checkbox"/> MenB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
MM/DD/YY <input type="checkbox"/> Unknown	<input type="checkbox"/> MenACWY <input type="checkbox"/> MenB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
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