

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) _____			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			College Student: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>If yes, please complete the following questions</i>		
Homeless: <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		
Sheltered homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Residence Type: <input type="checkbox"/> On Campus <input type="checkbox"/> Off Campus <input type="checkbox"/> Unknown		
HIV Status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown			Greek Life: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
International travel in the month before disease onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>Please capture all travel history for the case and close contacts in the month before disease onset, including who traveled (if contact specify relationship), the location, and the date of return to the United States.</i>					
<input type="checkbox"/> Case	<input type="checkbox"/> Contact(s): _____	City: _____	Country: _____	Date of return to U.S.: _____	
<input type="checkbox"/> Case	<input type="checkbox"/> Contact(s): _____	City: _____	Country: _____	Date of return to U.S.: _____	
<input type="checkbox"/> Case	<input type="checkbox"/> Contact(s): _____	City: _____	Country: _____	Date of return to U.S.: _____	
<input type="checkbox"/> Case	<input type="checkbox"/> Contact(s): _____	City: _____	Country: _____	Date of return to U.S.: _____	
<input type="checkbox"/> Case	<input type="checkbox"/> Contact(s): _____	City: _____	Country: _____	Date of return to U.S.: _____	
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					
Known epidemiologic link with any other meningococcal disease case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, case ID of linked case:: _____					
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 on the next page</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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<i>If yes to either, please complete the table below for each dose</i>	
Did the patient receive serogroup B meningococcal vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date	Vaccine		
	Type	Name	Lot Number
MM/DD/Y <input type="checkbox"/> Unknown	<input type="checkbox"/> MenACWY <input type="checkbox"/> MenB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
MM/DD/Y <input type="checkbox"/> Unknown	<input type="checkbox"/> MenACWY <input type="checkbox"/> MenB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
MM/DD/Y <input type="checkbox"/> Unknown	<input type="checkbox"/> MenACWY <input type="checkbox"/> MenB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
MM/DD/Y <input type="checkbox"/> Unknown	<input type="checkbox"/> MenACWY <input type="checkbox"/> MenB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
MM/DD/Y <input type="checkbox"/> Unknown	<input type="checkbox"/> MenACWY <input type="checkbox"/> MenB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		