

## 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 \_\_\_\_\_

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#### 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:

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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) \_\_\_\_\_