



<b>HOSPITAL</b> <b>36. Was the patient hospitalized for this illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNKNOWN <b>37. Hospital name:</b> _____ <b>38. Hospital ID:</b> _____ <b>39. Hospital ID Type:</b> _____ <b>40. Admission Date:</b> <b>41. Discharge Date:</b> <div style="display: flex; justify-content: space-around;"> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  MONTH      DAY      YEAR </div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  MONTH      DAY      YEAR </div> </div> <b>42. Total duration of stay within hospital:</b> <input type="text"/> <input type="text"/> <input type="text"/> Days		<b>43a. Hospital/lab iD where culture identified:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<b>43b. Hospital iD where patient treated:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<b>44a. Was patient transferred from another hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>44b. If Yes, hospital iD</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
<b>45. Illness Onset Date:</b> <div style="display: flex; justify-content: space-around;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  MONTH      DAY      YEAR </div>		<b>46. Illness End Date:</b> <div style="display: flex; justify-content: space-around;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  MONTH      DAY      YEAR </div>			
<b>47. Types of infection caused by organism (CHECK ALL THAT APPLY)</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Bacteremia without focus   <input type="checkbox"/> Meningitis   <input type="checkbox"/> Otitis media   <input type="checkbox"/> Pneumonia   <input type="checkbox"/> Cellulitis   <input type="checkbox"/> Epiglottitis   <input type="checkbox"/> Hemolytic uremic syndrome (HUS) </div> <div style="width: 33%;"> <input type="checkbox"/> Abscess (not skin)   <input type="checkbox"/> Peritonitis   <input type="checkbox"/> Pericarditis   <input type="checkbox"/> Septic abortion   <input type="checkbox"/> Chorioamnionitis   <input type="checkbox"/> Septic arthritis   <input type="checkbox"/> Osteomyelitis </div> <div style="width: 33%;"> <input type="checkbox"/> Empyema   <input type="checkbox"/> Endocarditis   <input type="checkbox"/> Endometritis   <input type="checkbox"/> STSS   <input type="checkbox"/> Necrotizing fasciitis   <input type="checkbox"/> Puerperal sepsis   <input type="checkbox"/> Other infection _____ </div> </div>		<b>48a. Bacterial species isolated from any normally sterile site (CHECK ALL THAT APPLY)</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> <i>Neisseria meningitidis</i>   <input type="checkbox"/> <i>Haemophilus influenzae</i>   <input type="checkbox"/> Group B streptococcus </div> <div style="width: 50%;"> <input type="checkbox"/> Abscess (not skin)   <input type="checkbox"/> Group A streptococcus   <input type="checkbox"/> <i>Streptococcus pneumoniae</i> </div> </div> <b>48b. Other bacterial species isolated from any normally sterile site</b> <hr/> <hr/> <hr/>			
<b>49. Sterile sites from which organism isolated: (CHECK ALL THAT APPLY)</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Blood   <input type="checkbox"/> CSF   <input type="checkbox"/> Pleural fluid   Specify  <input type="checkbox"/> Internal body site _____  <input type="checkbox"/> Other normally sterile site _____ </div> <div style="width: 33%;"> <input type="checkbox"/> Peritoneal fluid   <input type="checkbox"/> Pericardial fluid   <input type="checkbox"/> Joint </div> <div style="width: 33%;"> <input type="checkbox"/> Bone   <input type="checkbox"/> Muscle </div> </div>		<b>50. Date first positive culture obtained: (date specimen drawn)</b> <div style="display: flex; justify-content: space-around;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  MONTH      DAY      YEAR </div> <b>51. Other nonsterile sites from which organism isolated: (CHECK ALL THAT APPLY)</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Placenta   <input type="checkbox"/> Amniotic fluid   <input type="checkbox"/> Wound </div> <div style="width: 50%;"> <input type="checkbox"/> Middle ear   <input type="checkbox"/> Sinus   <input type="checkbox"/> Other nonsterile site _____ </div> </div>			
<b>52. Underlying causes or prior illness: (CHECK ALL THAT APPLY)</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> Current smoker   <input type="checkbox"/> Multiple myeloma   <input type="checkbox"/> Sickle cell anemia   <input type="checkbox"/> Splenectomy / asplenia   <input type="checkbox"/> Immunoglobulin deficiency  <input type="checkbox"/> Immunosuppressive therapy (Steroids, Chemotherapy, Radiation)  <input type="checkbox"/> Leukemia </div> <div style="width: 25%;"> <input type="checkbox"/> Hodgkin disease   <input type="checkbox"/> Asthma   <input type="checkbox"/> Emphysema / COPD   <input type="checkbox"/> Systemic lupus erythematosus (SLE)   <input type="checkbox"/> Diabetes mellitus   <input type="checkbox"/> Nephrotic syndrome   <input type="checkbox"/> Renal failure/Dialysis </div> <div style="width: 25%;"> <input type="checkbox"/> HIV infection   <input type="checkbox"/> AIDS or CD4 count &lt;200   <input type="checkbox"/> Cochlear implant   <input type="checkbox"/> Deaf / profound hearing loss   <input type="checkbox"/> Cirrhosis / Liver failure   <input type="checkbox"/> Alcohol Abuse   <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD) / (CAD) </div> <div style="width: 25%;"> <input type="checkbox"/> Heart failure / CHF   <input type="checkbox"/> Obesity   <input type="checkbox"/> CSF leak   <input type="checkbox"/> IVDU   <input type="checkbox"/> Cerebral vascular accident (CVA) / Stroke   <input type="checkbox"/> Complement deficiency </div> </div> Specify <input type="checkbox"/> Other malignancy _____ <input type="checkbox"/> Organ transplant _____ <input type="checkbox"/> Other prior illness _____					
<b>53. Was patient pregnant / post partum at time of first positive culture?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, outcome of fetus <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Survived, no apparent illness   <input type="checkbox"/> Survived, clinical infection </div> <div style="width: 33%;"> <input type="checkbox"/> Live birth / neonatal death   <input type="checkbox"/> Abortion / stillbirth </div> <div style="width: 33%;"> <input type="checkbox"/> Induced abortion   <input type="checkbox"/> Unknown </div> </div>					
<b>54. Is the patient &lt;1 month of age?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown    If yes, time of birth: _____:_____:_____ Gestational age: <input type="text"/> <input type="text"/> (wks)    Birth weight: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (gms)				<b>55. Did the patient die from this illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

VACCINATION RECORD					
Vaccine	Administered (mm/dd/yyyy)	Given by: Last Name /First Name Provider ID	Organization Name / ID	Lot Number	Expiration Date (mm/dd/yyyy)
Menomune, tetravalent meningococcal polysaccharide vaccine					
Menactra or Menveo, quadrivalent meningococcal conjugate vaccine					
Other (specify)_____					
Not Known					

EPIDEMIOLOGIC		
<b>64. Does this patient: (CHECK ALL THAT APPLY)</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>Attend a day care* facility</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown </div> <div> <b>Facility name</b> _____ </div> </div> <p style="font-size: small; margin-top: 5px;">*DAY CARE IS DEFINED AS A SUPERVISED GROUP OF 2 OR MORE UNRELATED CHILDREN FOR &gt;4 HOURS PER WEEK.</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div> <b>Reside in a long term care facility?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown </div> <div> <b>Facility name</b> _____ </div> </div>		
<b>65. Is this case part of an outbreak?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Outbreak name</b> _____  Where was this disease acquired? _____  <div style="display: flex; justify-content: space-between;"> <div>Imported Country: _____</div> <div>Imported City: _____</div> </div> <div style="display: flex; justify-content: space-between;"> <div>Imported State: _____</div> <div>Imported County: _____</div> </div>		
<b>CONFIRMATION METHOD</b>  <b>66. Case status:</b>  <input type="checkbox"/> Confirmed <input type="checkbox"/> Not a case <input type="checkbox"/> Probable <input type="checkbox"/> Unknown <input type="checkbox"/> Suspect	<b>67. Does this patient have recurrent disease with the same pathogen?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <b>If yes, previous (1st) state I.D.</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>68. CRF Status:</b>  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Complete  <input type="checkbox"/> Incomplete  <input type="checkbox"/> Edited &amp; Correct </div> <div> <input type="checkbox"/> Chart unavailable after 3 requests </div> </div>
<b>General Comments:</b> _____   		