



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
**RECORD OF INVESTIGATION OF BACTERIAL MENINGITIS
 OR BACTEREMIA CASE REPORT**

DATE OF REPORT
DATE OF ONSET

PATIENT'S NAME (LAST, FIRST, M.I.)		
PARENT'S NAME IF NOT AN ADULT		TELEPHONE NUMBER ()
ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)	HOSPITAL	PATIENT CHART NO.
PLACE EMPLOYED OR SCHOOL ATTENDED	OCCUPATION	

DETACH HERE - PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC

1. STATE (RESIDENCE OF PATIENT) (1-2)	2. COUNTY (RESIDENCE OF PATIENT) (3-12)	5. HOSPITALIZED? (25) IF YES, DATE OF ADMISSION (26-31)		
3. STATE CONDITION I.D. (13-18)	4. CDC I.D. (19-24)	1 <input type="checkbox"/> YES	MO	DAY
6. DATE OF BIRTH (32-37)	7A. AGE (38-39)	2 <input type="checkbox"/> NO		YEAR
MO	DAY	3. YEARS		
		7B. IS AGE IN DAY/MO/YR? (40)	7C. IF <6 YEARS OF AGE IS PATIENT IN DAYCARE? (41)	8. SEX (42)
		1 <input type="checkbox"/> DAYS	1 <input type="checkbox"/> YES	1 <input type="checkbox"/> MALE
		2 <input type="checkbox"/> MONTHS	2 <input type="checkbox"/> NO	2 <input type="checkbox"/> FEMALE
		3 <input type="checkbox"/> YEARS	9 <input type="checkbox"/> UNKNOWN	

9A. RACE (43)	9B. ETHNIC ORIGIN (44)	10. OUTCOME (45)	11. PHYSICIAN'S NAME AND TELEPHONE NUMBER
1 <input type="checkbox"/> WHITE	1 <input type="checkbox"/> HISPANIC	1 <input type="checkbox"/> SURVIVED	
2 <input type="checkbox"/> BLACK	2 <input type="checkbox"/> NON-HISPANIC	2 <input type="checkbox"/> DIED	()
3 <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE		9 <input type="checkbox"/> UNKNOWN	
4 <input type="checkbox"/> ASIAN/PACIFIC ISLANDER			
9 <input type="checkbox"/> NOT SPECIFIED			

12. TYPE OF INFECTION CAUSED BY ORGANISM (CHECK ALL THAT APPLY)

<input type="checkbox"/> PRIMARY BACTEREMIA (46)	<input type="checkbox"/> CELLULITIS (50)	<input type="checkbox"/> SEPTIC ARTHRITIS (54)
<input type="checkbox"/> MENINGITIS (47)	<input type="checkbox"/> EPIGLOTTITIS (51)	<input type="checkbox"/> CONJUNCTIVITIS (55)
<input type="checkbox"/> OTITIS MEDIA (48)	<input type="checkbox"/> PERITONITIS (52)	<input type="checkbox"/> OTHER (SPECIFY) (56)
<input type="checkbox"/> PNEUMONIA (49)	<input type="checkbox"/> PERICARDITIS (53)	

13. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE * (CHECK ONE) (59)

1 <input type="checkbox"/> <i>NEISSERIA MENINGITIDIS</i>	5 <input type="checkbox"/> <i>STREPTOCOCCUS PNEUMONIAE</i> * (PNEUMOCOCCUS)
2 <input type="checkbox"/> <i>HAEMOPHILUS INFLUENZAE</i>	6 <input type="checkbox"/> GROUP A STREPTOCOCCUS
3 <input type="checkbox"/> GROUP B STREPTOCOCCUS	8 <input type="checkbox"/> OTHER BACTERIAL SPECIES * (SPECIFY: INCLUDE MYCOBACTERIA, FUNGI)
4 <input type="checkbox"/> <i>LISTERIA MONOCYTOGENES</i>	

* REPORT **ONLY** CSF ISOLATES FOR PNEUMOCOCCUS OR OTHER BACTERIAL SPECIES (60-61)

14. SPECIMEN FROM WHICH ORGANISM ISOLATED (CHECK ALL THAT APPLY)	15. DATE FIRST POSITIVE CULTURE OBTAINED (72-77)
<input type="checkbox"/> BLOOD (62)	MO
<input type="checkbox"/> CSF (63)	DAY
<input type="checkbox"/> PLEURAL FLUID (64)	YEAR
<input type="checkbox"/> PERITONEAL FLUID (65)	
<input type="checkbox"/> PERICARDIAL FLUID (66)	
<input type="checkbox"/> JOINT (67)	
<input type="checkbox"/> PLACENTA (68)	
<input type="checkbox"/> OTHER NORMALLY STERILE SITE (69)	
SPECIFY (70-71)	

IMPORTANT - PLEASE COMPLETE FOR THE FOLLOWING ORGANISMS

HAEMOPHILUS INFLUENZAE

16A. DID PATIENT RECEIVE *HAEMOPHILUS b* VACCINE? (78)

1 YES 2 NO 9 UNKNOWN IF YES, PLEASE COMPLETE THE LIST BELOW.

DOSE	DATE GIVEN	VACCINE NAME/MANUFACTURER	LOT NUMBER
1 (79-84)	MO DAY YEAR	(85)	(86-95)
2 (96-101)	MO DAY YEAR	(102)	(103-112)
3 (113-118)	MO DAY YEAR	(119)	(120-129)
4 (130-135)	MO DAY YEAR	(136)	(137-146)

16B. WHAT WAS THE SEROTYPE? (147)	16C. IF <i>H. INFLUENZAE</i> WAS ISOLATED FROM BLOOD OR CSF, WAS IT RESISTANT TO:
1 <input type="checkbox"/> TYPE b 2 <input type="checkbox"/> NOT TYPEABLE 9 <input type="checkbox"/> NOT TESTED OR UNKNOWN	AMPICILLIN (150) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> NOT TESTED OR UNKNOWN
8 <input type="checkbox"/> OTHER (SPECIFY) (148-149)	CHLORAMPHENICOL (151) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> NOT TESTED OR UNKNOWN
	RIFAMPIN (152) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> NOT TESTED OR UNKNOWN

NEISSERIA MENINGITIDIS

17A. WHAT WAS THE SEROGROUP? (153)	17B. IF <i>N. MENINGITIDIS</i> WAS ISOLATED FROM BLOOD OR CSF, WAS IT RESISTANT TO:
1 <input type="checkbox"/> GROUP A 4 <input type="checkbox"/> GROUP Y 9 <input type="checkbox"/> UNKNOWN	SULFA (156) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> NOT TESTED OR UNKNOWN
2 <input type="checkbox"/> GROUP B 5 <input type="checkbox"/> GROUP W135 8 <input type="checkbox"/> OTHER (154-155)	RIFAMPIN (157) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> NOT TESTED OR UNKNOWN
3 <input type="checkbox"/> GROUP C 6 <input type="checkbox"/> NOT GROUPEABLE (SPECIFY)	

SUBMITTED BY (NAME OF AGENCY)	TELEPHONE NUMBER ()	DATE	RETURN COMPLETED REPORT TO: MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES, SECTION FOR COMMUNICABLE DISEASE PREVENTION PO BOX 570, JEFFERSON CITY, MO 65102
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