LOCAL USE ONLY

– NATIONAL BACTERIAL MENINGITIS AND BACTEREMIA CASE REPORT –

APPENDIX 4

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ _____ Hospital: _____ Patient Chart No.: _____
(Number, Street, City, State) (Zip Code)

DETACH HERE – Patient identifier information is not transmitted to CDC

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

NATIONAL BACTERIAL MENINGITIS AND BACTEREMIA CASE REPORT

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved OMB No. 0920-0009

1. STATE: (Residence of Patient) (1-2)

2. COUNTY: (Residence of Patient) (3-12)

3. STATE I.D.: (13-18) ☐☐☐☐☐☐

4. CDC I.D.: (19-24) ☐☐☐☐☐☐

5. HOSPITALIZED? (25) (If YES, date of admission)
1 ☐ Yes
2 ☐ No
(26-31) Mo. ☐☐ Day ☐☐ Yr. ☐☐

6. DATE OF BIRTH: (32-37) Mo. ☐☐ Day ☐☐ Yr. ☐☐

7a.) AGE: (38-39) ☐☐

b.) Is age in day/mo/yr? (40)
1 ☐ Days
2 ☐ Mos.
3 ☐ Yrs.

c.) If <6 years of age is patient in daycare? (41)
1 ☐ Yes
2 ☐ No
9 ☐ Unknown
(Daycare is defined as a supervised group of 2 or more unrelated children for >4 hours/week).

8. SEX: (42)
1 ☐ Male
2 ☐ Female

9a. RACE: (43)
1 ☐ White
2 ☐ Black
3 ☐ American Indian/ Alaskan Native
4 ☐ Asian/Pacific Islander
9 ☐ Not Specified

9b. ETHNIC ORIGIN: (44)
1 ☐ Hispanic
2 ☐ Non-Hispanic

10. OUTCOME: (45)
1 ☐ Survived
2 ☐ Died
9 ☐ Unknown

11. PHYSICIAN'S NAME:
_____
_____

12. TYPE OF INFECTION CAUSED BY ORGANISM: (Check all that apply)

1 ☐ Primary Bacteremia (46)
1 ☐ Meningitis (47)
1 ☐ Otitis media (48)
1 ☐ Pneumonia (49)
1 ☐ Cellulitis (50)
1 ☐ Epiglottitis (51)
1 ☐ Peritonitis (52)
1 ☐ Pericarditis (53)
1 ☐ Septic arthritis (54)
1 ☐ Conjunctivitis (55)
1 ☐ Other (specify) (56) _____ (57-58)

13. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:* (59) (Check one)

1 ☐ *Neisseria meningitidis*
2 ☐ *Haemophilus influenzae*
3 ☐ Group B streptococcus
4 ☐ *Listeria monocytogenes*
5 ☐ *Streptococcus pneumoniae** (pneumococcus)
8 ☐ Other Bacterial Species* (Specify: include mycobacteria, fungi) _____

*(Report *ONLY* CSF Isolates for Pneumococcus or Other Bacterial Species) (60-61)

14. SPECIMEN FROM WHICH ORGANISM ISOLATED: (Check all that apply)

1 ☐ Blood (62)
1 ☐ CSF (63)
1 ☐ Pleural Fluid (64)
1 ☐ Peritoneal Fluid (65)
1 ☐ Pericardial Fluid (66)
1 ☐ Joint (67)
1 ☐ Placenta (68)
1 ☐ Other Normally Sterile Site (69) (specify) (70-71) _____

15. DATE FIRST POSITIVE CULTURE OBTAINED: *(Date Specimen Drawn)*
(72-77) Mo. ☐☐ Day ☐☐ Yr. ☐☐

- 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 (Mo. / Day / Yr.)	VACCINE NAME/MANUFACTURER	LOT NUMBER
1	(79-84)	(85) _____ / _____	(86-95) _____
2	(96-101)	(102) _____ / _____	(103-112) _____
3	(113-118)	(119) _____ / _____	(120-129) _____
4	(130-135)	(136) _____ / _____	(137-146) _____

16b. What was the serotype? (147)
1 ☐ Type b
2 ☐ Not Typable
9 ☐ Not Tested or Unknown
8 ☐ Other (Specify) _____ (148-149)

16c. If *H. influenzae* was isolated from blood or CSF, was it resistant to:

Ampicillin	(150)	1 ☐ Yes	2 ☐ No	9 ☐ Not tested or Unknown
Chloramphenicol	(151)	1 ☐ Yes	2 ☐ No	9 ☐ Not tested or Unknown
Rifampin	(152)	1 ☐ Yes	2 ☐ No	9 ☐ Not tested or Unknown

NEISSERIA MENINGITIDIS

17a. What was the serogroup? (153)
1 ☐ Group A
2 ☐ Group B
3 ☐ Group C
4 ☐ Group Y
5 ☐ Group W135
6 ☐ Not groupable
9 ☐ Unknown
8 ☐ Other (Specify) _____ (154-155)

17b. If *N. meningitidis* was isolated from blood or CSF, was it resistant to:

Sulfa	(156)	1 ☐ Yes	2 ☐ No	9 ☐ Not tested or Unknown
Rifampin	(157)	1 ☐ Yes	2 ☐ No	9 ☐ Not tested or Unknown

(Please Print Clearly)

Submitted By: _____

Phone No.: ( ) _____ Date: ____/____/____

Return completed report to:
Meningitis and Special Pathogens Branch
Mailstop C-09
National Center for Infectious Diseases
Centers for Disease Control and Prevention
Atlanta, GA 30333

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; ATTN: PRA; Hubert H. Humphrey Bldg., Rm. 737-F; 200 Independence Ave., SW; Washington, DC 20201, and to the Office of Management and Budget; Paperwork Reduction Project (0920-0009); Washington, DC 20503.