Enhanced Meningococcal Disease Surveillance
Data Collection Guidance Worksheet

NNDSS Case ID: _____ **State ID:** _____ **Laboratory ID:** _____

DOB: / / OR **Age:** _____ years old

Case Status: ☐ Confirmed ☐ Probable

Event date: / /

Source: ☐ Blood ☐ CSF ☐ Other (specify): _____

Lab Ŏonfirmation Ƴethod:
☐ Culture ☐ PCR ☐ Latex
☐ Other ☐ Unknown

Test used to serogroup:
☐ Slide agglutination (SASG) ☐ PCR
☐ WGS ☐ Other

Serogroup:
☐ A ☐ B ☐ C ☐ E ☐ W
☐ X ☐ Y ☐ Not groupable ☐ Other (specify) _____

Outcome: ☐ Survived ☐ Died ☐ Unknown

hdzúōNŜI·ʅκ/fdzǎúŜN wŜfI·úŜŘ: ☐ Yes ☐ No ☐ Unknown

Homeless: ☐ Yes ☐ No ☐ Unknown

College Student: ☐ Yes ☐ No ☐ Unknown

HIV Status: ☐ Positive ☐ Negative ☐ Unknown

Symptoms:

	Yes	No	Unknown
Headache	☐	☐	☐
Fever	☐	☐	☐
Stiff neck	☐	☐	☐
Rash	☐	☐	☐
Photophobia	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Diarrhea	☐	☐	☐

Other (specify): _____

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?

☐ Males only ☐ Females only ☐ Both males and females
☐ Not sexually active ☐ Unknown ☐ Refused

MSM not otherwise specified: ☐ Yes ☐ No ☐ Unknown

Taking eculizumab/Soliris: ☐ Yes ☐ No ☐ Unknown *If yes, please complete the eculizumab case information table below*

ECULIZUMAB CASE INFORMATION*

Indication for eculizumab treatment: ☐ Paroxysmal nocturnal hemoglobinuria (PNH) ☐ Generalized myasthenia gravis (gMG)
☐ Atypical hemolytic uremic syndrome (aHUS) ☐ Other: _____ ☐ Unknown

Date eculizumab treatment started: / / ☐ Unknown

Date eculizumab treatment ended: / / ☐ Ongoing ☐ Unknown

Hospitalized? ☐ Yes ( ) days ☐ No ☐ Unknown

Sequelae: ☐ Yes: _____
☐ No ☐ Unknown

Was the patient taking antibiotics at the time of disease onset? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ Unknown

Did the patient receive serogroup B meningococcal vaccine? ☐ Yes ☐ No ☐ Unknown

If yes to either, please complete the table below for each dose

Date	Vaccine		
	Type	**Name**	**Lot Number**
MM/DD/YY ☐ **Unknown**	☐ **MenACWY** ☐ **MenB** ☐ **Other:** ______________________ ☐ **Unknown**		
M M/DD/YY ☐ **Unknown**	☐ **MenACWY** ☐ **MenB** ☐ **Other:** ______________________ ☐ **Unknown**		
MM/DD/YY ☐ **Unknown**	☐ **MenACWY** ☐ **MenB** ☐ **Other:** ______________________ ☐ **Unknown**		
MM/DD/YY ☐ **Unknown**	☐ **MenACWY** ☐ **MenB** ☐ **Other:** ______________________ ☐ **Unknown**		
MM/DD/YY ☐ **Unknown**	☐ **MenACWY** ☐ **MenB** ☐ **Other:** ______________________ ☐ **Unknown**		