

## Call for Cases: Meningococcal Disease Among Men who have Sex with Men (MSM)

Please fill out the following information for each identified meningococcal disease case occurring among a known MSM, and return all completed forms by email ([meningnet@cdc.gov](mailto:meningnet@cdc.gov)) or by fax (404-471-8372). Thank you for your assistance.

DEMOGRAPHICS	
NNDSS Case ID #: _____	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> N/A
Age: _____ years old	Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> N/A <input type="checkbox"/> Other or more than one race: _____
DOB:     /     /	
ZIP code: _____ (Residence of Patient)	

RISK FACTORS	
MSM: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Current smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	IV drug use, current: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HIV status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Other drug use, current: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify: _____
Travel during 2 weeks prior to symptom onset: <input type="checkbox"/> Yes (where _____) <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other risk factors: <input type="checkbox"/> Yes (specify: _____) <input type="checkbox"/> No <input type="checkbox"/> Unknown	

DIAGNOSIS, OUTCOME, AND ADDITIONAL INFORMATION	
Was case part of a cluster? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Onset date:     /     /
Hospitalized? <input type="checkbox"/> Yes (     ) days <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outcome: <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown
Positive Diagnostic Tests: <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not conducted	
<b>What was the serogroup?</b> <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> W <input type="checkbox"/> Unknown <input type="checkbox"/> B <input type="checkbox"/> Y <input type="checkbox"/> Not groupable <input type="checkbox"/> Other (specify) _____	<b>Types of infection: (Check all that apply):</b> <input type="checkbox"/> Bacteremia without focus <input type="checkbox"/> Meningitis <input type="checkbox"/> Septic shock <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
<b>Was an isolate or clinical specimen sent to CDC?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown ➤ If yes, please provide the local lab ID No. and date of specimen shipment, if known. Local lab ID # _____ Date of specimen shipment:     /     / ➤ Otherwise, do you still have an isolate or clinical specimen? <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown *(If yes, please send isolate or specimen to CDC Meningitis Lab following the enclosed instructions)	

VACCINATION INFORMATION			
Did patient receive meningococcal vaccine? <input type="checkbox"/> Yes (If yes, please complete the information below) <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	Vaccine		
Dose #	Date	Manuf.	Brand
1	MM/DD/YY		
N/A			<input type="checkbox"/> N/A
2	MM/DD/YY		
N/A			<input type="checkbox"/> N/A
3	MM/DD/YY		
N/A			<input type="checkbox"/> N/A

HEALTH DEPARTMENT CONTACT INFORMATION	OTHER CASE NOTES
Today's Date: MM/DD/ Name: _____ Agency: _____ Telephone Number: (____) _____ -- _____ Email Address: _____	