Please fill out the following information for each identified ciprofloxacin- and penicillin-resistant meningococcal disease case, and return all completed forms by email (meningnet@cdc.gov) or by fax (404-235-1822).

DEMOGRAPHICS

NNDSS Case ID: | **State ID:** | **Ethnicity**: ☐ Hispanic ☐ Not Hispanic ☐ N/A

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

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ White ☐ N/A ☐ Other or more than one race: _____

If Hispanic:
☐ Mexican ☐ Guatemalan ☐ Puerto Rican ☐ Colombian ☐ Cuban ☐ Honduran ☐ Salvadoran ☐ Ecuadorian ☐ Dominican ☐ Peruvian ☐ Other: _____

Residence at time of disease onset: ☐ Private Residence ☐ ICE Facility ☐ Long Term Care Facility ☐ Homeless ☐ Incarcerated ☐ College dormitory ☐ Other: _____

TRAVEL HISTORY

Please capture all travel history for the case and close contacts in the year before disease onset, including who travelled, the location, and the date of last travel to that location.

DOMESTIC:

☐ Case ☐ Contact(s): _____ **City:** _____ **State:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **State:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **State:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **State:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **State:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **State:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **State:** _____ **Date of last travel:** _____

INTERNATIONAL:

☐ Case ☐ Contact(s): _____ **City:** _____ **Country:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **Country:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **Country:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **Country:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **Country:** _____ **Date of last travel:** _____
☐ Case ☐ Contact(s): _____ **City:** _____ **Country:** _____ **Date of last travel:** _____

Large gatherings attended in the year before onset:
Please include any gatherings of over 50 people with participants from multiple states or countries.

☐ Case ☐ Contact(s): _____ **Location:** _____ **Dates attended:** _____ - _____
☐ Case ☐ Contact(s): _____ **Location:** _____ **Dates attended:** _____ - _____
☐ Case ☐ Contact(s): _____ **Location:** _____ **Dates attended:** _____ - _____
☐ Case ☐ Contact(s): _____ **Location:** _____ **Dates attended:** _____ - _____
☐ Case ☐ Contact(s): _____ **Location:** _____ **Dates attended:** _____ - _____

CLINICAL INFORMATION AND OUTCOME

Known epidemiologic link with any other meningococcal disease case? ☐ Yes ☐ No ☐ Unknown

If yes, case ID of linked case: _____

Was susceptibility testing done at the hospital, state, or other laboratory?
☐ No susceptibility test reported
☐ Susceptibility testing done
Source of test data: ☐ Hospital Lab Report ☐ Progress/Consult note ☐ State Lab ☐ Other Lab _____

Test Method: (Check all that apply)
☐ Unspecified ☐ Broth Microdilution ☐ Disk Diffusion ☐ Etest ☐ Agar Dilution ☐ Other:_____

Antibiotics Tested and Results (Check all that apply) *If additional cephalosporins, penicillins, or fluoroquinolones were tested, please list these results in "Other"*

S=susceptible, I=intermediate, R=Resistant, NS=non-susceptible

Ceftriaxone: ☐S ☐NS

Penicillin: ☐S ☐I ☐R

Ciprofloxacin: ☐S ☐I ☐R

Rifampin: ☐S ☐I ☐R

Other:_____ ☐S ☐I ☐R ☐NS

Other:_____ ☐S ☐I ☐R ☐NS

β-lactamase Phenotypic test: ☐Positive ☐Negative

TREATMENT

What treatment was given? (Check all that apply):

☐ Ceftriaxone/ Cefotaxime, days: _____

☐ Penicillin, days: _____

☐ Other_____, days: _____

CHEMOPROPHYLAXIS

How many close contacts were given chemoprophylaxis? _____

What antibiotic was used and for how many contacts?

☐ Ciprofloxacin for ____ contacts ☐ Ceftriaxone for ____ contacts

☐ Rifampin for ____ contacts ☐ Azithromycin for ____ contacts

Clinical presentation: (Check all that apply)

☐ Bacteremia ☐ Meningitis ☐ Bacteremic Pneumonia

☐ Other (specify): _____ ☐ Unknown

Hospitalized? ☐ Yes ( ) days ☐ No ☐Unknown

Underlying conditions: (Check all that apply): ☐ None ☐ Unknown

☐ Complement deficiency ☐ Other(s) _____

Sequelae: ☐ Yes: _____

☐ No ☐ Unknown

Outcome: ☐ Survived ☐ Died ☐ Unknown

HEALTH DEPARTMENT CONTACT INFORMATION	OTHER CASE NOTES
Today's Date: **Name:** _____ **Agency:**_____ **Telephone Number: (__ __ __) __ __ __ -- __ __ __ __** **Email Address:** _____	