

SURVEILLANCE OF MENINGITIS – CASE INVESTIGATION FORM
 EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH

The MOH or PHI should do the investigation personally. Necessary data should be obtained from the hospital by reference to the BHT/Physician or from the diagnosis card. Early investigation and return are essential.

| | | | |
|-----------------------------|--|--|---|
| Week ending of notification | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> d d m m y y | Serial No: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Please write the Serial No given in the Infectious Disease Register (ID Register) in the MOH Office |
|-----------------------------|--|--|---|

A. PARTICULARS OF PATIENT (Please tick (✓) the appropriate box where applicable)

1. Name of patient (BLOCK LETTERS)

2. Residential address:

3. Date of Birth: / / (dd/mm/yyyy)

| | | | | | |
|--|---|--|---|--|---|
| 4. Age <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> y y / m m | 5. Sex <input type="checkbox"/> 1. male <input type="checkbox"/> 2. female <input type="checkbox"/> 3. not known | 6. Ethnic group <input type="checkbox"/> 1. Sinhalese <input type="checkbox"/> 2. Tamil <input type="checkbox"/> 3. Moor <input type="checkbox"/> 4. others <input type="checkbox"/> 5. not known | 7. Occupation <input type="text"/> <input type="text"/> | 8. DPDHS Division (district) <input type="text"/> <input type="text"/> | 9. MOH area <input type="text"/> <input type="text"/> |
| FOR OFFICE USE ONLY | | | | | |

B. PRESENT ILLNESS/OUTCOME

| | | |
|---|--|--|
| 10. Date of onset of symptoms: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> d d m m y y 11. Where did the patient first seek medical advice? <input type="checkbox"/> 1. government hospital <input type="checkbox"/> 2. private hospital <input type="checkbox"/> 3. private practitioner <input type="checkbox"/> 4. Ayurvedic institution (public/private) <input type="checkbox"/> 5. other (specify) | 12. Was patient admitted to hospital? <input type="checkbox"/> 1. yes → to Q. 13 <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known } skip to Q. 21 13. If yes, date of admission: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> d d m m y y 14. Name of hospital: 15. Ward: 16. BHT no: | 17. Date of discharge/transfer or death: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> d d m m y y 18. If transferred, name of hospital 19. Was patient transferred from some other hospital? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no 20. If "yes", where was the patient transferred from? 21. Outcome of the case <input type="checkbox"/> 1. cured <input type="checkbox"/> 3. transferred <input type="checkbox"/> 2. died <input type="checkbox"/> 4. not known |
|---|--|--|

C. CLINICAL DATA

Surveillance case definition

Fever of acute onset with one or more of the following signs of meningeal irritation/inflammation: neck stiffness, poor sucking (in infants), bulging fontanelles (in infants), altered consciousness, irritability, seizures, other signs of meningeal irritation/inflammation

Case classification

1. **Suspected:** a case compatible with the surveillance case definition
2. **Probable bacterial meningitis:** a suspected case with a turbid ('cloudy') CSF or a CSF with an elevated protein (>100 mg/dl), decreased glucose (<40mg/dl) compared to the blood glucose level or leucocytosis (>100 WBC/mm³) with 80% neutrophils
Probable viral meningitis: a suspected case with CSF findings including pleocytosis (usually mononuclear, occasionally polymorphonuclear in the early stage), increased protein, normal sugar and absence of other causative organisms.
3. **Confirmed:** a suspected or probable case which is laboratory confirmed by isolation of a causal organism by CSF and/or blood culture and/or antigen detection.

| | |
|---|---|
| 22. Symptoms and signs <input type="checkbox"/> 1. runny nose <input type="checkbox"/> 8. skin rash <input type="checkbox"/> 15. photophobia <input type="checkbox"/> 2. cough <input type="checkbox"/> 9. neck stiffness <input type="checkbox"/> 16. confusion <input type="checkbox"/> 3. vomiting <input type="checkbox"/> 10. jaundice <input type="checkbox"/> 17. altered consciousness <input type="checkbox"/> 4. diarrhoea <input type="checkbox"/> 11. poor feeding <input type="checkbox"/> 18. convulsions <input type="checkbox"/> 5. irritability <input type="checkbox"/> 12. weak sucking <input type="checkbox"/> 19. others (specify): <input type="checkbox"/> 6. lethargy <input type="checkbox"/> 13. bulging fontanelles <input type="checkbox"/> 7. fever <input type="checkbox"/> 14. headache <input type="checkbox"/> 20. not known | 23. Complications <input type="checkbox"/> 1. none <input type="checkbox"/> 2. encephalopathy <input type="checkbox"/> 3. pneumonia <input type="checkbox"/> 4. others (specify): <input type="checkbox"/> 5. not known |
|---|---|

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| For office use only |
| Compatible with the case definition: <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No |

D. LABORATORY DATA

24. Were any laboratory investigations performed? 1. yes 2. no 3. not known

25. If yes, details of the investigations:

| Blood | CSF | |
|---|---|-------------------------------------|
| 1. CRP..... | 6. Cells in CSF (specify): Type of cell / Count | Isolation of organisms |
| 2. ESR..... | | Specify organism isolated |
| 3. Blood sugar..... | | Laboratory (MRI/gov't/private) |
| 4. Blood culture (specify organisms isolated) | | 10. direct smear |
| | 7. CSF protein | 11. culture |
| | 8. CSF sugar | 12. antigen detection test |
| 5. Laboratory (MRI/gov't/private) | 9. Laboratory (MRI/gov't/private) | 13. PCR |

26. Was the patient treated with antibiotics? 1. yes 2. no 3. not known

27. If yes, details of antibiotic treatment:

| Name of antibiotic/s given | Duration of use (days) |
|----------------------------|------------------------|
| 1. | |
| 2. | |
| 3. | |

E. VACCINATION STATUS

28. Has the patient been vaccinated for meningitis? 1. yes 2. no 3. not known

29. If yes, details of the vaccination status at disease onset:

| Dose | Date of vaccination* | Place of vaccination** | Batch number |
|-----------------------|--|------------------------|--------------|
| Hib 1 | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> d d m m y y | | |
| Hib 2 | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> d d m m y y | | |
| Hib 3 | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> d d m m y y | | |
| Meningococcal vaccine | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> d d m m y y | | |
| Pneumococcal vaccine | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> d d m m y y | | |

* If the date is unknown but the particular dose has been given, mark (✓) in the relevant cage

** GP/ private hospital/ others/ not known

30. Remarks:

| | | |
|---|--------------------|---|
| Signature: | Name:..... | For office use only Final classification Suspected <input type="checkbox"/> Probable bacterial meningitis <input type="checkbox"/> Probable viral meningitis <input type="checkbox"/> Confirmed <input type="checkbox"/> Other..... |
| Date: | Designation: | |
| Please return to: Epidemiologist, Epidemiology Unit, 231, De Saram Place, Colombo 10 email: epidunit@sltnet.lk Tel: 011-2695112 / 2681548 Fax: 011-2696583 | | |