

# Meningitis Investigation Form

<b>Surname:</b>		<b>First Name:</b>	
<b>DOB:</b> y/m/d		<b>Gender:</b> M: <input type="checkbox"/> F: <input type="checkbox"/>	
<b>Ethnicity:</b> <input type="checkbox"/> Dene <input type="checkbox"/> Metis <input type="checkbox"/> Inuit <input type="checkbox"/> Other		<b>Contact Number:</b>	
<b>Source of positive isolates(s) from sterile sites(s):</b> <input type="checkbox"/> Blood <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Bone <input type="checkbox"/> CSF <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Joint <input type="checkbox"/> Other			
<b>Date first positive culture obtained</b> (date specimen drawn): Y:      M:      D:			

<b>Hospitalized:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes please answer the following questions.	
<b>Facility:</b>	<b>Admitting Date:</b> Y:      M:      D:
<b>Transferred:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Final discharge date:</b> Y:      M:      D:
<b>Date discharged:</b> Y:      M:      D:	
<b>Facility Name(s):</b>	

<b>Organism:</b>			
<b>Death During This Illness:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Date of Death:</b> Y:      M:      D:	
<input type="checkbox"/> Bacteremia	<input type="checkbox"/> Epiglottitis	<input type="checkbox"/> Pericarditis	<input type="checkbox"/> Other
<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Empyema	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Septic arthritis	

<b>Other concurrent Infectious illnesses:</b> <input type="checkbox"/> None <input type="checkbox"/> No info available <input type="checkbox"/> Yes (Specify):		
<b>Underlying conditions or illnesses:</b> <input type="checkbox"/> None <input type="checkbox"/> No info available		
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> CSF leak	<input type="checkbox"/> Premature infant
<input type="checkbox"/> Asthma/RAD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Asplenia	<input type="checkbox"/> Homelessness	<input type="checkbox"/> Smoker (within past year)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Illicit Drug Use	<input type="checkbox"/> Stroke/CVA
<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Immunodeficiency disease	<input type="checkbox"/> Trauma
<input type="checkbox"/> Chronic renal failure	<input type="checkbox"/> Immunosuppressive therapy	<input type="checkbox"/> Other:
<input type="checkbox"/> Cirrhosis/liver failure	<input type="checkbox"/> Nephrotic syndrome	
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Pregnancy/post partum	

1. <b>Has patient received Neisseria meningitides vaccine?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
2. <b>Has patient received Pneumococcal vaccine?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
3. <b>Has the patient received HIB vaccine?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

<b>If yes, type and date(s) given:</b> <input type="checkbox"/> Conjugate C <input type="checkbox"/> Conjugate ACYW-135 <input type="checkbox"/> Polysaccharide		
(1) Y:      M:      D:	(2) Y:      M:      D:	(3) Y:      M:      D:

<b>Is patient currently attending college (15-24 year old only)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>OCMHO comments and Action Taken</b>

<b>Person Reporting:</b>	<b>Date:</b> Y:      M:      D:
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