MINISTRY OF HEALTH & WELLNESS

NATIONAL SURVEILLANCE UNIT, NATIONAL EPIDEMIOLOGY BRANCH,
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NATIONAL EPIDEMIOLOGY BRANCH

MENINGITIS/ENCEPHALITIS INVESTIGATION FORM

INITIAL DIAGNOSIS

☐ Meningitis ☐ Encephalitis ☐ Meningoencephalitis ☐ Other (Specify): _____

Date of Notification (DD/MM/YYYY): | Date Investigation Started: (DD/MM/YYYY)

PATIENT'S DEMOGRAPHICS

Patient's ID Type:
☐ Driver's License ☐ TRN ☐ Passport ☐ NIN

Patient's ID Number:

First Name: | Middle Name(s):

Last Name: | Pet Name(s)

Patient's Maiden Name (if applicable):

Sex Assigned at Birth: ☐ Male ☐ Female | Date of Birth: (DD/MM/YYYY) | Age:

Country of Residence: | Parish/State/Province:

House Number, Street Name:

Landmark or directions to address: | Community:

Phone Number: | Email Address:

Occupation:

Name of Workplace/School:

Address of Workplace/School:

Phone Number: | Email Address:

NEXT OF KIN

First Name: | Last Name:

Phone number:

Address: Lot/ Street/Community/Parish:

NOK's Phone number: | NOK's Email address

Relationship to the Patient:

☐ Wife	☐ Son	☐ Uncle	☐ Cousin
☐ Husband	☐ Daughter	☐ Aunt	☐ Friend
☐ Mother	☐ Sister	☐ Grandmother	☐ Guardian
☐ Father	☐ Brother	☐ Grandfather	☐ Other (specify):

CLINICAL PROFILE

Sign or Symptom	Presence			Date of Onset (DD/MM/YYYY)	Sign or Symptom	Presence			Date of Onset (DD/MM/YYYY)
	Yes	No	Unkown			Yes	No	Unkown	
Fever	☐	☐	☐		Confusion	☐	☐	☐	
Headache	☐	☐	☐		Paresis/Paralysis	☐	☐	☐	
Nausea	☐	☐	☐		Para-/Hyperesthesia	☐	☐	☐	
Vomiting	☐	☐	☐		Vesicles – hands/ feet	☐	☐	☐	
Neck stiffness	☐	☐	☐		Delirium	☐	☐	☐	
Disorientation	☐	☐	☐		Tremors	☐	☐	☐	
Itching	☐	☐	☐		Convulsions	☐	☐	☐	
Rash	☐	☐	☐		Spasticity	☐	☐	☐	
Ecchymoses	☐	☐	☐		Coma	☐	☐	☐	
Drowsiness	☐	☐	☐		Neckache/backache	☐	☐	☐	
Irritability	☐	☐	☐		Visual disturbances	☐	☐	☐	
Cough	☐	☐	☐		Other (Specify):	☐	☐	☐	
Stupor	☐	☐	☐		Other (Specify):	☐	☐	☐	

MENINGITIS/ENCEPHALITIS

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

Medical History

Pre-existing Conditions

☐ None	☐ Asthma	☐ Diabetes mellitus	☐ HIV/AIDS
☐ Malignancy	☐ Autoimmune	☐ Heart disease	☐ Hypertension
☐ Sickle cell disease	☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ Kidney disease	☐ Liver dysfunction
☐ Other (Specify):			

Pregnancy

Is Patient Pregnant: ☐ Yes ☐ No ☐ Unsure ☐ Not Applicable | Gestational Age:

VACCINATION HISTORY

Type of Vaccine	Number of doses	Date of last dose (DD/MM/YYYY):	Source of vaccination Information (Vaccination Card, Medical Record, Verbal)
BCG			
Diphtheria			
Pertussis			
Tetanus			
Haemophilus influenzae B			
Hepatitis B			
Polio – inactivated (IPV)			
Polio – oral (OPV)			
Measles			
Mumps			
Rubella			
Meningococcus ACYW			
Meningococcus B			
Pneumococcus (conjugate)			
Pneumococcus (polysaccharide)			
Other (Specify):			
Other (Specify):			

HOSPITALISATION

Admitted to Hospital? ☐ Yes ☐ No ☐ Unknown	Date of Admission (DD/MM/YYYY):	Date of Discharge (DD/MM/YYYY):
Hospital:	Medical Record Number	Ward:
Vital Status (Outcome): ☐ Alive ☐ Dead	Date of Death (DD/MM/YYYY):	Time of Death: ____:____ AM/PM

Place of Death: ☐ Home ☐ Dead on Arrival ☐ Ward ☐ ICU ☐ Other (Specify):

MEDICATION HISTORY

Has patient received antibiotics? ☐ Yes ☐ No ☐ Unknown

Past or Current Medication	Dosage	Frequency	Route of administration	Date of first administration	Number of doses

MENINGITIS/ENCEPHALITIS

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

SAMPLE AND LABORATORY DATA

Was a sample taken? ☐ Yes ☐ No ☐ Unsure

If yes, what specimen was taken?

☐ Acute Blood Sample	☐ Convalescent Blood	☐ CSF
☐ Stool	☐ Vesicle Swab	☐ Brain Tissue
☐ Urine	☐ Other (Specify): _____	

What date was the specimen taken? (DD/MM/YYYY):

Which lab is the sample being sent to? ☐ National Public Health Laboratory ☐ University of the West Indies ☐ Other

Specify Other Laboratory:

HAEMATOLOGY

	Blood Sample Date of Study (DD/MM/YYYY)	CSF Date of Study (DD/MM/YYYY)	Other (Specify): Date of Study (DD/MM/YYYY)	Other (Specify): Date of Study (DD/MM/YYYY)
Red cell count (RCC)				
White cell count (WCC)				
Neutrophil count				
Lymphocyte count				
Monocyte count				
Eosinophil count				
Basophil count				
Blast count				
Platelet count				
Neutrophil %				
Lymphocyte %				
Monocyte %				
Eosinophil %				
Basophil %				
Blast %				
Other:				

Microscopy

Study	Done	Date of Study (DD/MM/YYYY)	Findings			
			CSF	Blood	Other (specify):	Other (specify):
Gram Stain	☐ Yes ☐ No					
Ziehl Neelsen	☐ Yes ☐ No					
India Ink	☐ Yes ☐ No					

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Culture and Molecular

	Done		CSF	Blood	Urine	Other (specify):
Bacterial Culture	☐ Yes ☐ No					
Antimicrobial Sensitivity:	☐ Yes ☐ No	Sensitive to:				
		Resistant to:				
RT-PCR/PCR	☐ Yes ☐ No					
Viral Culture	☐ Yes ☐ No					
Antigen Detection	☐ Yes ☐ No					
Other test (specify):						
Other test (specify):						

Biochemistry

Study	Done	Date of Study (DD/MM/YYYY):	Results	
			CSF	Blood
Protein	☐ Yes ☐ No			
Glucose	☐ Yes ☐ No			

Parasitology

Study	Done	Date of Study (DD/MM/YYYY):	Findings			
			CSF	Blood	Stool	Other (specify):
Larvae/ Worms	☐ Yes ☐ No					

EXPOSURE PROFILE

Case or Institutional Contact	☐ Yes	☐ No	☐ Unknown	Details:
Recent History of Viral Illness	☐ Yes	☐ No	☐ Unknown	
Consumption of Lettuce, Cabbage, Snails, Shrimp, etc.	☐ Yes	☐ No	☐ Unknown	
Snail Infestation of Premises	☐ Yes	☐ No	☐ Unknown	
Dead Birds on Premise	☐ Yes	☐ No	☐ Unknown	
Other Exposure (Specify):	☐ Yes	☐ No	☐ Unknown	

Are there other cases present in the case's community of residence? ☐ Yes ☐ No

TRAVEL HISTORY

Travelled in the Last 23 days: ☐ Yes ☐ No ☐ Unknown

If travelled: ☐ Domestic Travel ☐ International Travel

Country/Parish Visited	City/Community Visited	Accommodation	Date Arrived (DD/MM/YYYY)	Date Departed (DD/MM/YYYY)

Date returned to Jamaica/Date returned to home address (DD/MM/YYYY):

MENINGITIS/ENCEPHALITIS

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PATIENTS' NAME:

SOCIAL ASSESSMENT
(To be completed for Haemophilus influenzae and Meningococcal meningitis)

LIVING ARRANGEMENT

☐ Lives alone	☐ Lives with partner	☐ Lives with family
☐ Lives with friends	☐ Other (Specify Other):	
Number of household members: _____		Number of household members under 5 years: _____

Are there any ill persons in the household? ☐ Yes ☐ No ☐ Unknown

Have there been any deaths in the case's community of residence in the last 3 months? ☐ Yes ☐ No ☐ Unknown

Have any family members travelled in the Last 3 months? ☐ Yes ☐ No ☐ Unknown

If Yes, where to?

Have there been any visitors from abroad in the last 3 months? ☐ Yes ☐ No ☐ Unknown

If yes, where from?

(NB. Check for the following symptoms: fever, sore throat, cough, runny nose, post nasal draining)

List of Contacts

Name	Age	Sex	Meningococcus Immunisation Status	Symptoms	Prophylaxis Given	Date Prophylaxis given (DD/MM/YYYY)	Immunisation Administered	Date immunisation given (DD/MM/YYYY)
					☐ Yes ☐ No ☐ Unkown		☐ Yes ☐ No	
					☐ Yes ☐ No ☐ Unkown		☐ Yes ☐ No	
					☐ Yes ☐ No ☐ Unkown		☐ Yes ☐ No	
					☐ Yes ☐ No ☐ Unkown		☐ Yes ☐ No	

MENINGITIS/ENCEPHALITIS

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

CLASSIFICATION

Initial Diagnosis: Meningitis/Encephalitis

Final Diagnosis:

Case classification:

☐ Laboratory Confirmed	☐ Probable	☐ Suspected
☐ Discarded	☐ Pending	☐ Inconclusive

Reason for classification:

Is the case epidemiologically linked? ☐ Yes ☐ No ☐ Unknown

Aetiology Category: ☐ Imported case ☐ Import-related case ☐ Endemic ☐ Unknown

Source country (If Imported or Import-Related):

DEATH CLASSIFICATION

Meningitis/Encephalitis related death? ☐ Confirmed ☐ Probable ☐ Suspected ☐ Discarded ☐ Under Investigation ☐ Cannot be classified

Date Investigation Completed (DD/MM/YYYY):

Additional Information/Action Taken/Control Measures Implemented:

Hypothesis as to source, method of transmission and existence of reservoirs or carriers:

Other Comments:

Notifier's /Investigator's Details:

First Name:	Last Name
Professional Group:	
Phone number:	Email Address:
Name of Institution:	
Parish:	Community:
Investigator's Office Number/Street Name:	

Health Region: ☐ SERHA ☐ NERHA ☐ SRHA ☐ WRHA

Investigator's Signature:	Date Signed by Investigator (DD/MM/YYYY):

Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H) (DD/MM/YYYY):