Meningitis Report Form

Texas Department of State Health Services
Infectious Disease Control Unit
1100 W. 49th St., Austin, Texas 78756
ph: (512) 458-7676 fax: (512) 458-7616

Report For Meningitis ☐ Bacterial ☐ Aseptic (viral) ☐ Fungal ☐ Other

(Excludes Invasive Streptococcal, Meningococcal or *Haemophilus influenzae* type B infections)

PATIENT INFORMATION

Name: _____
Last First MI

Address: _____
Street City County Zip

(_____)_____ _____/_____/_____ _____ _____
Phone Birth Date Sex Race*

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

*W = White; B = Black/African American; N = American Indian/Alaska Native; P = Native Hawaiian/Pacific Islander; A = Asian; O = Other; U = Unknown

MEDICAL INFORMATION

_____ (_____)_____
Physician Name Physician Phone

Diagnosis (check one): ☐ Clinical ☐ Isolate ☐ CSF Antigen

Hospitalized? ☐ Yes ☐ No **Hospital Name**_____ ____/____/____ ____/____/____
Admit Date Discharge Date

Onset Date ____/____/____ **Outcome (check one):** ☐ Died ____/____/____ ☐ Recovering ☐ Unknown
Date

Did the patient have underlying conditions? (check all that apply): ☐ Diabetes mellitus ☐ HIV ☐ AIDS ☐ Cochlear Implant ☐ Asthma

☐ Alcohol Abuse ☐ Injecting Drug User (IDU) ☐ Chronic Lung Disease (COPD) ☐ Current Smoker ☐ Malignancy (specify)_____

Other prior illness within two weeks of onset (specify) _____

LABORATORY INFORMATION (please attach lab report if available)

Date Collected ____/____/____ **Specimen Source:** ☐ CSF ☐ Blood ☐ Other Sterile Site (specify): _____

☐ Culture ☐ CSF Antigen ☐ Other test (specify) _____ **Result:** _____

COMMENTS

Reported by: _____ **Phone:** (_____)_____ **Date Reported:** ____/____/____

Investigated by: _____

Agency: _____ **Phone:** (_____)_____

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