

Meningitis Rapid Assessment Worksheet

(Please refer to the Disease investigation Guideline for additional guidance.)

1. Date: _____	Time: _____	2. Reporter: _____			
3. Medical Contact: (if different from reporter)		Hospital or Clinic Location:			
Phone: () ()	Pager: () ()	Phone: () ()	Pager: () ()	Fax: () ()	Other: () ()
4. Patient Information	Last Name: _____		First Name: _____		Date of Birth: _____
Address: _____		City of Residence: _____		State: _____	County of Residence: _____

Date of Onset: ___/___/___ First Symptom experienced: _____

Status: Hospitalized; Location: _____ Admit: ___/___/___ Discharge: ___/___/___

Died; date of death: ___/___/___ Other; describe: _____

Symptoms	No	Unk	Yes	Comments / Specifics:
Fever				Highest recorded temp: _____
Headache				
Stiff neck				
Photophobia				
Altered mental status, confusion				
Coma / Unresponsive				
Lethargic				
Nausea				
Vomiting				
Rash (describe)				
Other symptoms (list):				

Initial Treatment /Testing

	No	Unk	Yes	Date	Time	Notes
Any antibiotic treatment started						
Lumbar puncture performed						
Blood culture specimen collected						

	CSF Result	Serum/Blood Result	Notes
Gram Stain:			
Color/Clarity:			
Pressure:			
Protein:			
Glucose:			
RBC Count:			
WBC Count:			
Predominate Cell Type:			
Latex Agglutination:			
Cryptococcal antigen:			
Other (specify):			

Additional Laboratory Testing

	Laboratory Performing	CSF Result	Serum/Blood result
Bacterial Culture			
PCR testing			

