

Case Abstraction Form for Disseminated Gonococcal Infections



Case Report Form ID Number: _____

A. Patient Identifier Information

Last Name: _____ First Name: _____ Chart Number: _____

Address: _____ (Number, Street, Apt. No.) Hospital: _____

(City) (State) (Zip Code) Phone Number: _____

****Note: Patient Identifier information is not transmitted to CDC****

B. Case Information

1. State: (Residence of Patient) ____	2. County: (Residence of Patient) _____	3. Date Reported to State ____ / ____ / ____ month day year (4 digits)	4. Case Reform Status: <input type="checkbox"/> 1=Complete <input type="checkbox"/> 3=Edited & Corrected <input type="checkbox"/> 2=Incomplete <input type="checkbox"/> 4=Chart Unavailable after 3 attempts	5a. Hospital/lab where culture identified: _____ 5b. Hospital/lab where patient treated: _____
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6a. Age (in years): _____ 6b. Date of birth: ____ / ____ / ____ month day year (4 digits) <input type="checkbox"/> Unknown (1)	7a. Gender: <input type="checkbox"/> 1=Male <input type="checkbox"/> 2=Female <input type="checkbox"/> 3=Transgender: male to female <input type="checkbox"/> 4=Transgender: female to male <input type="checkbox"/> 9=Unknown	7b. Gender of Sex Partner (within past 12 months): <input type="checkbox"/> 1=Women only <input type="checkbox"/> 2=Men only <input type="checkbox"/> 3=Both men and women <input type="checkbox"/> 9=Unknown	8a. Ethnic Origin: <input type="checkbox"/> 1=Hispanic or Latino <input type="checkbox"/> 9=Unknown <input type="checkbox"/> 2=Not Hispanic or Latino 8b. Race: (Check all that apply) <input type="checkbox"/> 1=White <input type="checkbox"/> 1=Native Hawaiian or Other Pacific Islander <input type="checkbox"/> 1=Black <input type="checkbox"/> 1=American Indian or Alaska Native <input type="checkbox"/> 1=Asian <input type="checkbox"/> 1=Unknown <small>*Please note: the "Unknown" checkbox should be only checked if another race category is not selected</small>
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9. Sterile site(s) and culture dates from which <i>Neisseria gonorrhoeae</i> was isolated: (Check all that apply) *Please record all dates as "month/day/year (4 digits)"			
Sterile Site	Date of Specimen Collection	Sterile Site	Date of Specimen Collection
<input type="checkbox"/> 1=Blood	Date: ____ / ____ / ____	<input type="checkbox"/> 1=Pericardial fluid	Date: ____ / ____ / ____
<input type="checkbox"/> 1=Joint/Synovial fluid	Date: ____ / ____ / ____	<input type="checkbox"/> 1=Peritoneal fluid	Date: ____ / ____ / ____
<input type="checkbox"/> 1=Muscle/Fascia/Tendon	Date: ____ / ____ / ____	<input type="checkbox"/> 1=Other normally sterile site (specify)	Date: ____ / ____ / ____
<input type="checkbox"/> 1=Cerebrospinal fluid (CSF)	Date: ____ / ____ / ____		

10. Other sites from which <i>Neisseria gonorrhoeae</i> was isolated: (Check all that apply) *Please record all dates as "month/day/year (4 digits)" **If multiple specimens are collected from the same source, please record the date for the FIRST positive specimen/culture. Please see the CRF Instructions for further detail on non-sterile site specimen/isolate collection.					
	Date of Specimen Collection	Diagnostic Test Type			
<input type="checkbox"/> 1=Skin lesion(s)	Date: ____ / ____ / ____	<input type="checkbox"/> 1=NAATs	<input type="checkbox"/> 2=Culture	<input type="checkbox"/> 3=Other, specify _____	
<input type="checkbox"/> 1=Cervix	Date: ____ / ____ / ____	<input type="checkbox"/> 1=NAATs	<input type="checkbox"/> 2=Culture	<input type="checkbox"/> 3=Other, specify _____	
<input type="checkbox"/> 1=Vagina	Date: ____ / ____ / ____	<input type="checkbox"/> 1=NAATs	<input type="checkbox"/> 2=Culture	<input type="checkbox"/> 3=Other, specify _____	
<input type="checkbox"/> 1=Rectum	Date: ____ / ____ / ____	<input type="checkbox"/> 1=NAATs	<input type="checkbox"/> 2=Culture	<input type="checkbox"/> 3=Other, specify _____	
<input type="checkbox"/> 1=Oropharynx	Date: ____ / ____ / ____	<input type="checkbox"/> 1=NAATs	<input type="checkbox"/> 2=Culture	<input type="checkbox"/> 3=Other, specify _____	
<input type="checkbox"/> 1=Urine/Urethra	Date: ____ / ____ / ____	<input type="checkbox"/> 1=NAATs	<input type="checkbox"/> 2=Culture	<input type="checkbox"/> 3=Other, specify _____	
<input type="checkbox"/> 1=Other specimen site (specify)	Date: ____ / ____ / ____	<input type="checkbox"/> 1=NAATs	<input type="checkbox"/> 2=Culture	<input type="checkbox"/> 3=Other, specify _____	

11. Bacterial species other than <i>Neisseria gonorrhoeae</i> isolated from any normally sterile site (specify), including date of specimen collection:			12. Was patient hospitalized?	13. Outcome
Species	Sterile Site (specify)	Date of Specimen Collection	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No <input type="checkbox"/> 9=Unknown	<input type="checkbox"/> 1=Survived <input type="checkbox"/> 2=Died <input type="checkbox"/> 9=Unknown
_____	_____	Date: ____ / ____ / ____ month day year (4 digits)	If yes, what were the dates of admission and discharge?	
_____	_____	Date: ____ / ____ / ____ month day year (4 digits)	12a. Admission Date: ____ / ____ / ____ month day year (4 digits)	
			12b. Discharge Date: ____ / ____ / ____ month day year (4 digits)	

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*Please note, questions 14a, 14b, and 14c should only be completed for female cases

<div>14a. At time of first positive culture, patient was:</div> <div><input type="checkbox"/> 1=Pregnant</div> <div><input type="checkbox"/> 2=Postpartum</div> <div><input type="checkbox"/> 3=Neither</div> <div><input type="checkbox"/> 9=Unknown</div>	<div>14b. If pregnant or postpartum, what was the date of the last menstrual period (LMP) of the patient?</div> <div><div>_____/_____/_____</div><div>month day year (4 digits)</div></div>	<div>14c. If pregnant or postpartum, what was the outcome of the fetus:</div> <div><div><input type="checkbox"/> 1=Survived, no apparent illness<input type="checkbox"/> 5=Induced abortion</div><div><input type="checkbox"/> 2=Survived, clinical infection<input type="checkbox"/> 6=Still pregnant</div><div><input type="checkbox"/> 3=Live birth/neonatal death<input type="checkbox"/> 9=Unknown</div><div><input type="checkbox"/> 4=Abortion/stillbirth</div></div>
<div>15. Types of infection caused by this organism: (Check all that apply)</div> <div><div><input type="checkbox"/> 1=Bacteremia<input type="checkbox"/> 1=Meningitis<input type="checkbox"/> 1=Polyarthralgia<input type="checkbox"/> 1=Other, specify _____</div><div><input type="checkbox"/> 1=Cellulitis<input type="checkbox"/> 1=Myocarditis<input type="checkbox"/> 1=Proctitis<input type="checkbox"/> 1=Unknown</div><div><input type="checkbox"/> 1=Cervicitis<input type="checkbox"/> 1=Perihepatitis (i.e., Fitz-Hugh-Curtis Syndrome)<input type="checkbox"/> 1=Septic arthritis</div><div><input type="checkbox"/> 1=Endocarditis<input type="checkbox"/> 1=Petechial/Pustular Skin Lesions<input type="checkbox"/> 1=Tenosynovitis</div><div><input type="checkbox"/> 1=Hepatitis<input type="checkbox"/> 1=Pharyngitis<input type="checkbox"/> 1=Urethritis</div></div>		
<div>16. Underlying conditions or prior illnesses: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box)</div> <div><div><input type="checkbox"/> 1=atypical Hemolytic Uremic Syndrome (aHUS)<input type="checkbox"/> 1=Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)<input type="checkbox"/> 1=Previous Gonorrhea Infection</div><div><input type="checkbox"/> 1=Complement Deficiency<input type="checkbox"/> 1=Intravenous Drug User (IVDU), Current<input type="checkbox"/> 1=Previous Meningococcal Infection</div><div><input type="checkbox"/> 1=Endometritis<input type="checkbox"/> 1=Intravenous Drug User (IVDU), Past<input type="checkbox"/> 1=Systemic lupus erythematosus (SLE)</div><div><input type="checkbox"/> 1=Epididymitis<input type="checkbox"/> 1=Paroxysmal Nocturnal Hemoglobinuria (PNH)<input type="checkbox"/> 1=Other, specify _____</div><div><input type="checkbox"/> 1=Generalized Myasthenia Gravis (GMG)<input type="checkbox"/> 1=Pelvic Inflammatory Disease (PID)<input type="checkbox"/> 1=Unknown</div></div>		
<div>17. Prior to this gonorrhea infection, did the patient receive or have history of receipt of Eculizumab or Ravulizumab?</div> <div><input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No</div> <div>If yes, what was the date of the last dose in which either medicine was administered:</div> <div><div>_____/_____/_____</div><div>month day year (4 digits)</div></div> <div>If the patient received either medicine, did the patient receive antibiotic prophylaxis as a result of receipt of this medicine?</div> <div><input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No</div> <div>If the patient received antibiotic prophylaxis, please specify which antibiotic (name and dose) they received?</div> <div>_____</div>		
<div>18. Treatment for current disseminated gonorrhea infection</div> <div><div><div>A. Antibiotic Treatment 1 (Treatment Received During Hospitalization):</div><div><input type="checkbox"/> 1 = Ceftriaxone 1-2 g IV or IM every 24 hrs PLUS Azithromycin 1 g orally in single dose</div><div><input type="checkbox"/> 2=Other, specify (name, dose, and route) _____</div><div><input type="checkbox"/> 3=None</div></div><div><div>A. Antibiotic Treatment 2 (Treatment Received Upon Discharge):</div><div><input type="checkbox"/> 1 = Ceftriaxone 1-2 g IV or IM every 24 hrs PLUS Azithromycin 1 g orally in single dose</div><div><input type="checkbox"/> 2=Other, specify (name, dose, and route) _____</div><div><input type="checkbox"/> 3=None</div></div></div> <div><div>B. Number of doses: _____</div><div>C. Date Started: ____/____/____ month day year (4 digits)</div><div>D. Date Completed: ____/____/____ month day year (4 digits)</div></div> <div><div>B. Number of doses: _____</div><div>C. Date Started: ____/____/____ month day year (4 digits)</div><div>D. Date Completed: ____/____/____ month day year (4 digits)</div></div>		
<div>19a. Does the patient have any concomitant/current sexually transmitted infections (STIs)?</div> <div><input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No <input type="checkbox"/> 9=Unknown</div>		
<div>19b. If yes, record what STIs are documented in the medical chart: (Check all that apply)</div> <div><div><input type="checkbox"/> 1=Anogenital Warts<input type="checkbox"/> 1=Genital HSV Infection<input type="checkbox"/> 1=Lymphogranuloma Venereum (LGV)<input type="checkbox"/> 1=Trichomoniasis</div><div><input type="checkbox"/> 1=Chancroid<input type="checkbox"/> 1=Hepatitis B Infection<input type="checkbox"/> 1=Pelvic Inflammatory Disease (PID)<input type="checkbox"/> 1=Other, specify</div><div><input type="checkbox"/> 1=Chlamydia trachomatis<input type="checkbox"/> 1=Hepatitis C Infection<input type="checkbox"/> 1=Primary, secondary or early latent syphilis<input type="checkbox"/> 1=Unknown</div><div><input type="checkbox"/> 1=Epididymitis<input type="checkbox"/> 1=HIV Infection<input type="checkbox"/> 1 = Latent (>1 year) syphilis</div></div>		
<div>20. Comments</div> <div>_____</div> <div>_____</div> <div>_____</div>		
<div>21. Was case first identified through audit?</div> <div><input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No <input type="checkbox"/> 9=Unknown</div>		
<div>22. Does this case have recurrent disease with the same pathogen?</div> <div><input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No <input type="checkbox"/> 9=Unknown</div> <div>If YES, previous (1st) state ID: _____</div>	<div>23. S.O. Initials _____</div>	
<div>Submitted By: _____ Phone No: _____</div> <div>Physician's Name: _____ Phone No: _____</div> <div>Date: _____</div>		