Wisconsin vaccine history and serogroup worksheet (submit with F-44151) for the reporting of invasive *Neisseria meningitidis, Haemophilus influenzae* and *Streptococcus pneumoniae*

Patient Name: _____

Date of Birth: _____/_____/_____

Person completing form: _____ Phone: (_____)_____-_____

A. Type of infection caused by organism (check all that apply):

____ Primary bacteremia ____ Meningitis ____ Otitis media ____ Pneumonia

____ Cellulitis ____ Epiglottitis ____ Peritonitis ____ Pericarditis

____ Septic abortion ____ Amnionitis ____ Septic arthritis ____ Conjunctivitis

____ Other (specify _____)

Specimen source from which organism was isolated (check all that apply):

____ Cerebrospinal fluid (CSF) ____ Blood ____ Other sterile site (specify _____)

____ No organism isolated (suspect case)

Date of collection of first positive culture: _____/_____/_____

If younger than 6 years of age, does the patient attend daycare? ____ Yes ____ No

Does the patient have any of the following (check all that apply)?

_____ Cochlear implant _____ Permanent shunt _____ Facial fracture

Choose the causative organism below and provide additional information:

____ 1. *Haemophilus influenzae:*

Serotype: ____ **Serotype b** ____ Other serotype (specify ____)

____ Non-typeable ____ Serotype unknown, pending or not tested

Did patient receive the *Haemophilus influenzae* serotype b (Hib) vaccine? ____ Yes ____ No

If yes, complete the following information:

Dose	Date Received	Vaccine	/ Manufacturer	/ Lot #
1	_____/_____/_____	_____/	_____/	_____
2	_____/_____/_____	_____/	_____/	_____
3	_____/_____/_____	_____/	_____/	_____
4	_____/_____/_____	_____/	_____/	_____

_____ **2.*Neisseria meningitidis:***

Serogroup: ____ A ____ B ____ C ____ Y ____ W-135 ____ Other (specify ____)

____ Non-groupable ____ Serogroup unknown, pending or not tested

Did the patient receive the *Neisseria meningitidis* (meningococcal) vaccine? ____ Yes ____ No

If yes, complete the following information:

Date Received	Vaccine	/ Manufacturer	/ Lot #
_____/_____/_____	_____/	_____/	_____

Did the patient receive booster dose(s) of the *Neisseria meningitidis* vaccine? ____ Yes ____ No

If yes, complete the following information:

	Date Received	Vaccine	/ Manufacturer	/ Lot #
Booster 1	_____/_____/_____	_____/	_____/	_____
Booster 2	_____/_____/_____	_____/	_____/	_____

_____ **3.*Streptococcus pneumoniae:***

Did patient receive the *Streptococcus pneumoniae* (pneumococcal) vaccine? ____ Yes ____ No

If yes, please complete the following information:

Dose	Date Received	Vaccine	/ Manufacturer	/ Lot #
1	_____/_____/_____	_____/	_____/	_____
2	_____/_____/_____	_____/	_____/	_____
3	_____/_____/_____	_____/	_____/	_____
4	_____/_____/_____	_____/	_____/	_____

Submitted by: _____ County: _____

Telephone #: (_____)_____-_____ Date: _____/_____/_____

NOTE: Serotype testing is performed at the Wisconsin State Laboratory of Hygiene (WSLH) at no cost to the submitting laboratory. It is strongly encouraged that **all** invasive isolates of *Neisseria meningitidis* and *Haemophilus influenzae* be sent to the WSLH for serotyping. Serotyping results are also needed for state and national surveillance programs. Transport costs can be covered through the Invasive Bacteria Laboratory Surveillance (IBLS) program. If your laboratory does not participate in IBLS, please contact the Invasive Bacteria Surveillance Coordinator by telephone (608-261-6955) to learn how shipping costs for relevant organisms can be paid through the IBLS program.