

Case Report Form, Data Dictionary and Key Variables



Toolkit

Use this form to collect standardized patient information to notify public health officials about suspected meningitis cases for both routine case-based surveillance and in outbreak situations.

INTRODUCTION

High quality surveillance and laboratory confirmation are critical for informing policy decisions, evaluating vaccine effectiveness and programs, detecting and responding to outbreaks, and monitoring changes in disease epidemiology. While many bacteria can cause bacterial meningitis, the most common pathogens are *Neisseria meningitidis* (Nm), *Streptococcus pneumoniae* (Sp), and *Haemophilus influenzae* (Hi). Determining the causative pathogen is essential to inform routine immunization programs and to guide an appropriate response during outbreaks.

With the introduction of the meningococcal serogroup A conjugate vaccine (MACV, MenAfriVac™) in the meningitis belt of sub-Saharan Africa, there was a drastic reduction of serogroup A *N. meningitidis* disease (NmA). Robust case-based surveillance is an effective strategy to monitor impact of new vaccination programs on disease incidence. Case-based surveillance aims to collect information on case demographics, clinical symptoms, and laboratory testing. This information can be used to monitor other meningococcal serogroups or pathogens, as well as assess MACV effectiveness, duration of immunity, and herd protection.

The target audience for this document includes all national stakeholders at the Ministry of Health (MoH) or private healthcare institutions working on epidemiology, microbiology, surveillance, disease control, and immunization. This includes all health providers/surveillance officers responsible for reporting suspected cases of meningitis to MoH surveillance departments. This MenAfriNet Case Report Form (CRF) can assist in the management of cases for both routine surveillance and in outbreak situations.

BEFORE YOU START:

The MenAfriNet CRF was created to include all priority variables for meningitis case-based surveillance. Prior to implementing this CRF it is recommended that you adapt the form to include only the diagnostics (cytology, rapid diagnostic test, gram stain, latex, culture, antibiogram, or PCR) that are available at the different levels of the healthcare system. To facilitate adapting this CRF, it is available both in Word and PDF formats. The Data Dictionary defines each variable and includes information about the data format and coding of responses to facilitate the development of meningitis surveillance data management system.

TOOL CONTENTS:

- A CRF for case-based meningitis surveillance
- A CRF with variable names
- A Data Dictionary with variable names, definitions, data formats, and whether the variables are Required or Optional for case-based surveillance



You can also find downloadable and modifiable versions of the documents on this website to adapt to specific country needs.

TOOL INSTRUCTIONS:

Complete the CRF in as much detail as possible for all **suspected cases of meningitis:**

Definition of suspected cases of meningitis:

- Any person with sudden onset of fever (>38.5°C rectal or 38.0°C axillary) and one of the following signs: neck stiffness, altered consciousness, or other meningeal signs.
- Any toddler with sudden onset of fever (>38.5°C rectal or 38.0°C axillary) and one of the following signs: neck stiffness, flaccid neck, bulging fontanel, convulsion, or other meningeal signs.

Source: WHO Regional Office for Africa's [Standard Operating Procedures for Enhanced Meningitis Surveillance in Africa](#)

All variables indicated as Required Variables were determined to be essential for meningitis surveillance in all situations, while Optional Variables are helpful in non-outbreak situations.

As part of case-based meningitis surveillance, a completed CRF should be accompanied by a cerebrospinal fluid specimen, according to the algorithm established by the MoH guidelines.

ACKNOWLEDGEMENTS

This document is the product of collaborative efforts between several agencies, including the U.S. Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) Headquarters, WHO–Regional Office for Africa (WHO–AFRO), WHO–AFRO Inter-Country Support Teams (WHO–AFRO/IST), Agence de Médecine Préventive (AMP), and Ministries of Health (MoH) and National Reference Laboratories from Burkina Faso, Mali, Niger, Chad, and Togo, the Bill & Melinda Gates Foundation, Gavi, the Vaccine Alliance, and the CDC Foundation. The authors thank all MenAfriNet Consortium members and several MenAfriNet Consortium working groups, including Data Management, Surveillance and Outbreak, Research and Evaluation, and Laboratory Working Groups for the creation of the following Case Report Form, Data Dictionary and key variables.

Add Ministry of Health logo here
as appropriate



UNIQUE IDENTIFIER N° (EPID):
(TO BE ASSIGNED AT DISTRICT LEVEL)

COUNTRY

REGION

DISTRICT

YEAR

DISEASE

N° CASE

REPORTING HEALTH FACILITY NAME:

Sub-district:

District:

Region:

PATIENT IDENTIFICATION

Patient surname: _____ **Patient other name(s):** _____

Date of birth: ____/____/____ (dd/mm/yyyy) **OR** Age in years: ____ If <12 months: Age in months: ____ **OR** Age in days: ____

Sex: Female Male **Occupation:** _____

Patient's residence (Address) District of residence: _____ **Sub-district:** _____ **Community:** _____

Neighborhood: _____ **House number:** _____ **Location:** _____ Urban / Rural

Father's/mother's/caregiver's name: _____ **Telephone N° of the patient/parents/caregiver:** _____

Date seen at health facility: ____/____/____ (dd/mm/yyyy) **Date of disease onset:** ____/____/____ (dd/mm/yyyy)

Signs and symptoms: Fever Neck stiffness Headache Bulging fontanel Seizure/Convulsion Altered consciousness
 Rash Photophobia Nausea Vomiting Diarrhea Other (specify): _____ Unknown

Antibiotic treatment: Amoxicillin Ceftriaxone Chloramphenicol Penicillin G Oxacillin Others (specify): _____ Unknown

Date of first dose: ____/____/____ (dd/mm/yyyy)

Hospitalization status: Patient hospitalized Outpatient

Outcome: Recovered Dead On treatment Referred Unknown

VACCINATION STATUS

Vaccinated: YES NO UNKNOWN (If vaccinated, please complete the rest of this section)

Vaccine	Received	Date Received (dd/mm/yyyy)	No	Unknown	If Yes, source of vaccination information:
MenAC	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
MenACW	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
MenACWY	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
MenA(conjugate)	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
MenC(conjugate)	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
Menactra	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
PCV13 – dose 1	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
PCV13 – dose 2	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
PCV13 – dose 3	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
Hib – dose 1	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
Hib – dose 2	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown
Hib – dose 3	<input type="checkbox"/> Yes: ____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Card <input type="checkbox"/> Vaccination register <input type="checkbox"/> Verbal <input type="checkbox"/> Unknown

Specimen source: CSF Blood Urine Other: _____

CSF SPECIMEN COLLECTED: YES NO (Note: IF NO, please STILL complete the form and send to district disease control officer)

IF NO: Reason: Lack of LP kit Lack of provider with LP collection skill LP contraindicated Other (specify): _____

IF YES: Date of specimen collection: ____/____/____ (dd/mm/yyyy) **Time of specimen collection:** ____/____/____ AM PM

Appearance of CSF: Clear Turbid Bloody Xanthochromic Viscous Purulent

Time of inoculation into transport media: ____/____/____ AM PM

Specimen (s) sent to the laboratory: Yes No **If No, why?:** _____

If Yes, date specimen sent to the: District laboratory: ____/____/____ (dd/mm/yyyy)

Regional laboratory: ____/____/____ (dd/mm/yyyy)

National reference laboratory: ____/____/____ (dd/mm/yyyy) **Name of laboratory:** _____

Specimen container used: Dry tube Trans-Isolate (T- I) Cryotube Other (specify): _____

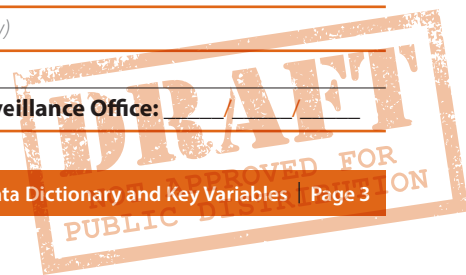
Date of notification to District/Region/National Surveillance Office: ____/____/____ (dd/mm/yyyy)

Name of person filling the form: _____

Telephone: _____

Date form sent to Surveillance Office: ____/____/____

Date form received at Surveillance Office: ____/____/____



DISTRICT LABORATORY NAME: _____

Specimen ID District: _____

Specimen date received: ____/____/____ **Specimen container received:** Dry tube Trans-Isolate **Specimen condition:**
Time: ____/____/____ AM PM Cryotube Other (specify): _____ Adequate Not adequate

CSF appearance: Clear Turbid Bloody Xanthochromic Viscous Purulent Not done

Type of tests performed: Cytology Gram stain RDT (Dipstick/other) Latex Other (specify): _____

Cytology: Leucocytes: _____/mm³ PMN: _____% LYMPH: _____% Not done

Gram: GPD GND GPB GNB Other pathogens: _____ No organism seen Not done

RDT performed: Yes No Not done

Type RDT: Pastorex CERMES Dipstick Other (specify): _____ **RDT Results:** _____

Latex: NmA NmC NmW/Y NmB/E. coli K1 S. pneumoniae Hib StrepB Negative Not done

Date results sent to reporting health facility: ____/____/____ **Date specimen sent to regional lab/NRL:** ____/____/____

REGIONAL LABORATORY NAME: _____

Specimen ID Region: _____

Specimen date received: ____/____/____ **Specimen container received:** Dry tube Trans-Isolate **Specimen condition:**
Time: ____/____/____ AM PM Cryotube Other (specify): _____ Adequate Not adequate

CSF appearances: Clear Turbid Bloody Xanthochromic Viscous Purulent Not done

Type of tests performed: Cytology Gram stain RDT (Dipstick/other) Latex Culture Other (specify): _____

Cytology: Leucocytes: _____/mm³ PMN: _____% LYMPH: _____% Not done

Gram: GPD GND GPB GNB Other pathogens: _____ No organism seen Not done

RDT performed: Yes No Not done

Type RDT: Pastorex CERMES Dipstick Other (specify): _____ **RDT Results:** _____

Latex: NmA NmC NmW/Y NmB/E. coli K1 S. pneumoniae Hib StrepB Negative Not done

Culture:

NmA NmC NmW NmY NmB
 NmX Nm indeterminate StrepB
 S. pneumoniae Hib Hi non-b
 Other germs (specify): _____
 Contaminated Negative Not done NA

Antibiogram:

Amoxicillin	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Ceftriaxone	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Chloramphenicol	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Penicillin G	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Oxacillin	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Others: _____	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done

Date results sent to reporting health facility: ____/____/____

Date specimen sent to NRL: ____/____/____

NATIONAL REFERENCE LABORATORY NAME: _____

Specimen ID NRL: _____

Specimen date received: ____/____/____ **Specimen container received:** Dry tube Trans-Isolate **Specimen condition:**
Time: ____/____/____ AM PM Cryotube Other (specify): _____ Adequate Not adequate

CSF appearances: Clear Turbid Bloody Xanthochromic Viscous Purulent Not done

Type of tests performed: Cytology Gram stain RDT (Dipstick/other) Latex Other (specify): _____

Cytology: Leucocytes: _____/mm³ PMN: _____% LYMPH: _____% Not done

Gram: GPD GND GPB GNB Other pathogens (specify): _____ No organism seen Not done

RDT performed: Yes No Not done

Type RDT: Pastorex CERMES Dipstick Other (specify): _____ **RDT Results:** _____

Latex: NmA NmC NmW/Y NmB/E. coli K1 S. pneumoniae Hib StrepB Negative Not done

Culture:

NmA NmC NmW NmY NmB
 NmX Nm indeterminate StrepB
 S. pneumoniae Hib Hi non-b
 Other germs (specify): _____
 Contaminated Negative Not done NA

Antibiogram:

Amoxicillin	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Ceftriaxone	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Chloramphenicol	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Penicillin G	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Oxacillin	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done
Others: _____	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Resistant	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Not done

PCR: NmA NmC NmW NmY NmB NmX Nm indeterminate S. pneumoniae (genotype: _____)
 Hib Hi non-b Contaminated (specify): _____ Negative Not done NA

Type of PCR: _____ **Date PCR performed:** ____/____/____

Observations: _____

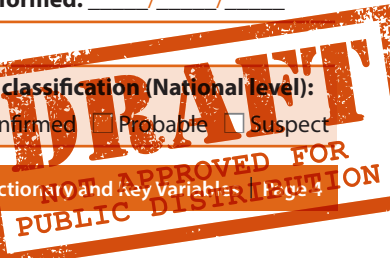
Final laboratory result: _____

Date results sent to: Health facility: ____/____/____

Disease Surveillance Department/MoH: ____/____/____

Final classification (National level):

Confirmed Probable Suspect



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UNIQUE IDENTIFIER N° (EPID): 1.EpidNumber (TO BE ASSIGNED AT DISTRICT LEVEL) COUNTRY REGION DISTRICT 2.Year 3.Disease 4.CaseNumber YEAR DISEASE N° CASE

REPORTING HEALTH FACILITY NAME: 5.HealthFacility

Sub-district: 6.SubDistrict District: 7.District Region: 8.Region

PATIENT IDENTIFICATION Patient surname: 9.FamilyName Patient other name(s): 10.FirstName

Date of birth: 11.DateOfBirth / (dd/mm/yyyy) OR Age in years: 12.AgeYears If <12 months: Age in months: 13.AgeMonths OR Age in days: 14.AgeDays

Sex: 15.Sex Female Male Occupation: 16.Profession

Patient's residence (Address) District of residence: 17.DistrictOfResidence Sub-district: 18.SubDistrictOfResidence Community: 19.Village

Neighborhood: 20.Neighborhood House number: Location: 21.Address 22.UrbanRural Urban Rural

Father's/mother's/caregiver's name: 23.ParentName Telephone N° of the patient/parents/caregiver: 24.PhoneNum

Date seen at health facility: 25.DateConsultation / (dd/mm/yyyy) Date of disease onset: 26.DateOnset / (dd/mm/yyyy)

Signs and symptoms: 27.Fever 28.NeckStiff 29.Headache 30.BulgeFontanel 31.Convulsion 32.AltConsciousness 33.Rash 34.Photophobia 35.Nausea 36.Vomiting 37.Diarrhea 38.OtherSx 39.SxUnknown

Antibiotic treatment: 40.Antibiotic Amoxicillin Ceftriaxone Chloramphenicol Penicillin G Oxacillin Others (specify): 41.OtherAbx Unknown

Date of first dose: 42.DateAbx / (dd/mm/yyyy)

Hospitalization status: Patient hospitalized Outpatient 43.InOutPatient

Outcome: Recovered Dead 44.Outcome On treatment Referred Unknown

VACCINATION STATUS 45.VaccinationStatus Vaccinated: YES NO UNKNOWN (If vaccinated, please complete the rest of this section)

Vaccine Received Date Received(dd/mm/yyyy) No Unknown If Yes, source of vaccination information: MenAC 46.MenAC Yes: / / No Unknown 47.DateMenAC Card Vaccination register Verbal Unknown 48.SourceMenAC MenACW 49.MenACW Yes: / / No Unknown 50.DateMenACW Card Vaccination register Verbal Unknown 51.SourceMenACW MenACWY 52.MenACWY Yes: / / No Unknown 53.DateMenACWY Card Vaccination register Verbal Unknown 54.SourceMenACWY MenA(conjugate) 55.MenA Yes: / / No Unknown 56.DateMenA Card Vaccination register Verbal Unknown 57.SourceMenA MenC(conjugate) 58.MenC Yes: / / No Unknown 59.DateMenC Card Vaccination register Verbal Unknown 60.SourceMenC Menactra 61.Menactra Yes: / / No Unknown 62.DateMenactra Card Vaccination register Verbal Unknown 63.SourceMenactra PCV13 - dose 1 64.PCV1 Yes: / / No Unknown 65.DatePCV1 Card Vaccination register Verbal Unknown 66.SourcePCV1 PCV13 - dose 2 67.PCV2 Yes: / / No Unknown 68.DatePCV2 Card Vaccination register Verbal Unknown 69.SourcePCV2 PCV13 - dose 3 70.PCV3 Yes: / / No Unknown 71.DatePCV3 Card Vaccination register Verbal Unknown 72.SourcePCV3 Hib - dose 1 73.Hib1 Yes: / / No Unknown 74.DateHib1 Card Vaccination register Verbal Unknown 75.SourceHib1 Hib - dose 2 76.Hib2 Yes: / / No Unknown 77.DateHib2 Card Vaccination register Verbal Unknown 78.SourceHib2 Hib - dose 3 79.Hib3 Yes: / / No Unknown 80.DateHib3 Card Vaccination register Verbal Unknown 81.SourceHib3

Specimen source: 82.SpecimenSource CSF Blood Urine Other: _____

CSF SPECIMEN COLLECTED: YES NO (Note: IF NO, please STILL complete the form and send to district disease control officer) 83.SpecimenCollected

IF NO: Reason: 84.SpecimenNOTcollected_why Lack of LP kit Lack of provider with LP collection skill LP contraindicated 85.SpecimenNOTcollected_Other Other (specify): _____

IF YES: Date of specimen collection: 86.DateSpecimenCollected (dd/mm/yyyy) Time of specimen collection: 87.TimeSpecimenCollected AM PM

Appearance of CSF: Clear Turbid Bloody Xanthochromic Viscous Purulent 88.ASPECT

Time of inoculation into transport media: / / AM PM 89.TransportMedia_InoculationTime

Specimen (s) sent to the laboratory: Yes No 90.SpecimenSentToLab If No, why?: 91.SpecimenNOTSentToLab Why

If Yes, date specimen sent to the: District laboratory: 92.DateCSFSentDistrict / / (dd/mm/yyyy)

Regional laboratory: 93.DateCSFSentRegional / / (dd/mm/yyyy)

National reference laboratory: 94.DateCSFSentNRL / / (dd/mm/yyyy) Name of laboratory: 95.LabCSFSent

Specimen container used: Dry tube Trans-Isolate (T-I) Cryotube Other (specify): 96.TransportMedia_DryTube 97.TransportMedia_TI 98.TransportMedia_Cryotube 99.TransportMedia_Other

Date of notification to District/Region/National Surveillance Office: 100.DateNotification / / (dd/mm/yyyy)

Name of person filling the form: 101.ReporterHF Telephone: 102.ReporterPhone

Date form sent to Surveillance Office: / / 103.DateFormSent Date form received at Surveillance Office: 104.DateFormReceived



DISTRICT LABORATORY NAME: 105.DistrictLab

Specimen ID District: 106.SpecimenIDDistrict

Specimen date received: 107.DateReceivedDistrict
Time: / / AM PM
Specimen container received: Dry tube Trans-Isolate
 Cryotube Other (specify):
Specimen condition: Adequate Not adequate
CSF appearance: Clear Turbid Bloody Xanthochromic Viscous Purulent Not done

Type of tests performed: Cytology Gram stain RDT (Dipstick/other) Latex Other (specify):
Cytology: Leucocytes: /mm³ PMN: % LYMPH: % Not done

Gram: GPD GND GPB GNB Other pathogens: No organism seen Not done

RDT performed: Yes No Not done
Type RDT: Pastorex CERMES Dipstick Other (specify): **RDT Results:**

Latex: NmA NmC NmW/Y NmB/E. coli K1 S. pneumoniae Hib StrepB Negative Not done

Date results sent to reporting health facility: **Date specimen sent to regional lab/NRL:**

REGIONAL LABORATORY NAME: 133.RegionLab

Specimen ID Region: 134.SpecimenIDRegion

Specimen date received: 135.DateReceivedRegion
Time: / / AM PM
Specimen container received: Dry tube Trans-Isolate
 Cryotube Other (specify):
Specimen condition: Adequate Not adequate
CSF appearances: Clear Turbid Bloody Xanthochromic Viscous Purulent Not done

Type of tests performed: Cytology Gram stain RDT (Dipstick/other) Latex Culture Other (specify):
Cytology: Leucocytes: /mm³ PMN: % LYMPH: % Not done

Gram: GPD GND GPB GNB Other pathogens: No organism seen Not done

RDT performed: Yes No Not done
Type RDT: Pastorex CERMES Dipstick Other (specify): **RDT Results:**

Latex: NmA NmC NmW/Y NmB/E. coli K1 S. pneumoniae Hib StrepB Negative Not done

Culture: NmA NmC NmW NmY NmB NmX Nm indeterminate StrepB S. pneumoniae Hib Hi non-b Other germs (specify): Contaminated Negative Not done NA
Antibiogram:
Amoxicillin Sensitive Resistant Intermediate Not done
Ceftriaxone Sensitive Resistant Intermediate Not done
Chloramphenicol Sensitive Resistant Intermediate Not done
Penicillin G Sensitive Resistant Intermediate Not done
Oxacillin Sensitive Resistant Intermediate Not done
Others: Sensitive Resistant Intermediate Not done

Date results sent to reporting health facility: **Date specimen sent to NRL:**

NATIONAL REFERENCE LABORATORY NAME: 171.NRL

Specimen ID NRL: 172.SpecimenIDNRL

Specimen date received: 173.DateReceivedNRL
Time: / / AM PM
Specimen container received: Dry tube Trans-Isolate
 Cryotube Other (specify):
Specimen condition: Adequate Not adequate
CSF appearances: Clear Turbid Bloody Xanthochromic Viscous Purulent Not done

Type of tests performed: Cytology Gram stain RDT (Dipstick/other) Latex Other (specify):
Cytology: Leucocytes: /mm³ PMN: % LYMPH: % Not done

Gram: GPD GND GPB GNB Other pathogens (specify): No organism seen Not done

RDT performed: Yes No Not done
Type RDT: Pastorex CERMES Dipstick Other (specify): **RDT Results:**

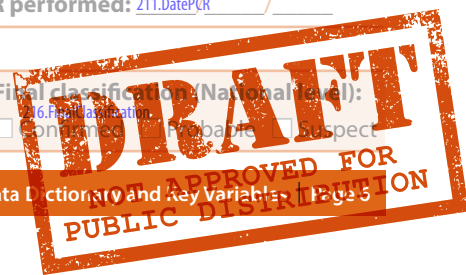
Latex: NmA NmC NmW/Y NmB/E. coli K1 S. pneumoniae Hib StrepB Negative Not done

Culture: NmA NmC NmW NmY NmB NmX Nm indeterminate StrepB S. pneumoniae Hib Hi non-b Other germs (specify): Contaminated Negative Not done NA
Antibiogram:
Amoxicillin Sensitive Resistant Intermediate Not done
Ceftriaxone Sensitive Resistant Intermediate Not done
Chloramphenicol Sensitive Resistant Intermediate Not done
Penicillin G Sensitive Resistant Intermediate Not done
Oxacillin Sensitive Resistant Intermediate Not done
Others: Sensitive Resistant Intermediate Not done

PCR: NmA NmC NmW NmY NmB NmX Nm indeterminate S. pneumoniae (genotype:) Negative Not done NA
Type of PCR: **Date PCR performed:**

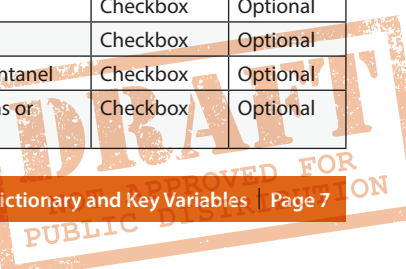
Observations:

Final laboratory result: **Date results sent to:** Health facility: Disease Surveillance Department/MoH: **Final classification (National level):**

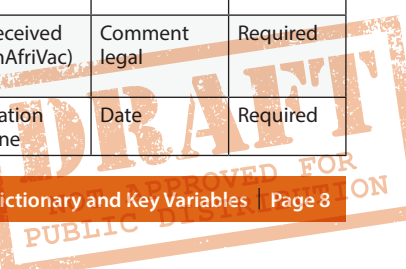


Data Dictionary

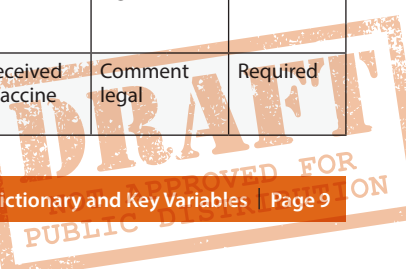
Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
1	EpidNumber	EPID		Unique case identification number comprised of country-region-district-year-illness-case notification number	Text (read only)	Required
2	Year	Epi Year		Year that case was reported	Number	Required
3	Disease	Disease		Disease of notification	Comment legal	Required
4	CaseNumber	Case Number		Unique case identification number attributed by the district	Number ####	Required
5	HealthFacility	Reporting Health Facility		Name of the health facility reporting the case	Text	Required
6	SubDistrict	Reporting Sub-District		Name of the sub-district of the health facility reporting the case	Legal value	Optional
7	District	Reporting District		Name of the district of the health facility reporting the case	Legal value	Required
8	Region	Reporting Region		Indicate the region reporting the case	Legal value	Required
9	FamilyName	Patient Surname		Patient surname	Text (UPPERCASE)	Required
10	FirstName	Patient First Name		Patient first name	Text (UPPERCASE)	Required
11	DateOfBirth	Date of Birth		Patient date of birth	Date	Required
12	AgeYears	Age (years)		Age in years, if patient aged ≥ 12 months	Number ##	Required
13	AgeMonths	Age (months)		Age in months, if patient aged <12 months	Number ###	Required
14	AgeDays	Age (days)		Age in days, if patient aged <1 month otherwise indicate in months	Number ##	Required
15	Sex	Sex	1-Male 2-Female 9-Unknown	Patient sex	Comment legal	Required
16	Profession	Profession		Patient's occupation	Text	Optional
17	DistrictOfResidence	District of Residence		Patient district of residence	Legal value	Required
18	SubDistrictofResidence	Subdistrict of Residence		Patient sub-District of residence	Legal value	Optional
19	Village	Town/City/Village		Patient village, town or city of residence	Text (UPPERCASE)	Required
20	Neighborhood	Neighborhood/locality		Patient neighborhood of residence	Text (UPPERCASE)	Optional
21	Address	Address		Patient street address of residence	Text (UPPERCASE)	Optional
22	UrbanRural	Urban/Rural	1-Urban 2-Rural 9-Unknown	Indicate whether case's residence is in a urban or rural area	Comment legal	Optional
23	ParentName	Name of Parent or Guardian		Name of patient's parent or guardian	Text (UPPERCASE)	Optional
24	PhoneNum	Phone Number		Patient phone number or their guardian	Text	Optional
25	DateConsultation	Date Seen at Health Facility		Date patient was seen at the health facility	Date	Required
26	DateOnset	Date of onset of symptoms		Date of the patient's initial onset of symptoms	Date	Required
27	Fever	Fever		Patient has fever	Checkbox	Optional
28	NeckStiff	Stiff Neck		Patient has stiff neck	Checkbox	Optional
29	Headache	Headache		Patient has headache	Checkbox	Optional
30	BulgFontanel	Bulging Fontanel		Patient has bulging fontanel	Checkbox	Optional
31	Convulsion	Convulsion or Seizures		Patient has convulsions or seizures	Checkbox	Optional



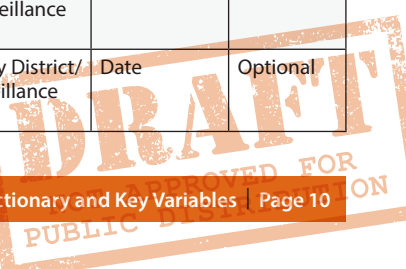
Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
32	AltConsciousness	Altered Consciousness		Patient has altered consciousness	Checkbox	Optional
33	Rash	Rash		Patient has a rash	Checkbox	Optional
34	Photophobia	Photophobia		Patient has photophobia	Checkbox	Optional
35	Nausea	Nausea		Patient has nausea	Checkbox	Optional
36	Vomiting	Vomiting		Patient has vomiting	Checkbox	Optional
37	Diarrhea	Diarrhea		Patient has diarrhea	Checkbox	Optional
38	OtherSx	Other symptoms		Specify any other symptom observed	Text	Optional
39	SxUnknown	Unknown		Patient symptoms are unknown	Checkbox	Optional
40	AntibioticTx	Antibiotic Treatment	1-Amoxicillin 2-Ceftriaxone 3-Chloramphenicol 4-Penicillin G 5-Oxacillin 6-Other 7-Unknown	Specify the antibiotic treatment given to patient	Comment legal	Optional
41	OtherAbx	Other Antibiotic		If Other selected, please specify the name of other antibiotic treatment given to patient	Text	Optional
42	DateAbx	Date of first dose of antibiotic treatment		Date of the first dose of the antibiotic treatment given to patient	Date	Optional
43	InOutPatient	In-patient/out-patient	1-Inpatient 2-Outpatient 9-Unknown	Whether the patient was treated as inpatient or outpatient	Comment legal	Optional
44	Outcome	Patient Outcome	1-Alive (in treatment/recovered) 2-Died 9-Unknown	Patient outcome	Comment legal	Required
45	VaccinationStatus	Vaccination status	1-Yes 2-No 9-Unknown	Whether the patient had received any vaccines	Comment legal	Required
46	MenAC	MenAC (PS)	1-Yes 2-No 9-Unknown	Whether the patient received MenAC (polysaccharide) vaccination	Comment Legal	Required
47	DateMenAC	Date of vaccination: MenAC (PS)		Date of last vaccination with MenAC (polysaccharide) vaccine	Date	Required
48	SourceMenAC	Source of information: MenAC (PS)	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of information for MenAC (polysaccharide) vaccination status	Comment legal	Required
49	MenACW	MenACW (PS)	1-Yes 2-No 9-Unknown	Whether the patient received MenACW (polysaccharide) vaccination	Comment Legal	Required
50	DateMenACW	Date of vaccination: MenACW (PS)		Date of last vaccination with MenACW (polysaccharide) vaccines	Date	Required
51	SourceMenACW	Source of information: MenACW (PS)	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of information for MenACW (polysaccharide) vaccination status	Comment legal	Required
52	MenACWY	MenACWY (PS)	1-Yes 2-No 9-Unknown	Whether the patient received MenACWY (polysaccharide) vaccination	Comment legal	Required
53	DateMenACWY	Date of vaccination: MenACWY (PS)		Date of last vaccination with MenACWY (polysaccharide) vaccine	Date	Required
54	SourceMenACWY	Source of information: MenACWY (PS)	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of information for MenACWY (polysaccharide) vaccination status	Comment legal	Required
55	MenA	MenA conjugate (MenAfriVac)	1-Yes 2-No 9-Unknown	Whether the patient received Men A conjugate (MenAfriVac) vaccination	Comment legal	Required
56	DateMenA	Date of vaccination: MenAfriVac		Date of the last vaccination with MenAfriVac vaccine	Date	Required



Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
57	SourceMenA	Source of information: MenAfriVac	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of information for MenAfriVac vaccine	Comment legal	Required
58	MenC	MenC conjugate	1-Yes 2-No 9-Unknown	Whether the patient received Men C conjugate vaccination	Comment legal	Required
59	DateMenC	Date of vaccination: MenC conjugate		Date of the last vaccination with MenC conjugate vaccine	Date	Required
60	SourceMenC	Source of information: MenC conjugate	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of information for MenC conjugate vaccination	Comment legal	Required
61	Menactra	Menactra	1-Yes 2-No 9-Unknown	Whether the patient received Menactra vaccination	Comment legal	Required
62	DateMenactra	Date of vaccination: Menactra		Date of the last vaccination with Menactra vaccine	Date	Required
63	SourceMenactra	Source of information: Menactra	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of information for the Menactra vaccination	Comment legal	Required
64	PCV1	PCV13-1	1-Yes 2-No 9-Unknown	Whether the patient received the first dose of PCV 13	Comment legal	Required
65	DatePCV1	Date of PCV1 vaccination		Date the first dose of PCV 13 vaccine	Date	Required
66	SourcePCV1	Source of PCV1 information	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of the information for first dose of PCV 13 vaccine	Comment legal	Required
67	PCV2	PCV13-2	1-Yes 2-No 9-Unknown	Whether the patient received the second dose of PCV 13 vaccine	Comment legal	Required
68	DatePCV2	Date of PCV2 vaccination		Date of the second dose of PCV 13 vaccine	Date	Required
69	SourcePCV2	Source of PCV2 information	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of information on second dose of PCV 13 vaccine	Comment legal	Required
70	PCV3	PCV13-3	1-Yes 2-No 9-Unknown	Whether the patient received the third dose of PCV 13 vaccine	Comment legal	Required
71	DatePCV3	Date of PCV3 vaccination		Date of the third dose of PCV 13 vaccine	Date	Required
72	SourcePCV3	Source of PCV3 information	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of information for the third dose of PCV 13 vaccine	Comment legal	Required
73	Hib1	Hib 1	1-Yes 2-No 9-Unknown	Whether the patient received the first dose of Hib vaccine	Comment legal	Required
74	DateHib1	Date of Hib1 vaccination		Date of the first dose of Hib vaccine	Date	Required
75	SourceHib1	Source of Hib1 information	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of the information for the first dose of Hib vaccine	Comment legal	Required
76	Hib2	Hib 2	1-Yes 2-No 9-Unknown	Whether the patient received the second dose of Hib vaccine	Comment legal	Required
77	DateHib2	Date of Hib2 vaccination		Date of the second dose of Hib vaccine	Date	Required
78	SourceHib2	Source of Hib2 information	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of the information for the second dose of Hib vaccine	Comment legal	Required
79	Hib3	Hib 3	1-Yes 2-No 9-Unknown	Whether the patient received the third dose of Hib vaccine	Comment legal	Required

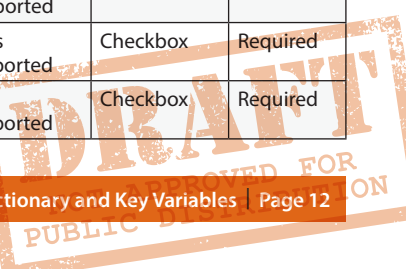


Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
80	DateHib3	Date of Hib3 vaccination		Date of the third dose of Hib vaccine	Date	Required
81	SourceHib3	Source of Hib3 information	1-Vaccination card 2-Verbal recall 3-Vaccine register 9-Unknown	Source of the information for the third dose of Hib vaccine	Comment legal	Required
82	SpecimenSource	Specimen Source	1-CSF 2-Blood 3-Urine 9-Unknown	Source of the specimen	Comment legal	Required
83	SpecimenCollected	Specimen collected	1-Yes 2-No 9-Unknown	Was a CSF specimen was collected?	Comment legal	Required
84	SpecimenNOTcollected_why	Reason specimen not collected	1-Lack of LP kit 2-Lack of skill LP 3-LP contraindication 4-Other	Reason why specimen not collected	Comment legal	Optional
85	SpecimenNOTcollected_Other	Other reason why specimen not collected		Specify other reason why specimen not collected	Text	Optional
86	DateSpecimenCollected	Date specimen collected		Date specimen collected	Date	Required
87	TimeSpecimenCollected	Time specimen collected		Time specimen collected	Time	Optional
88	ASPECT	Macroscopic analysis	1-Clear 2-Turbid/ Cloudy 3-Bloody 4-Xanthochromic/ Yellow 5-Viscous 6-Purulent 9-Not done	Clarity of specimen (Note: Variable coding list includes term/alternate term. Please select term that best fits what is used in-country)	Comment legal	Required
89	TransportMedia_InoculationTime	Time of inoculation into transport media		Time of Transport Media Inoculation	Time	Optional
90	SpecimenSentToLab	Was the sample sent to the Lab	1-Yes 2-No	Whether the sample was sent to the laboratory	Comment legal	Required
91	SpecimenNOTSentToLab_Why	If NOT sent to lab, WHY		Reason why specimen was not sent to the lab	Text	Optional
92	DateCSFSentDistrict	Date CSF sent to district lab		Date that the specimen was sent to the lab.	Date	Required
93	DateCSFSentRegional	Date CSF sent to regional lab		Date that the specimen was sent to the lab.	Date	Required
94	DateCSFSentNRL	Date CSF sent to NRL		Date that the specimen was sent to the lab.	Date	Required
95	LabCSFSent	Name of the analysis lab		Name of the lab that receives the CSF sample	Text	Required
96	TransportMedia_Dry Tube	Transportation media		Whether specimen sent in dry tube	Checkbox	Required
97	TransportMedia_TI	Transportation media		Whether specimen sent in Trans-Isolate	Checkbox	Required
98	TransportMedia_Cryotube	Transportation media		Whether specimen sent in cryotube	Checkbox	Required
99	TransportMedia_Other	Transportation media		Whether specimen sent in Other transport media (please specify)	Text	Required
100	DateNotification	Date health facility notified district/region/MoH		Date the health facility notifies the district/regional/national surveillance office	Date	Optional
101	ReporterHF	Name of Reporter		Name of the reporter of the case notified at the health facility level	Text (UPPERCASE)	Optional
102	ReporterPhone	Reporter Phone		Reporter phone of the case notified	Text	Optional
103	DateFormSent	Date form sent to district/region/MoH		Date Form Sent to District/regional/national surveillance office	Date	Optional
104	DateFormReceived	Date form received at district/region/MoH		Date Form Received by District/Region/National surveillance office	Date	Optional

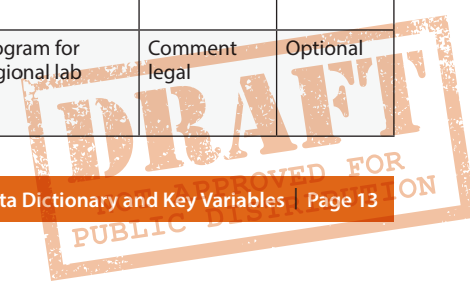


Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
105	DistrictLab	Name of District Lab		Name of the district lab performing testing	Text	Required
106	SpecimenIDDistrict	Specimen ID		Number listed in the laboratory registry at the district lab	Text	Optional
107	DateReceivedDistrict	Date district lab received		Date that the district lab received the specimen	Date	Required
108	TimeSpecimenReceivedDistrict	Time		Time specimen was received by district lab	Time	Optional
109	DryTubeDistrict	Dry tube received District		Whether specimen was received in a dry tube by district lab	Checkbox	Required
110	TIDistrict	TI received District		Whether specimen was received in a Trans-Isolate by district lab	Checkbox	Required
111	CryotubeDistrict	Cryotube received District		Whether specimen was received in cryotubes by district lab	Checkbox	Required
112	OtherMediaDistrict	Other media received District		Specify the Other media received by district lab	Text	Optional
113	SpecimenConditionDistrict	Specimen Condition	1-Adequate 2-Not adequate	Condition of specimen received at the district lab: 1-Adequate (indicating both volume and temperature of specimen) or 2-Not adequate (indicating if cracked, empty, transported at incorrect temperature, insufficient volume or illegible labeling)	Comment legal	Required
114	AspectDistrict	Macroscopic analysis (District)	1-Clear 2-Turbid/ Cloudy 3-Bloody 4-Xanthochromic/ Yellow 5-Viscous 6-Purulent 9-Not done	Clarity of specimen received at the district lab (Note: Variable coding list includes term/alternate term. Please select term that best fits what is used in-country)	Comment legal	Required
115	LabTestCYTOLOGIEDistrict	Type of tests performed		Whether cytology was performed	Checkbox	Required
116	LabTestGRAMDistrict	Type of tests performed		Whether gram stain test was performed	Checkbox	Required
117	LabTestTDRDistrict	Type of tests performed		Whether RDT lab test was performed	Checkbox	Required
118	LabTestLATEXDistrict	Type of tests performed		Whether latex test was performed	Checkbox	Required
119	LabTestAUTREDistrict	Type of tests performed		Specify Other type of lab tests completed	Text	Required
120	WhiteCellCountDistrict	White cell count (District)		White blood count on case reported (district lab)	Number	Required
121	PolyPercentDistrict	Polymorphonucleocytes % (District)		Polymorphonucleocytes on case report (district lab)	Number	Optional
122	MonoPercentDistrict	Lymphocytes % (District)		Mono Lymphocytes level (district lab): elevated lymphocytes can show inflammation of the meninges	Number	Optional
123	CytologyDistrictNotDone	Cytology (District)		Specify whether cytology not completed	Checkbox	Optional
124	GramDistrict	Gram (District)	1-DGP/CGP 2-DGN/CGN 3-GPB/BGP 4-GNB/BGN 5-Other germs 6-No organisms 7-Not done	Organism identified by gram stain test at the district lab	Comment legal	Required
125	GramOtherDistrict	Gram - other (District)		Other pathogen identified by Gram at district lab	Text	Optional
126	TDR_MeningitisDRS	Rapid Diagnostic Test Meningitis (District)	1-Yes 2-No 3-Not done	Whether RDT was performed at the district lab	Comment Legal	Optional

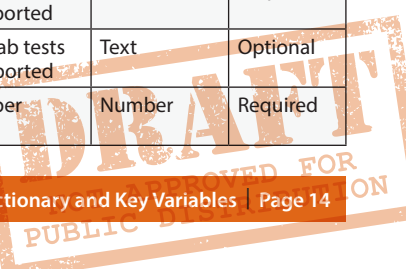
Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
127	TDR_TypeDRS	Type of Rapid Diagnostic Test Meningitis (District)	1-Pastorex 2-CERMES Dipstick 3-Other (specify in next variable)	Type of RDT Meningitis at district lab	Comment Legal	Optional
128	TestAUTREDistrict	Other type of TDR (specify name)		Specify the type and results if other Lab test utilized at district lab	Text	Optional
129	TDR_OtherResultsDRS	Rapid Diagnostic Test Meningitis (District)	1-NmA 2-NmC 3-NmW 4-NmY 5-Negative 6-Not done	RDT Results performed at district lab	Comment legal	Optional
130	LatexDistrict	LatexDistrict	1-NmA 2-NmC 3-NmW/Y 4-NmB/ <i>E. coli</i> K1 5- <i>S. pneumoniae</i> 6-Hib 7-StrepB 8-Negative 9-Not done	Results of the latex test at the district lab	Comment legal	Optional
131	ResultSentHealthFacility	Date Result sent to reporting health facility		Date that the result is sent to the reporting health facility	Date	Optional
132	SpecimenSentRegionalNRL	Date specimen is sent to the regional lab or NRL		Date the specimen is sent to regional lab or NRL	Date	Optional
133	RegionLab	Name of Regional Lab	Country specific list	Name of regional lab receiving the specimen	Text	Required
134	SpecimenIDRegion	Specimen ID		Specimen ID at regional lab	Text	Optional
135	DateReceivedRegion	Date regional lab received		Date the regional lab received the specimen	Date	Required
136	TimeSampleReceivedRegion	Time		Time the specimen was received at regional lab	Time	Optional
137	DryTubeRegion	Dry tube (Region)		Whether the specimen received in dry tube by regional lab	Checkbox	Required
138	TIRegion	TI (Region)		Whether the specimen was received in Trans-Isolate by regional lab	Checkbox	Required
139	CryotubeRegion	Cryotube (Region)		Whether the specimen was received in cryotube by regional lab	Checkbox	Required
140	OtherMediaRegion	Sample received in OTHER media		Specify the OTHER media received by regional lab	Text	Optional
141	SpecimenConditionRegion	Specimen Condition (Region)	1-Adequate 2-Not adequate	Whether a specimen was: 1-Adequate (indicating both volume and temperature of specimen) or 2-Not adequate (indicating if cracked, empty, transported at incorrect temperature, insufficient volume or illegible labeling)	Comment legal	Required
142	AspectRegion	Macroscopic exam (Region)	1-Clear 2-Turbid/ Cloudy 3-Bloody 4-Xanthochromic/ Yellow 5-Viscous 6-Purulent 9-Not done	Clarity of specimen (Note: Variable coding list includes term/alternate term. Please select term that best fits what is used in-country)	Comment legal	Required
143	LabTestCYTOLOGIERegion	Type of tests performed		Whether cytology performed on case reported	Checkbox	Required
144	LabTestGRAMRegion	Type of tests performed		Whether gram stain tests were performed on case reported	Checkbox	Required
145	LabTestTDRRegion	Type of tests performed		Whether RDT lab tests completed on case reported	Checkbox	Required
146	LabTestLATEXRegion	Type of tests performed		Whether latex test was performed on case reported	Checkbox	Required
147	labTestCULTURERegion	Type of tests performed		Whether culture was performed on case reported	Checkbox	Required



Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
148	LabTestAUTRERegion	Type of tests performed		Specify OTHER type of lab tests completed on case reported	Text	Optional
149	WhiteCellCountRegion	White cell count (region)		White blood count of case reported at regional lab	Number	Required
150	PolyPercentRegion	Polymorphonucleocytes % (Region)		Polymorphonucleocytes recorded at the regional lab	Number	Optional
151	MonoPercentRegion	Lymphocytes % (Region)		Mono Lymphocytes recorded at regional lab (Elevated lymphocytes can show inflammation of the meninges)	Number	Optional
152	CytologyRegionNotDone	Cytology (Region)		Specify whether cytology not completed	Checkbox	Optional
153	GramRegion	Gram (Region)	1-DGP/CGP 2-DGN/CGN 3-GPB/BGP 4-GNB/BGN 5-Other germs (specify) 6-No organisms 7-Not done	Pathogen identified by gram stain test at regional lab	Comment legal	Required
154	GramOtherRegion	Gram-other (Region)		If other germ identified, please specify the other pathogen identified at the regional lab	Text	Required
155	TDR_MeningitisRegion	Rapid Diagnostic Test Meningitis		Whether RDT was performed at the regional lab	Checkbox	Required
156	TDR_TypeRegion	Type of Rapid Diagnostic Test Meningitis	1-Pastorex 2-CERMES Dipstick 3-Other	Type of RDT Meningitis at regional lab	Comment Legal	Required
157	TestAUTRERegion	Other type of testing (specify name)		Specify the type of Other Lab test utilized	Text	Optional
158	TDR_OtherResultsRegional	Rapid Diagnostic Test Meningitis	1-NmA 2-NmC 3-NmW 4-NmY 5-Negative 6-Not done	RDT Results performed at regional lab	Comment legal	Required
159	LatexRegion	Latex (region)	1-NmA 2-NmC 3-NmW/Y 4-NmB/ <i>E. coli</i> K1 5- <i>S. pneumoniae</i> 6-Hib 7-StrepB 8-Negative 9-Not done	Results of the latex test at the Regional lab	Comment legal	Required
160	CultureRegion	Culture (region)	1-NmA 2-NmC 3-NmW 4-NmY 5-NmB 6-NmX 7-Nm Indeterminate 8- <i>S. pneumoniae</i> 9-Hib 10-Hi non-b 11-StrepB 12-Other organism (specify next) 13-Contaminated 14-Negative 15-Not done 16-Not Available	Results of culture test at regional lab for the case notified	Comment legal	Required
161	CultureOtherRegion	Culture - other (region)		Specify other organism identified by culture at regional lab	Text	Optional
162	AmoxicillinRegion	Amoxicillin	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for amoxicillin at regional lab	Comment legal	Optional
163	CeftriaxoneRegion	Ceftriaxone	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for ceftriaxone at regional lab	Comment legal	Optional



Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
164	ChloramphenicolRegion	Chloramphenicol	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for Chloramphenicol at regional lab	Comment legal	Optional
165	PenicillinRegion	Penicillin	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for penicillin at regional lab	Comment legal	Optional
166	OxacillineRegion	Oxacillin	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for oxacilline at regional lab	Comment legal	Optional
167	OtherAntibioticRegion	Other antibiotic		Name of the other Antibiotic tested by antibiogram at regional lab	Text	Optional
168	OtherAntibioticSensitivityRegion	Other antibiotic sensitivity	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for the other antibiotic at regional lab	Comment legal	Optional
169	ResultSentHF_Region	Date Results sent to reporting health facility		Date results sent to reporting health facility	Date	Optional
170	SpecimenSentNRL	Date specimen sent to the NRL		Date specimen sent to the NRL	Date	Optional
171	NRL	Name of National Reference Lab		Name of NRL	Text	Required
172	SpecimenIDNRL	Specimen ID		Specimen id at NRL	Text	Optional
173	DateReceivedNRL	Date NRL received		Date that the NRL received the specimen	Date	Required
174	TimeSampleReceivedNRL	Time		Time the specimen was received by NRL	Time	Optional
175	DryTubeNRL	Dry Tube (NRL)		Whether the specimen received in dry tube by NRL	Checkbox	Required
176	TINRL	T-I Media (NRL)		Whether the specimen was received in a Trans-Isolate by NRL	Checkbox	Required
177	CryotubeNRL	Cryotube (NRL)		Whether specimen was received in cryotube by NRL	Checkbox	Required
178	OtherMediaNRL	Sample received in OTHER media (NRL)		Specify Other media received by NRL	Checkbox	Optional
179	SpecimenConditionNRL	Specimen Condition	1-Adequate 2-Not adequate	Whether a specimen was: 1-Adequate (indicating both volume and temperature of specimen) or 2-Not adequate (indicating if cracked, empty, transported at incorrect temperature, insufficient volume or illegible labeling)	Comment legal	Required
180	AspectNRL	Macroscopic (NRL)	1-Clear 2-Turbid/ Cloudy 3-Bloody 4-Xanthochromic/ Yellow 5-Viscous 6-Purulent 9-Not done	Clarity of specimen (Note: Variable coding list includes term/alternate term. Please select term that best fits what is used in-country)	Comment legal	Required
181	LabTestCYTOLOGIENRL	Type of tests performed		Whether cytology performed on case reported	Checkbox	Required
182	LabTestGRAMNRL	Type of tests performed		Whether gram stain tests were performed on case reported	Checkbox	Required
183	LabTestTDRNRL	Type of tests performed		Whether RDT lab tests completed on case reported	Checkbox	Required
184	LabTestLATEXNRL	Type of tests performed		Whether latex test was performed on case reported	Checkbox	Required
185	labTestCULTURENRL	Type of tests performed		Whether culture was performed on case reported	Checkbox	Required
186	LabTestAUTRENRL	Type of tests performed		Specify other type of lab tests completed on case reported	Text	Optional
187	WhiteCellCountNRL	White cell count (NRL)		White count cell number reported at NRL	Number	Required



Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
188	PercentMonoNRL	Lymphocytes % (NRL)		Percent of lymphocytes identified at NRL	Number	Required
189	PercentPolyNRL	Polymorphonucleocytes % (NRL)		Percent Polymorphonucleocytes recorded at the NRL	Number	Required
190	CytologyNRLNotDone	Cytology (NRL)		Specify whether cytology not completed	Checkbox	Optional
191	GramNRL	Gram (NRL)	1-DGP/CGP 2-DGN/CGN 3-GPB/BGP 4-GNB/BGN 5-Other germs 6-No organisms 7-Not done	Organism identified by gram stain test at the NRL	Comment legal	Required
192	GramOtherNRL	Gram -other (NRL)		Specify Other organism identified by gram stain test at NRL	Text	Required
193	TDR_MeningitisNRL	Rapid Diagnostic Test Meningitis		Whether RDT was performed at the NRL	Checkbox	Required
194	TDR_TypeNRL	Type of Rapid Diagnostic Test Meningitis	1-Pastorex 2-CERMES Dipstick 3-Other	Type of RDT Meningitis at NRL	Comment Legal	Required
195	TestAUTRENRL	Other type of testing (name and results)		Specify the type of test and results of Other Lab test utilized at NRL	Text	Optional
196	TDR_OtherResultsNRL	Rapid Diagnostic Test Meningitis Results	1-NmA 2-NmC 3-NmW 4-NmY 5-Negative 6-Not done	RDT Results performed at NRL	Comment legal	Required
197	LatexNRL	Latex (NRL)	1-NmA 2-NmC 3-NmW/Y 4-NmB/ <i>E. coli</i> K1 5- <i>S. pneumoniae</i> 6-Hib 7-StrepB 8-Negative 9-Not done	Results of the Latex test at the NRL	Comment legal	Required
198	CultureNRL	Culture (NRL)	1-NmA 2-NmC 3-NmW 4-NmY 5-NmB 6-NmX 7-Nm Indeterminate 8- <i>S. pneumoniae</i> 9-Hib 10-Hi non-b 11-StrepB 12-Other organism (specify next) 13-Contaminated 14-Negative 15-Not done 16-Not Available	Results of culture test at NRL for the case notified	Comment legal	Required
199	CultureOtherNRL	Culture - other (NRL)		Specify other organism identified by culture at NRL	Text	Required
200	Amoxicillin	Amoxicillin	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for amoxicillin at NRL	Comment legal	Optional
201	Ceftriaxone	Ceftriaxone	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for ceftriaxone at NRL	Comment legal	Optional
202	Chloramphenicol	Chloramphenicol	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for Chloramphenicol at NRL	Comment legal	Optional

Variable No.	Variable Name	Electronic Reporting Prompt	Variable Coding	Definition	Format	Required/Optional
203	Penicillin	Penicillin	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for penicillin at NRL	Comment legal	Optional
204	Oxacilline	Oxacillin	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for Oxacilline at NRL	Comment legal	Optional
205	OtherAntibiotic	Other antibiotic		Name of other antibiotic tested by antibiogram at NRL	Text	Optional
206	OtherAntibioticSensitivity	Other antibiotic sensitivity	1-Sensitive 2-Resistant 3-Intermediate 9-Not done	Results of antibiogram for the other antibiotic at NRL	Comment legal	Optional
207	PCR	PCR	1-NmA 2-NmC 3-NmW 4-NmY 5-NmB 6-NmX 7-Nm Indeterminate 8- <i>S. pneumoniae</i> (specify genotype next) 9-Hib 10-Hi non-b 11-Contaminated (specify) 12-Negative 13-Not done 14- Not Available	Serotype identified by PCR according to the PCR testing algorithm	Comment legal	Required
208	Genotype_Sp	Genotype of <i>S. pneumoniae</i>		Specify results of genotype for <i>S. pneumoniae</i>	Text	Optional
209	FinalResultOtherNRL	Final lab result - other		Specify other organism identified by PCR	Text	Required
210	PCRTYPE	PCR type	1-Conventional 2-Real Time	Whether conventional or real-time PCR was used at NRL	Comment legal	Required
211	DatePCR	Date PCR Performed		Date that the PCR test was performed	Date	Required
212	ObservationsNRL	Observations (NRL)		Observations of the National Reference laboratory	Text	Optional
213	FinalResultNRL	Final lab result	1-NmA 2-NmC 3-NmW 4-NmY 5-NmB 6-NmX 7-Nm Indeterminate 8-NmW/Y 9-NmB/ <i>E. coli</i> K1 10. <i>S. pneumoniae</i> 11-Hib 12-Hi non-b 13-StrepB 14- Other organism 15-Contaminated 16-Negative 17-Not done	Serotype identified in the final lab results from the national reference laboratory	Comment legal	Required
214	DateResultsSentHF	Date lab sent final lab results to clinician		Date results sent to reporting health facility	Date	Optional
215	DateFinalResultsSentMOH	Date lab sent final lab results to MoH		Date results sent to the MoH Surveillance Department	Date	Optional
216	FinalClassification	Final case classification	1-Confirmed 2-Probable 3-Suspect	Final classification according to the clinical symptoms (case definition), epidemiology and laboratory result: confirmed, probable, and suspect.	Comment legal	Required