NDD no:

MENINGOCOCCAL DISEASE – Follow up of contacts of a case

Note to the prescriber: *For each contact referred by the PHU, please check that they are well, check contraindications and explain side effects. The right hand side of this form should be completed and faxed back to PHU on . If you have questions or concerns, please contact the PHU on (business hours) or (after hours).* ***If the contact is clinically unwell and meningococcal disease is suspected, please notify the PHU urgently.***

1. **PHU** to complete & fax to prescriber								2. **Prescriber** to complete & fax to PHU on				
Name of contact	Age and sex	Phone / email	Type of contact	Info given (verbal and/or written)	Clearance Abs indicated	Who will provide antibiotics? *(if indicated)*	PHU officer, date	Contact well?	Contraindications checked & side effects explained?	Antibiotic prescribed / dispensed	Date & Time	Prescriber ,date
			☐ Low-level ☐ Close		☐ No ☐ Yes			☐ No ☐ Yes	☐ No ☐ Yes	☐Cipro ☐Rifampicin ☐Ceftriaxone	Date: Time:	
			☐ Low-level ☐ Close		☐ No ☐ Yes			☐ No ☐ Yes	☐ No ☐ Yes	☐Cipro ☐Rifampicin ☐Ceftriaxone	Date: Time:	
			☐ Low-level ☐ Close		☐ No ☐ Yes			☐ No ☐ Yes	☐ No ☐ Yes	☐Cipro ☐Rifampicin ☐Ceftriaxone	Date: Time:	
			☐ Low-level ☐ Close		☐ No ☐ Yes			☐ No ☐ Yes	☐ No ☐ Yes	☐Cipro ☐Rifampicin ☐Ceftriaxone	Date: Time:	
			☐ Low-level ☐ Close		☐ No ☐ Yes			☐ No ☐ Yes	☐ No ☐ Yes	☐Cipro ☐Rifampicin ☐Ceftriaxone	Date: Time:	
			☐ Low-level ☐ Close		☐ No ☐ Yes			☐ No ☐ Yes	☐ No ☐ Yes	☐Cipro ☐Rifampicin ☐Ceftriaxone	Date: Time:	
			☐ Low-level ☐ Close		☐ No ☐ Yes			☐ No ☐ Yes	☐ No ☐ Yes	☐Cipro ☐Rifampicin ☐Ceftriaxone	Date: Time:	

* Contacts usually meeting public health criteria for information AND clearance antibiotics include: household, household-like, sexual, travel, childcare, health care worker (see definitions in *Guidelines*)

Notes

ANTIBIOTIC	USUAL DOSE FOR CLEARANCE	KEY CONTRAINDICATIONS
CIPROFLOXACIN	500 mg PO stat.	Pregnancy, breastfeeding, child under 12 years, allergy
RIFAMPICIN	**Adults:** 600mg b.d. for 2 days **Children:** 10 mg/kg (max 600mg) b.d. for 2 days **Infants <1 month:** 5 mg/kg b.d. for 2 days	Pregnancy, jaundice, alcoholism, liver disease, allergy
CEFTRIAXONE	**Adults**: 250 mg IMI **Children <12 yrs:** 125 mg IMI	Allergy to cephalosporins or penicillins

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FOLLOW UP OF GROUPS OF CONTACTS *(eg information given to schools, clinics held, local media, etc)*				
Date	**Group**	**Number**	**Intervention**	**Details**

Notes