STREPTOCOCCUS PNEUMONIAE CASE INVESTIGATION - Page 1 of 3

Indiana State Department of Health
State Form 49218 (R/11-04)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

Sex:
- ○ Male
- ○ Female
- ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Section 2. Clinical Information

Was the patient hospitalized?

○ Yes ○ No

If Yes, admission date: / /

Discharge date: / /

Hospital:

Patient chart number:

Physician:

Physician phone: - -

Outcome:

○ Survived ○ Died ○ Unknown

Does this patient:

○ Attend a Day-care Facility ○ Reside in a Long-term Care Facility

Facility Name

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Section 2. Clinical Information (continued)

Date first positive culture obtained:

__ __ / __ __ / __ __

Type of infection caused by organism (Check all that apply):

- ○ Bacteremia
- ○ Meningitis
- ○ Otitis Media
- ○ Pneumonia
- ○ Celluitis
- ○ Epiglottitis
- ○ Peritonitis
- ○ Pericarditis
- ○ Septic Arthritis
- ○ Other, specify:

Preexisting medical conditions (check all that apply):

- ○ Chronic Cardiovascular Disease (do not include hypertension)
- ○ Chronic Pulmonary Disease (do not include asthma)
- ○ HIV Infection
- ○ Sickle Cell Disease
- ○ Splenectomy
- ○ Organ/Bone Marrow Transplant
- ○ Chronic Renal Failure
- ○ Chronic Liver Disease
- ○ Diabetes Mellitus
- ○ Cochlear Implant
- ○ Deaf/Profound Hearing Loss
- ○ Immunosuppressive Condition -Type:
- ○ Malignancy - Type:
- ○ Other, specify:
- ○ None

Specimen from which organism isolated (Check all that apply):

- ○ Blood
- ○ CSF
- ○ Pleural Fluid
- ○ Peritoneal Fluid
- ○ Pericardial Fluid
- ○ Joint
- ○ Tympanocentesis
- ○ Other, specify:

The following will be completed by Indiana State Department of Health.

Serotyping done? ○ Yes ○ No **If Yes, serotype:**

Section 3. Vaccines

Did patient receive pneumococcal vaccine *prior* to illness? ○ Yes ○ No ○ Unknown

If Yes, please enter information below:

Dose: 1. __ __ / __ __ / __ __ **Date given** **Vaccine name**

Manufacturer **Lot number**

Dose: 2. __ __ / __ __ / __ __ **Date given** **Vaccine name**

Manufacturer **Lot number**

Vaccine information continued on the next page.

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Section 3. Vaccines (continued)

Dose: 3.

Date given ___/___/___ Vaccine name _____

Manufacturer _____ Lot number _____

Dose: 4.

Date given ___/___/___ Vaccine name _____

Manufacturer _____ Lot number _____

Section 4. Laboratory

Laboratory Resistance Testing Results

(Attach copy of Resistance Report or complete below)

Antimicrobial Agent	S/I/R Results	Antimicrobial Agent	S/I/R Results
Azithromycin	○ S ○ I ○ R	Erythromycin	○ S ○ I ○ R
Cefotaxime	○ S ○ I ○ R	Levofloxacin	○ S ○ I ○ R
Ceftriaxone	○ S ○ I ○ R	Penicillin	○ S ○ I ○ R
Cefuroxime Axetil	○ S ○ I ○ R	Tetracycline	○ S ○ I ○ R
Chloramphenicol	○ S ○ I ○ R	Trimethoprim/ Sulfamethoxazole	○ S ○ I ○ R
Clindamycin	○ S ○ I ○ R		
Other	○ S ○ I ○ R	Vancomycin	○ S ○ I ○ R

If Other, specify _____

S/I/R RESULTS: The S (susceptible), I (intermediate), R (resistant) result indicates whether the microorganism is susceptible or not susceptible (intermediate or resistant) to the anitmicrobial being tested.

Section 5. Comments/Follow-up

Comments:

Investigator Name _____

Agency _____

Phone Number ___-___-___ Date ___/___/___