

SEVERE STAPHYLOCOCCUS AUREUS INFECTION IN A PREVIOUSLY HEALTHY PERSON*

CASE INVESTIGATION – Page 1 of 2

Indiana State Department of Health
State Form 53653 (6-08)

*A **Previously Healthy Person** is defined as a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or cutaneous medical device at the time of culture.

INITIAL SCREENING FOR CASE DEFINITION	
Did the patient's infection result in: ICU admission <input type="radio"/> Yes <input type="radio"/> No Death <input type="radio"/> Yes <input type="radio"/> No	
If No to both of the above, patient does not meet the case definition. Please do not complete or submit this form.	
Does the patient have ANY of the following? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, check all that apply	
<input type="checkbox"/> Hospitalized within the past year (including >48 hours prior to first <i>S. aureus</i> positive culture)	
<input type="checkbox"/> Surgery within past year	
<input type="checkbox"/> Dialysis (hemo or peritoneal) within past year	
<input type="checkbox"/> Residence in long-term care within the past year	
<input type="checkbox"/> Percutaneous device or indwelling catheter (e.g. BROVIAC®, foley, tracheostomy, gastrostomy)	
If ANY risk factor is checked, patient does not meet the case definition. Please do not complete or submit this form.	

SECTION 1. DEMOGRAPHIC INFORMATION			
Patient Name – Last	First	MI	Date of Birth _____/_____/_____
		Age	Sex
			<input type="radio"/> Male <input type="radio"/> Female
Number & Street		ZIP Code	
City		State	
		County	
Race: <input type="radio"/> Asian		<input type="radio"/> Other/Multiracial	
<input type="radio"/> Unknown		<input type="radio"/> Black or African American	
<input type="radio"/> American Indian or Alaska Native		<input type="radio"/> White	
<input type="radio"/> Native Hawaiian or Other Pacific Islander		Ethnicity:	
		<input type="radio"/> Hispanic or Latino	
		<input type="radio"/> Non-Hispanic or Non-Latino	
		<input type="radio"/> Unknown	
Occupation			

SECTION 2. CLINICAL DATA			
Patient Hospitalized? <input type="radio"/> Yes <input type="radio"/> No	If Yes, Hospital Name	City	ZIP code
Admit Date _____/_____/_____		Medical Record Number	
Illness Onset Date _____/_____/_____	Name of Health Care Provider – Last		Telephone Number
		First	
Chest X-ray <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
If Yes, <input type="radio"/> Normal <input type="radio"/> Abnormal describe _____			
Was a clinically-relevant infection associated with the positive culture? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
If Yes, type of infection (<i>check all that apply</i>)			
<input type="radio"/> Bacteremia		<input type="radio"/> Septic embolism	
<input type="radio"/> Bursitis		<input type="radio"/> Endocarditis	
<input type="radio"/> Pyomyositis		<input type="radio"/> Skin or soft tissue infection (<i>specify if known</i>) _____	
<input type="radio"/> Meningitis		<input type="radio"/> Osteomyelitis	
<input type="radio"/> Septic arthritis		<input type="radio"/> Necrotizing fasciitis	
		<input type="radio"/> Other infection (<i>specify</i>) _____	
		<input type="radio"/> Toxic shock syndrome	
Underlying condition(s) (<i>check all that apply</i>):			
<input type="radio"/> Alcohol abuse		<input type="radio"/> HIV/AIDS	
<input type="radio"/> Asthma		<input type="radio"/> Injecting drug use	
<input type="radio"/> Eczema		<input type="radio"/> Diabetes mellitus	
<input type="radio"/> Psoriasis		<input type="radio"/> Emphysema/COPD	
<input type="radio"/> Folliculitis		<input type="radio"/> Heart failure/CHF	
<input type="radio"/> Other chronic dermatologic condition (<i>specify</i>) _____		<input type="radio"/> Immunosuppressive therapy	
		<input type="radio"/> Liver disease	
		<input type="radio"/> Malignancy – hematologic	
		<input type="radio"/> Malignancy – solid organ	
		<input type="radio"/> Chronic renal insufficiency	
		<input type="radio"/> Current smoker	
		<input type="radio"/> Other (<i>specify</i>) _____	
		<input type="radio"/> None	
Past Medical History <input type="radio"/> Staphylococcal disease <input type="radio"/> MRSA infection or colonization			
Patient Outcome <input type="radio"/> Survived (as of _____/_____/_____) <input type="radio"/> Died (Date _____/_____/_____) <input type="radio"/> Unknown			

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SECTION 3. Diagnostic Tests

Is the isolate: <input type="radio"/> MRSA <input type="radio"/> MSSA	Culture date: ____/____/____	Hospital/clinic where culture obtained:
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Site from which *S. aureus* was isolated (check all that apply)

<input type="radio"/> Blood	<input type="radio"/> Joint	<input type="radio"/> Skin (swab/aspirate)	<input type="radio"/> Urine	<input type="radio"/> Cerebrospinal fluid
<input type="radio"/> Bone	<input type="radio"/> Sputum/trach	<input type="radio"/> Ear (drainage/aspirate)	<input type="radio"/> Pleural fluid	<input type="radio"/> Surgical specimen
<input type="radio"/> Nares	<input type="radio"/> Eye	<input type="radio"/> Peritoneal fluid	<input type="radio"/> Wound	(specify) _____

Other (specify) _____

Susceptibility Results (or attach laboratory report of antibiotic susceptibilities)	Susceptible	Intermediate	Resistant	Not tested or unknown
Amox/ K Clav	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amp/Sulbactam (Unasyn)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Azithromycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cefazolin (Kefzol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cefuroxime	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ciprofloxacin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clindamycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Erythromycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gentamicin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imipenem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Levofloxacin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Linezolid (Zyvox)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oxacillin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pip/Tazo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rifampin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Synercid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tetracycline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trimeth/Sulfa (Septra, Bactrim)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vancomycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (specify)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Laboratory-confirmed influenza? A B Type of test _____ Date ____/____/____

SECTION 4. EPIDEMIOLOGIC INFORMATION

Did the patient reside in or participate in any of the following in the year prior to the culture? (Check all that apply.)

Correctional facility Residential care facility Pre-school/child care Team sports

SECTION 5. ASSOCIATION WITH OTHER CASES

Was this patient's illness associated with other cases of *S. aureus* illness? Yes No Unknown

If Yes, specify nature of other illness _____

Specify nature of association with other case(s) Household Sexual Other _____

Section 6. Comments/Follow-up

Attachments/Reports:
Please attach laboratory report of antibiotic susceptibilities unless susceptibility results have been provided above.

Investigator Name	Agency	Telephone Number	Date (month, day, year)
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