Rapidly Fatal or Serious Community-associated *Staphylococcus aureus* Infection Case Report Form

Reported by: _____ **Phone:** _____ **Date:** ☐☐ / ☐☐ / ☐☐☐☐

1. Patient name:
_____
(Last) (First)

2. Medical record number: _____

3. ID number: ☐☐☐☐☐☐

4. Patient address:
_____
Street Address
City: _____ State: _____ Zip: _____

5. Age : _____
1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.
DOB ☐☐ / ☐☐ / ☐☐☐☐

6. Sex:
1 ☐ Male 2 ☐ Female

7. Phone: ☐☐☐ ☐☐☐ ☐☐☐☐

8. Next of kin name/phone number:
_____
_____

9. Patient race:
1 ☐ White
2 ☐ Black
3 ☐ American Indian/ Alaskan Native
4 ☐ Asian/Pacific Islander
5 ☐ Other _____
9 ☐ Unknown

9a. Ethnicity:
1 ☐ Hispanic
2 ☐ Non-Hispanic
9 ☐ Unknown

10a. Attending physican name/phone:
_____
_____

11. Was patient pregnant?
1 ☐ Yes 2 ☐ No 9 ☐ Unk

12. Hospital/clinic where culture obtained: _____

10b. Primary physician name/phone:
_____

***13. Initial screening for healthcare-associated illness:**
Does patient have ANY risk factor a-f below? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

(please review chart for **ALL** risk factors a-f and check all that apply)

☐ a) Hospitalized > 48 hours prior to first MRSA
☐ b) Dialysis (hemo or PD) within past year
☐ c) Surgery within the past year
☐ d) Hospitalized within the past year
☐ e) Residence in long-term care within the past year
☐ f) Percutaneous device or indwelling catheter (e.g., broviac, foley, tracheostomy, gastrostomy)

***If any risk factor a-f in Question #13 is checked, please stop here and do not complete or submit this form.**

14. Does patient have prior history of MRSA infection or colonization? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

15. Did the patient reside in or participate in any of the following in the year prior to the culture? (select all and describe)

1 ☐ Correctional facility _____
2 ☐ Indian reservation _____
3 ☐ Preschool/childcare _____
4 ☐ Sports team _____
5 ☐ Residential facility _____
6 ☐ Other: _____
9 ☐ Unknown

16. Is the isolate: ☐ **MRSA or** ☐ **MSSA?**

17. Culture date: ☐☐ / ☐☐ / ☐☐☐☐ (please send isolate to MDH)

18. Site from which *S. aureus* was isolated: (check all that apply)

1 ☐ Blood	1 ☐ Joint	1 ☐ Skin (swab/aspirate)	1 ☐ Urine
1 ☐ CSF	1 ☐ Bone	1 ☐ Sputum/trach	1 ☐ Ear (drainage/aspirate)
1 ☐ Pleural fluid	1 ☐ Surgical specimen	1 ☐ Nares	1 ☐ Eye
1 ☐ Peritoneal fluid	1 ☐ Post-op wound	1 ☐ Device/catheter	1 ☐ Other (specify) _____

MDH laboratory specimen number: ☐☐☐☐☐☐☐☐☐☐

You may fax this form to 1-800-233-1817

19. Was a clinically relevant infection associated with the positive culture? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If "YES," type of infection: (check all that apply)

1 ☐ Bacteremia
1 ☐ Bursitis
1 ☐ Meningitis
1 ☐ Wound infection
1 ☐ Toxic shock syndrome
1 ☐ Other infection (specify) _____

1 ☐ Osteomyelitis
1 ☐ Otitis (media or externa)
1 ☐ Pneumonia
☐ Necrotizing ☐ Hemorrhagic
1 ☐ Septic arthritis

1 ☐ Skin infection (specify below)
1 ☐ Abscess 1 ☐ Folliculitis
1 ☐ Cellulitis 1 ☐ Impetigo
1 ☐ Necrotizing fasciitis
1 ☐ Other skin _____

20. Susceptibility results: (please complete OR attach copy of the susceptibility results to this form)

Ciprofloxacin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Clindamycin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Daptomycin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Erythromycin (or other macrolide)	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Gentamicin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Oxacillin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Linezolid	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Rifampin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Synercid	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Tetracycline	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Trimethoprim-sulfamethoxazole	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Telitromycin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Vancomycin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown
Other (specify) _____	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ Not tested or unknown

21. Illness signs and symptoms: (first 4 days of illness) **Onset date:** ☐☐ / ☐☐ / ☐☐☐☐

1 ☐ Vomiting
1 ☐ Diarrhea
1 ☐ Abdominal pain
1 ☐ Myalgia
1 ☐ Dyspnea
1 ☐ Headache
1 ☐ Cough
1 ☐ Sore throat
1 ☐ Rigors
1 ☐ Disorientation
1 ☐ Seizures
1 ☐ Cardiac arrythmia
1 ☐ Syncope
1 ☐ Rash
1 ☐ Focal rash _____
1 ☐ Sunburn-like rash
1 ☐ Petichial/purpuric rash
1 ☐ Other _____

22. Clinical laboratory findings: (first 4 days of illness, most abnormal values, high and low)

WBC count
High _____ /mm^3
Low _____ /mm^3

Neutrophils
High _____ %
Low _____ %

Platelets
High _____ /mm^3
Low _____ /mm^3

SGOT (AST)
High _____ IU/L
Low _____ IU/L

Hemoglobin
High _____ mg/dL
Low _____ mg/dL

BUN (Highest value)
_____ mg/dL

Creatinine (Highest value)
_____ mg/dL

SGPT (ALT)
High _____ IU/L
Low _____ IU/L

Bilirubin
High _____ mg/dL
Low _____ mg/dL

Alkaline phosphotase
High _____ IU/L
Low _____ IU/L

Amylase
High _____ units/dL
Low _____ units/dL

Influenza positive (within 10 days of onset date)? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Culture ☐ Rapid test ☐

23. Other clinical findings: **Highest fever** _____ F

Chest x-ray 1 ☐ Yes 2 ☐ No 9 ☐ Unknown If "Yes," result ☐ Normal
☐ Abnormal (describe) _____

Blood pressure High Low
Systolic _____ _____
Diastolic _____ _____

24. Was patient hospitalized? (If "No," skip to #27) **If YES, date of admission:** ☐☐ / ☐☐ / ☐☐☐☐ **Date of discharge:** ☐☐ / ☐☐ / ☐☐☐☐

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

25. Was patient in intensive care? **If YES, date of ICU admission:** ☐☐ / ☐☐ / ☐☐☐☐ **Date of ICU discharge:** ☐☐ / ☐☐ / ☐☐☐☐

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

26. Was patient on ventilator? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown If "Yes," number of days ________

27. Patient outcome:

1 ☐ Survived
2 ☐ Died
3 ☐ Unknown

27a. If patient died, date of death: Mo. ☐☐ / Day ☐☐ / Year ☐☐☐☐

Cause of death: ______________________

27b. If patient died, was *S. aureus* contributory?

1 ☐ Yes
2 ☐ No
9 ☐ Unknown

28. Was IVIG given? 1 ☐ Yes 2 ☐ No 9 ☐ Unk

29. Was activated protein C given? 1 ☐ Yes 2 ☐ No 9 ☐ Unk

30. Were antibiotics given? 1 ☐ Yes 2 ☐ No 9 ☐ Unk (If "Yes," list all)

Antibiotic name: ____________ **Dosage:** ____________ **Route:**
Abx start date ☐☐ / ☐☐ / ☐☐☐☐ Abx end date ☐☐ / ☐☐ / ☐☐☐☐ IV / IM / PO (circle)

Antibiotic name: ____________ **Dosage:** ____________ **Route:**
Abx start date ☐☐ / ☐☐ / ☐☐☐☐ Abx end date ☐☐ / ☐☐ / ☐☐☐☐ IV / IM / PO (circle)

Antibiotic name: ____________ **Dosage:** ____________ **Route:**
Abx start date ☐☐ / ☐☐ / ☐☐☐☐ Abx end date ☐☐ / ☐☐ / ☐☐☐☐ IV / IM / PO (circle)

31. Does patient have a past history of staphylococcal disease?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown If "Yes," describe: ______________________

32. Underlying conditions: 1 ☐ Yes 2 ☐ No 9 ☐ Unknown (If "Yes," check all that apply)

1 ☐ Alcohol abuse
1 ☐ Asthma
1 ☐ Eczema
1 ☐ Psoriasis
1 ☐ Folliculitis
1 ☐ Other chronic dermatological condition (specify) ______________
1 ☐ HIV/AIDS
1 ☐ IVDU
1 ☐ Diabetes mellitus
1 ☐ Emphysema/COPD
1 ☐ Heart failure/CHF
1 ☐ Immunosuppressive therapy
1 ☐ Liver disease
1 ☐ Malignancy - hematologic
1 ☐ Malignancy - solid organ
1 ☐ Chronic renal insufficiency
Dialysis 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
1 ☐ Current smoker
1 ☐ Other (specify) ______________

33. If patient female, was patient menstruating? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

33a. If "Yes," was tampon in place? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Other comments: ____

Case meets serious staph case definition? 1 ☐ **Yes** 2 ☐ **No** 9 ☐ **Unknown**