Minnesota Department of Health

Vancomycin-Intermediate and Vancomycin-Resistant *Staphylococcus aureus* (VISA/VRSA) Case Report Form

- **Please CALL MDH immediately at 651-201-5414 or 1-877-676-5414 to report any VISA or VRSA isolate.**
- **Please fax this case report form to MDH at 1-800-233-1817.**
- **Please send the isolate to the MDH Public Health Laboratory (project # 880).**

Reported by: ______________ **Phone:** ______________ **Date:** ____ / ____ / ______

1. Patient name: ______________________ (*Last, First, MI*)

2. Medical record number: ______________

3. State ID number: ______________

4. Patient address:

Street ______________________

City ______________ State ____ Zip ________

Phone (_____) ____________

Is this a long-term care facility? __ Yes __ No __ Unknown

If Yes, name of LTCF ______________________

5. Age : ________ ☐ Days ☐ Mos. ☐ Yrs.

DOB ____ / ____ / ______

6. Sex: ☐ Male ☐ Female

7a. Race (*check all that apply*): ☐ Unknown

☐ Black or African American ☐ White

☐ Native Hawaiian or Other Pacific Islander ☐ Asian

☐ American Indian or Alaska Native ☐ Other ________

7b. Ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Unknown

8. Culture Date: ____ / ____ / ______

9. Identifying Laboratory: ______________

10. Hospital/clinic where culture obtained: ______________

11. Specimen source (*specify site where indicated*):

☐ Blood ______ ☐ Joint ________ ☐ Eye ________ ☐ Wound ________

☐ CSF ☐ Bone ________ ☐ Sputum/trach ☐ Surgical specimen ________

☐ Pleural fluid ☐ Nares ☐ Ear (drainage/aspirate) ☐ Skin (swab) ________

☐ Peritoneal fluid ☐ Urine ☐ Device/catheter ________ ☐ Other (specify) ________

12a. Attending physican name/phone: ______________________

12b. Primary physician name/phone: ______________________

13a. Was patient hospitalized at time of culture? ☐ Yes ☐ No

If Yes: Admit date: ____ / ____ / ______ Discharge date: ____ / ____ / ______

13b. Is patient currently hospitalized? ☐ Yes ☐ No If No, where was patient discharged? ______________

14. Outcome: ☐ Survived ☐ Died If died, date of death ____ / ____ / ______

Patient Risk Factors

15. Does patient have a prior history of MRSA?

☐ Yes ☐ No ☐ Unknown

Most recent culture date/site: ______________

16. Does patient have a prior history of VRE?

☐ Yes ☐ No ☐ Unknown

Most recent culture date/site: ______________

17. Did patient receive vancomycin in the past year? ☐ Yes ☐ No ☐ Unknown

Dates received: ______________________

18. Was patient hospitalized in the past year? ☐ Yes ☐ No ☐ Unknown

19. Did patient have dialysis in the past year? ☐ Yes ☐ No ☐ Unknown

Dialysis center name/phone: ______________________

20. Did patient reside in a long-term care or group home facility in the last year? ☐ Yes ☐ No ☐ Unknown

Facility name/phone:

21. Underlying conditions (*check all that apply*): ☐ None ☐ Unknown

- ☐ Alcohol abuse
- ☐ Asthma
- ☐ Eczema
- ☐ Other chronic dermatological condition (specify) ______
- ☐ Chronic renal insufficiency
- ☐ Current smoker
- ☐ Diabetes mellitus
- ☐ Emphysema/COPD
- ☐ Heart failure/CHF
- ☐ HIV
- ☐ AIDS or CD4 count < 200
- ☐ Immunosuppressive therapy
- ☐ Intravenous drug use
- ☐ Liver disease
- ☐ Malignancy - hematologic
- ☐ Malignancy - solid organ
- ☐ Other (specify) ______

22. Type of infection associated with the positive culture: ☐ None ☐ Unknown

- ☐ Bacteremia
- ☐ Bursitis
- ☐ Meningitis
- ☐ Osteomyelitis
- ☐ Pneumonia
- ☐ Septic arthritis
- ☐ Skin infection (specify) ______
- ☐ Wound infection
- ☐ Other (specify) ______

Clinical lab results (ask a microbiology laboratory technologist to answer questions 23-30)

23. What was the vancomycin MIC? ______ **24. Was the test repeated?** ☐ Yes ☐ No ☐ Unknown

25. Were other bacteria isolated in the culture? ☐ Yes ☐ No ☐ Unknown

If Yes, specify organisms: ______

26. Was the purity check pure? ☐ Yes ☐ No ☐ Unknown

27. Did the organism grow on the vancomycin screen plate? ☐ Yes ☐ No ☐ Not tested ☐ Unknown

28. What susceptiblity testing method was used? ______

29. Antibiotic susceptibility testing results: (please fax a copy of the susceptibility results to MDH)

Antibiotic				
Ciprofloxacin	☐ S	☐ I	☐ R	☐ Not tested or unknown
Clindamycin	☐ S	☐ I	☐ R	☐ Not tested or unknown
Daptomycin MIC: ______	☐ S	☐ Nonsusceptible		☐ Not tested or unknown
Erythromycin	☐ S	☐ I	☐ R	☐ Not tested or unknown
Gentamicin	☐ S	☐ I	☐ R	☐ Not tested or unknown
Oxacillin	☐ S	☐ I	☐ R	☐ Not tested or unknown
Levofloxacin	☐ S	☐ I	☐ R	☐ Not tested or unknown
Linezolid	☐ S	☐ I	☐ R	☐ Not tested or unknown
Rifampin	☐ S	☐ I	☐ R	☐ Not tested or unknown
Synercid	☐ S	☐ I	☐ R	☐ Not tested or unknown
Tetracycline	☐ S	☐ I	☐ R	☐ Not tested or unknown
Trimethoprim-sulfamethoxazole	☐ S	☐ I	☐ R	☐ Not tested or unknown
Vancomycin	☐ S	☐ I	☐ R	☐ Not tested or unknown
Other, specify: ______	☐ S	☐ I	☐ R	☐ Not tested or unknown

30. Can the isolate be submitted to MDH for confirmation? ☐ Yes ☐ No

MDH USE ONLY

Specimen number: ______ **Vancomycin MIC result:** ______ Panel ______ Etest

Organism identification: ☐ *Staphylococcus aureus* ☐ Other (specify): ______

Final result: ☐ MRSA ☐ MSSA ☐ Other species (not *S. aureus)* ☐ VISA ☐ VRSA

NOTES (including infection prevention recommendations):