

Patient ID: _____

StateID: _____

– Severe Community – Onset *Staphylococcus aureus* Infection Surveillance Case Report Form –

Patient's Name: _____ (Last, First, M.I.) Phone No.: () _____
 Address: _____ (Number, Street, Apt. No.) Patient Chart No.: _____
 _____ (City, State) _____ (Zip Code) Hospital: _____

– Patient identifier information is NOT transmitted to CDC –

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

SEVERE COMMUNITY-ONSET *STAPHYLOCOCCUS AUREUS* INFECTION SURVEILLANCE CASE REPORT FORM



Section 1 – Exclusion Criteria: Complete this section to determine whether the case should be reported to the Severe Community-Onset *Staphylococcus aureus* Infection Surveillance Project.

1. Site from which <i>Staphylococcus aureus</i> (susceptible or resistant) was initially isolated: <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Lung tissue <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Bronchoalveolar lavage (BAL) <input type="checkbox"/> Other (If Other, STOP!) Was this culture a: <input type="checkbox"/> Methicillin-Susceptible <i>Staphylococcus aureus</i> (MSSA) <input type="checkbox"/> Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) Lab ID where isolate was cultured: _____	2. Was patient reported to this surveillance in the previous 30 days? <input type="checkbox"/> Yes (If Yes, STOP!) <input type="checkbox"/> No <input type="checkbox"/> Unknown	3. DATE OF BIRTH: Mo Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	3a. AGE: <input type="text"/> <input type="text"/> <input type="text"/>	3b. Is age in day/mo/yr? <input type="checkbox"/> Days <input type="checkbox"/> Mos. <input type="checkbox"/> Yrs. (If Age > 50 years, STOP!)
5. Was the patient admitted to an acute care facility during the 5 day time period including the 2 calendar days before and the 2 calendar days after the date of initial culture? (where date of admission=Day 0) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If NO, STOP!) If Yes, Date of Admission: Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> If known, Date of Discharge: Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	6. Residence of Patient: State: _____ (Complete if different than above) County: _____ [If Patient Residence is outside of defined population-based surveillance catchment area, STOP!] Treatment Hospital: _____ (Complete if different than above) Treatment Hospital ID: _____ [If Patient Admission is outside of defined sentinel-based surveillance catchment area, STOP!]	7. a) Hospitalized overnight in previous 12 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown b) Residence in a long term/ skilled nursing facility in previous 12 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If YES, STOP!)	8. Did the patient have an indwelling invasive device in place at time of admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If YES, STOP!)	

This completes the Exclusion Criteria Section 1. If you have not reached a STOP point for any of the above 8 questions, then case should be reported and continue to complete Sections 2 and 3.

Comments: _____

Section 2 – ABCs *Staphylococcus aureus* Core Questions:

The information collected in this section asks many of the same questions as the Invasive MRSA ABCs Case Report form and can be used to collect much of that required data. However, if this is an invasive MRSA case, be sure to also collect all additional data required for that surveillance form.

9. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	10. ETHNIC ORIGIN: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	11. RACE: (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Unknown
12. WEIGHT: _____ lbs _____ oz OR _____ kg <input type="checkbox"/> Unknown	15. PATIENT OUTCOME: <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown If died: Date of Death: Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Was <i>Staphylococcus aureus</i> (susceptible or resistant) contributory or causal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
13. HEIGHT: _____ ft _____ in OR _____ cm <input type="checkbox"/> Unknown		
14. Was an infection related to the initial culture included in the admission diagnosis? (Was <i>Staphylococcus aureus</i> (susceptible or resistant) infection the reason for hospital admission?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

16. Was the initial specimen (listed in #1 above) polymicrobial? Yes No Unknown

If YES, list other organisms isolated: (check all that apply)

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> <i>Acinetobacter baumannii</i> | <input type="checkbox"/> Enterococcus spp. | <input type="checkbox"/> <i>Morganella morganii</i> | <input type="checkbox"/> <i>Staphylococci</i> | <input type="checkbox"/> <i>Streptococcus Group B</i> |
| <input type="checkbox"/> Bacteroides spp. | <input type="checkbox"/> <i>Escherichia coli</i> | <input type="checkbox"/> <i>Mycoplasma pneumoniae</i> | <input type="checkbox"/> coagulase-negative | <input type="checkbox"/> <i>Streptococcus Group D</i> |
| <input type="checkbox"/> <i>Bordetella pertussis</i> | <input type="checkbox"/> <i>Haemophilus influenzae</i> | <input type="checkbox"/> <i>Neisseria meningitidis</i> | <input type="checkbox"/> (<i>Staphylococcus epidermis</i>) | <input type="checkbox"/> <i>Streptococcus pneumoniae</i> |
| <input type="checkbox"/> <i>Burkholderia cepacia</i> | <input type="checkbox"/> Klebsiella spp. | <input type="checkbox"/> Proteus spp. | <input type="checkbox"/> <i>Stenotrophomonas</i> | <input type="checkbox"/> <i>Streptococcus viridans</i> |
| <input type="checkbox"/> Candida spp. | <input type="checkbox"/> <i>Legionella pneumophila</i> | <input type="checkbox"/> Pseudomonas spp. NOS | <input type="checkbox"/> maltophilia | <input type="checkbox"/> Other pathogen |
| <input type="checkbox"/> Citrobacter spp. | <input type="checkbox"/> <i>Listeria monocytogenes</i> | <input type="checkbox"/> <i>Pseudomonas aeruginosa</i> | <input type="checkbox"/> Streptococcus spp. NOS | (specify): _____ |
| <input type="checkbox"/> Enterobacter spp. | <input type="checkbox"/> <i>Moraxella catarrhalis</i> | <input type="checkbox"/> Serratia spp. | <input type="checkbox"/> <i>Streptococcus Group A</i> | |

17. Were cultures of the SAME site (listed in #1 above) positive with any *Staphylococcus aureus* (susceptible or resistant) between 7 and 30 days after initial culture (i.e., persistent disease)?

Yes No Unknown

18. Were cultures of OTHER site(s) positive with *Staphylococcus aureus* (susceptible or resistant) within 30 days after initial culture? Yes No Unknown

If YES, list site(s) (check all that apply):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Blood | <input type="checkbox"/> Internal Body Site (specify): _____ | <input type="checkbox"/> Pleural Fluid | <input type="checkbox"/> Urine |
| <input type="checkbox"/> Bone | | <input type="checkbox"/> Rectal/Stool | <input type="checkbox"/> Other Sterile Site (specify): _____ |
| <input type="checkbox"/> Bronchoalveolar lavage (BAL) | <input type="checkbox"/> Joint/Synovial Fluid (specify) _____ | <input type="checkbox"/> Skin and/or Soft Tissue (specify) _____ | |
| <input type="checkbox"/> Catheter/Device (specify): _____ | <input type="checkbox"/> Lung tissue | <input type="checkbox"/> Sputum | <input type="checkbox"/> Other Non-Sterile Site (specify): _____ |
| <input type="checkbox"/> CSF | <input type="checkbox"/> Nares | <input type="checkbox"/> Throat/Nasopharynx | |
| | <input type="checkbox"/> Pericardial Fluid | <input type="checkbox"/> Tracheal Aspirate | |
| | <input type="checkbox"/> Peritoneal Fluid | | |

19. Were any blood cultures drawn on the day of admission or the following 2 calendar days?

Yes No Unknown

20. Was an active surveillance test culture (i.e. nasal swab or other site listed as "surveillance") collected from the patient on the day of admission or the following 2 calendar days? Yes No Unknown

If YES, what was the result? Negative MSSA-positive MRSA-positive Unknown

21. Types of infection associated with initial culture (listed in #1 above): (check all that apply) None Unknown

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Abscess (not skin) | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Pressure Ulcer | <input type="checkbox"/> Surgical Site (internal) |
| <input type="checkbox"/> Bacteremia | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Septic Arthritis | <input type="checkbox"/> Traumatic Wound |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Otitis Media | <input type="checkbox"/> Septic Emboli | <input type="checkbox"/> Urinary Tract |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Pericarditis | <input type="checkbox"/> Septic Shock | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Empyema | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Skin and/or Soft Tissue Abscess | |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Pneumonia (If checked, answer Q26) | <input type="checkbox"/> Surgical Incision | |

22. Underlying Conditions: (check all that apply) (If none or no chart available, check appropriate box) None Unknown

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS or CD4 Count < 200 | <input type="checkbox"/> Decubitus Ulcer | <input type="checkbox"/> Metastatic Solid Tumor | <input type="checkbox"/> Other Condition(s) (specify): _____ |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Dementia | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other Drug Use | |
| <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD/CAD) | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Peripheral Vascular Disease (PVD) | <u>Skin Disease:</u> |
| <input type="checkbox"/> Chronic Liver Disease | <input type="checkbox"/> Heart Failure/CHF | <input type="checkbox"/> Premature Birth | <input type="checkbox"/> Abscess/Boil |
| <input type="checkbox"/> Chronic Renal Insufficiency | <input type="checkbox"/> Hematologic Malignancy | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Skin/Soft Tissue Infection |
| <input type="checkbox"/> Current Smoker | <input type="checkbox"/> Hemiplegia/ Paraplegic | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Other Dermatological Condition(s) (specify): _____ |
| <input type="checkbox"/> CVA/Stroke (not TIA) | <input type="checkbox"/> HIV | <input type="checkbox"/> Solid Organ Malignancy | |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Immunosuppressive Therapy | <input type="checkbox"/> Systemic Lupus Erythematosus | |
| | <input type="checkbox"/> IVDU | <input type="checkbox"/> Peptic Ulcer Disease | |

23. Was there documentation that the patient had influenza within 10 days prior to the initial *S. aureus* culture (listed in #1 and #4 above)?

Yes No Unknown

24. Classification – Healthcare-associated and Community-associated: (check all that apply)

- | | | | | | | | |
|---|---|--|-------|------|--|--|----------------------------------|
| Hospitalized within year before initial culture date? | <input type="checkbox"/> Yes <input type="checkbox"/> Unknown | If YES and known: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Month</td><td>Year</td></tr><tr><td> </td><td> </td></tr></table> | Month | Year | | | <input type="checkbox"/> Unknown |
| Month | Year | | | | | | |
| | | | | | | | |
| Surgery within year before initial culture date? | <input type="checkbox"/> Yes <input type="checkbox"/> Unknown | If YES and known: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Month</td><td>Year</td></tr><tr><td> </td><td> </td></tr></table> | Month | Year | | | <input type="checkbox"/> Unknown |
| Month | Year | | | | | | |
| | | | | | | | |
| Residence in long-term care/skilled nursing facility within year before initial culture date? | <input type="checkbox"/> Yes <input type="checkbox"/> Unknown | | | | | | |

25. Susceptibility Results of initial culture (listed in #1 above):

[S=Susceptible; I=Intermediate; R=Resistant; NS=Non-Susceptible; U=Unknown/Not Reported]

- | | | | |
|--|---|---|--|
| Ampicillin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Doxycycline: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Moxifloxacin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Rifampin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Cefazolin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Erythromycin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Nafcillin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Tetracycline: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Chloramphenicol: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Gentamicin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Oxacillin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Tigecycline: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Ciprofloxacin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Imipenem: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Penicillin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Trimethoprim-Sulfamethoxazole: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Clindamycin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Levofloxacin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Quinupristin/ Dalfopristin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Vancomycin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Daptomycin: <input type="checkbox"/> S <input type="checkbox"/> NS <input type="checkbox"/> U | Linezolid: <input type="checkbox"/> S <input type="checkbox"/> NS <input type="checkbox"/> U | | Other (specify): _____ <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |

26. Supplemental Pneumonia Questions: (Complete only if checked Pneumonia in Q21)

a) Are any of the following listed in the discharge summary narrative?

- MRSA pneumonia
- Staphylococcal pneumonia
- Pneumonia
- Aspiration pneumonia
- No pneumonia specified
- Viral pneumonia
- Hemorrhagic Pneumonia
- Necrotizing pneumonia

c) Chest Radiology Results: (check all that apply) Not Done

Source of results: CT X-Ray

- Cavitation
- Air space density/ opacity
- Pleural effusion
- Single lobar infiltrate
- Multiple lobar infiltrate (unilateral)
- Multiple lobar infiltrate (bilateral)
- New or changed infiltrate
- Bronchopneumonia/pneumonia
- Consolidation
- Interstitial infiltrate
- Cannot rule out pneumonia
- No evidence of pneumonia
- Not available
- Other (specify): _____

b) Discharge Diagnosis: (check all that apply) N/A Unknown

- 482.40
- 482.41
- 482.42
- 482.49
- V09.0
- None of these listed

Section 3 – Additional Respiratory-Related Clinical and Laboratory Questions: The information collected in this final section asks additional required questions regarding respiratory-related clinical symptoms, treatments, and laboratory test results. These questions should be answered for every case.

27. Signs and symptoms identified at admission (from History & Physical): (check all that apply)

- Chest pain
- Chills
- Cough (new onset or change)
- Diarrhea
- Dyspnea (shortness of breath)
- Fever (>38°C)
- Headache
- Hemoptysis (coughing blood)
- Hypothermia (<36°C)
- Hypoxia (supplemental O2 ordered)
- Lethargy/Malaise
- Rales/Bronchial breath sounds
- Respiratory arrest
- Sore Throat
- Sputum (new or increased)
- Tachypnea (respiratory rate > 20)
- Vomiting
- Wheezing
- Other, specify: _____

28. Was there documentation that the patient, in the 30 days prior to admission:

- Had a wound that required dressing changes? Yes Unknown
- Received antibiotics to treat something other than the current *S. aureus* infection? Yes Unknown

29. Was the patient admitted to the ICU within 7 days following hospital admission? Yes No Unknown

30. Was the patient placed on mechanical ventilation?

- Yes No Unknown

31. Physical findings and laboratory values (most abnormal) collected during the 5 days time period including the 2 calendar days before and the 2 calendar days after the date of initial culture?

- Temperature: _____ F or _____ C Not Obtained
- Blood Pressure: Systolic _____ / Diastolic _____ Not Obtained
- Respiratory Rate: _____ per minute Not Obtained
- WBC count: _____ mm³ Not Obtained
- Neutrophils: _____ % Bands: _____ % Not Obtained
- Platelets: _____ mm³ Not Obtained
- Hematocrit: _____ Not Obtained
- Pulse Ox: _____ (prior to O2 administration) Not Obtained

32. Did the patient receive influenza vaccine prior to this admission, during the current/most recent influenza season?

- Yes No Unknown

33. Was the patient tested for influenza during this admission?

- Yes No Unknown

If YES, was influenza virus infection confirmed by laboratory test?

- Yes No Unknown

If YES, what laboratory test was used?

- IFA or DFA
- Viral Culture
- Serology
- RT-PCR
- Rapid Antigen
- Other, specify: _____

What was the type of influenza detected:

- A B Both A and B Unspecified

Date of influenza test: ____/____/____ (mm/dd/yyyy)

34. Was the patient tested for any of the following other respiratory viruses?

- Respiratory syncytial virus: Yes No Unknown If YES, Result: Positive Negative Unknown
 - Parainfluenza virus: Yes No Unknown If YES, Result: Positive Negative Unknown
 - Adenovirus: Yes No Unknown If YES, Result: Positive Negative Unknown
 - Rhinovirus: Yes No Unknown If YES, Result: Positive Negative Unknown
 - Other: Yes No Unknown If YES, Result: Positive Negative Unknown
- If OTHER, specify: _____

35. Treatment:

a) Were antibiotics administered on the day of or the day after this admission? Yes No Unknown

If YES, check all antibiotics administered on the day of or the day after this admission:

- Azithromycin
- Ceftriaxone
- Clindamycin
- Daptomycin
- Gatifloxacin
- Levofloxacin
- Linezolid
- Moxifloxacin
- Quinupristin/Dalfopristin
- Rifampin
- Tigecycline
- Trimethoprim-Sulfamethoxazole
- Vancomycin
- Other 1 (specify): _____
- Other 2 (specify): _____
- Unknown

b) Were antivirals administered in the 7 days prior to this admission? Yes No Unknown

If YES, check all antivirals administered in the 7 days prior to this admission:

- Amantadine (Symmetrel)
- Oseltamivir (Tamiflu)
- Rimantadine (Flumadine)
- Zanamivir (Relenza)
- Unknown

c) Were antivirals administered on the day of or the day after this admission? Yes No Unknown

If YES, check all antivirals administered on the day of or the day after this admission:

- Amantadine (Symmetrel)
- Oseltamivir (Tamiflu)
- Rimantadine (Flumadine)
- Zanamivir (Relenza)
- Unknown

36. Case Report Form Status: Complete Incomplete Edited and Corrected Chart unavailable after 3 requests