

## SEVERE STAPHYLOCOCCUS AUREUS INFECTION IN A PREVIOUSLY HEALTHY PERSON\* CASE REPORT

\*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.”

### SECTION 1. INITIAL SCREENING FOR CASE DEFINITION

**Did the patient’s infection result in:** ICU admission  Yes  No      Death  Yes  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?**  Yes  No  Unknown

**If yes, check all that apply**

Hospitalized within the past year (including >48 hours prior to first *S. aureus* positive culture)

Surgery within past year

Dialysis (hemo or peritoneal) within past year

Residence in long-term care within the past year

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 2. DEMOGRAPHIC INFORMATION

Patient Name – Last	First	Middle Initial	Date of Birth ____/____/____	Age _____ years	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (number, street)	City	State	ZIP code	County	Telephone Number
Race (check all that apply) <input type="checkbox"/> African-American <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____			Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
If Asian/Pacific Islander, check all that apply: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____					
Occupation					

### SECTION 3. CLINICAL INFORMATION

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

**SECTION 4. LABORATORY INFORMATION**

Is the isolate: <input type="checkbox"/> MRSA <input type="checkbox"/> 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="checkbox"/> Blood	<input type="checkbox"/> Joint	<input type="checkbox"/> Skin (swab/aspirate)	<input type="checkbox"/> Urine	<input type="checkbox"/> Cerebrospinal fluid
<input type="checkbox"/> Bone	<input type="checkbox"/> Sputum/trach	<input type="checkbox"/> Ear (drainage/aspirate)	<input type="checkbox"/> Pleural fluid	<input type="checkbox"/> Surgical specimen
<input type="checkbox"/> Nares	<input type="checkbox"/> Eye	<input type="checkbox"/> Peritoneal fluid	<input type="checkbox"/> Wound	specify _____
<input type="checkbox"/> Other (specify) _____				

Susceptibility Results (or attach laboratory report of antibiotic susceptibilities)	Susceptible	Intermediate	Resistant	Not tested or unknown
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clindamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin (or other macrolide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gentamicin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxacillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Linezolid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Synercid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trimethoprim-sulfamethoxazole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telithromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vancomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Laboratory-confirmed influenza? A B Type of test \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 5. 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 Indian reservation Pre-school/child care Team sports

**SECTION 6. 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 \_\_\_\_\_

**ADDITIONAL INFORMATION**

Comments/Remarks:

  
  
  
  
  
  
  
  
  
  

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

**REPORTING AGENCY**

Investigator Name	Local Health Jurisdiction	Telephone Number	Date
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**STATE USE ONLY**

Case Counted <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for case classification
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