Invasive Bacterial Disease

All Streptococcus pneumoniae

West Virginia Electronic Disease Surveillance System
Division of Surveillance and Disease Control
Infectious Disease Epidemiology Program
Phone: 304-558-5358 or 800-423-1271 in West Virginia
Fax: 304-558-8736

Disease Under Investigation

(Bacterial species isolated from any normally sterile site)

* indicates required fields

○ *Drug Resistant Streptococcus pneumoniae ('Pneumococcus')* ○ *Streptococcus pneumoniae in children less than age 5*
○ *Streptococcus pneumoniae, all other*

Investigation Status*
○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*
○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	**First Name***	**Middle Initial**

Street Address

City	**County**	**State**	**Zip**
		West Virginia	

Is the patient's residence a:
○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____
○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	**Ext.**	**Other Phone** ###-###-####	**Ext.**	**Report Date** mm/dd/yyyy

Parent / Guardian Information

Last Name	**First Name**	**Middle Initial**	**Relationship to Patient**

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	**County**	**State**	**Zip**
		West Virginia	

Home Phone ###-###-####	**Ext.**	**Other Phone** ###-###-####	**Ext.**

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	**Age**	**Age Units** ○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native*
☐ *Asian*
☐ *Black or African American*
☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White*
☐ *Unknown*
☐ *Failure to report race/missing race*
☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms mm/dd/yyyy	**Date of diagnosis** mm/dd/yyyy

Was the patient hospitalized for the disease? ○ *Yes* ○ *No* ○ *Unknown*	**Name of Hospital**	**Date of Admission** mm/dd/yyyy

Patient outcome from this disease: ○ *Died* ○ *Survived* ○ *Unknown*	**Date of Death** mm/dd/yyyy

Types of infection caused by organism

(Check all that apply)

☐ *Abscess (not skin)*
☐ *Bacteremia without focus*
☐ *Cellulitis*
☐ *Chorioamnionitis*
☐ *Endometritis*
☐ *Epiglottitis*
☐ *Hemolytic Uremic Syndrome (HUS)*
☐ *Meningitis*
☐ *Necrotizing fasciitis*
☐ *Osteomyelitis*
☐ *Otitis media*
☐ *Pericarditis*
☐ *Peritonitis*
☐ *Pneumonia*
☐ *Puerperal sepsis*
☐ *Septic abortion*
☐ *Septic arthritis*
☐ *STSS*
☐ *Other (specify)*_____

Laboratory Results

Sterile sites from which the organism was isolated:

(Check all that apply)

☐ *Blood*
☐ *Bone*
☐ *CSF*
☐ *Internal body site: (specify)*_____
☐ *Joint*
☐ *Muscle*
☐ *Pericardial fluid*
☐ *Peritoneal fluid*
☐ *Pleural fluid*
☐ *Other normally sterile site: (specify)*_____

Date first positive culture obtained

mm/dd/yyyy

Other sites from which organism isolated:

(Check all that apply)

☐ *Amniotic fluid* ☐ *Middle ear* ☐ *Placenta* ☐ *Sinus* ☐ *Wound* ☐ *Other:*_____

Laboratory Name	**Phone** ###-###-####	**Ext.**	**Fax Number** ###-###-####

Address

State: West Virginia	**Zip:**

Oxacillin Disk Susceptibility Testing Results

Oxacillin zone size (valid 00-30mm)	**Oxacillin interpretation**
	○ *R<20 (possibly resistant)* ○ *S>=20 (susceptible)* ○ *Unknown; not tested*

Minimum Inhibitory Concentration (MIC) Susceptibility Testing Results

Antimicrobial Agent	Susceptibility Method	S/I/R/U Result	Sign**	MIC Value
	A=Agar dilution method B=Broth dilution D=Disk diffusion (Kirby Bauer) S=Strip: Antimicrobial gradient strip (E-test)	Result indicates microorganism's susceptibility to the antimicrobial being tested	Select Sign	(e.g., 0.06 ug/ml)
PENICILLIN				
AMOXICILLIN				
AMOXICILLIN+CLAVULANATE				
CEFOTAXIME				
CEFTRIAXONE				
CEFUROXIME				
VANCOMYCIN				
ERYTHROMYCIN				
AZITHROMYCIN				
TETRACYCLINE				
LEVOFLOXACIN				
SPARFLOXACIN				
GATIFLOXACIN				
MOXIFLOXACIN				
TRIMETHOPRIM+SULFAMETHOXAZOLE				
CLINDAMYCIN				
QUINUPRISTIN+DALFOPRISTIN				
LINEZOLID				
OTHER 1 (Specify Below)				
OTHER 2 (Specify Below)				

Record Other Antimicrobial Agent 1

Record Other Antimicrobial Agent 2

**** Note: Indicates whether the MIC is >,<,=,<=,>= to the numerical MIC value in the last column**

Reporting Source

Last Name	First Name	
Phone ###-###-####	**Ext.**	**Fax** ###-###-####
Facility		
Address		
City	**State** West Virginia	**Zip**
E-mail		

Provider with Further Patient Information

Last Name	First Name	
Phone ###-###-####	**Ext.**	**Fax** ###-###-####
Address		
City	**State** West Virginia	**Zip**

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy

Investigator	Date public health investigation began mm/dd/yyyy	Health Department	Phone ###-###-####
Ext.			

Investigation ID	Part of an Outbreak?	Outbreak Name	Lost to follow-up?
	○ *Yes* ○ *No* ○ *Unknown*		○ *Yes* ○ *No*

○ *Check if epi-linked to another case and complete information below*

Last Name of Epi-linked Case	First Name	DOB mm/dd/yyyy
County	**Onset Date** mm/dd/yyyy	

Indicate underlying causes or prior illness

If none or information not available, check here:

○ *None* ○ *Unknown*

(Check all that apply)

- ☐ *AIDS or CD4 count < 200*
- ☐ *Alcohol abuse*
- ☐ *Asthma*
- ☐ *Atherosclerotic cardiovascular disease (ASCVD)/CAD*
- ☐ *Obesity*
- ☐ *Cerebral Vascular Accident (CVA)/Stroke*
- ☐ *Cirrhosis/Liver failure*
- ☐ *Cochlear implant*
- ☐ *CSF leak (2 deg trauma/surgery)*
- ☐ *Current smoker*
- ☐ *Deaf/Profound hearing loss*
- ☐ *Diabetes mellitus*
- ☐ *Emphysema/COPD*
- ☐ *Heart failure/CHF*
- ☐ *HIV infection*
- ☐ *Hodgkin's disease*
- ☐ *Immunoglobulin deficiency*
- ☐ *Immunosuppressive therapy (steroids, chemotherapy, radiation)*
- ☐ *IVDU*
- ☐ *Leukemia*
- ☐ *Multiple myeloma*
- ☐ *Nephrotic syndrome*
- ☐ *Renal failure / renal dialysis*
- ☐ *Sickle cell anemia*
- ☐ *Splenectomy / asplenia*
- ☐ *Systemic lupus erythematosus (SLE)*
- ☐ *Transplant (specify):*_____
- ☐ *Other malignancy (specify):*_____
- ☐ *Other prior illness (specify):*_____
- ☐ *Complement Deficiency*

Complete for patients with invasive Streptococcus pneumoniae infection

Has the patient received 23-valent pneumococcal polysaccharide vaccine?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, list date most recently given?

mm/dd/yyyy

Vaccine Name?

How many doses has the patient received?

If < 15 years of age, did the patient receive pneumococcal conjugate vaccine?

If Yes, complete the table below

○ *Yes* ○ *No* ○ *Unknown*

Dose	Date given	Vaccine Name	Vaccine Manufacturer	Lot Number
	mm/dd/yyyy			
1.				
2.				
3.				
4.				

What was the serotype?

○ *1* ○ *2* ○ *3* ○ *4* ○ *5*
○ *6B* ○ *7F* ○ *8* ○ *9N* ○ *9V*
○ *10A* ○ *11A* ○ *12F* ○ *14* ○ *15B*
○ *17F* ○ *18C* ○ *19A* ○ *19F* ○ *20*
○ *22F* ○ *23F* ○ *33F* ○ *Not done* ○ *Not vaccine strain (specify)*_____

Public Health Action Taken

Describe public health action taken