Antibiotic Resistant Staphylococcus aureus

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

* indicates required fields

○ *Community-acquired methicillin resistant Staphylococcus aureus* ○ *Vancomycin intermediate resistant Staphylococcus aureus*

○ *Vancomycin resistant Staphylococcus aureus*

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○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*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*_____

Laboratory Information

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

Address

State: West Virginia	**Zip:**

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

Did patient die from this disease? ○ *Yes* ○ *No* ○ *Unknown*	**Date of Death** mm/dd/yyyy

Did the patient use antibiotics in the year prior to onset?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, indicate treatment history below

Antibiotic	Start date	Stop date	Reason prescribed
	mm/dd/yyyy	mm/dd/yyyy	

Specify site of the positive culture

(Check all that apply)

☐ *Axilla* ☐ *Blood* ☐ *CSF* ☐ *Groin* ☐ *Nares*
☐ *Pericardial Fluid* ☐ *Peritoneal Fluid* ☐ *Pleural Fluid* ☐ *Skin Lesion (Specify Location)* ☐ *Sputum*
☐ *Synovial Fluid* ☐ *Tympanocentesis* ☐ *Urine* ☐ *Wound / Burn (Specify Location)* ☐ *Other*_____

Resistance Testing Results

Oxacillin zone size
(valid 00-30mm)

Oxacillin interpretation

○ *R<=10 mm (resistant)* ○ *11-12 mm (intermediate)* ○ *S>=13 mm (susceptible)* ○ *Unknown; not tested*

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)	Indicates microorganism's susceptibility to the antimicrobial being tested	Select Sign	(e.g., 0.06 ug/ml)
OXACILLIN				
PENICILLIN				
AZITHROMYCIN				
CLARITHROMYCIN				
ERYTHROMYCIN				
CLINDAMYCIN				
LINEZOLID				
TRIMETHOPRIM+SULFAMETHOXAZOLE				
VANCOMYCIN				
CHLORAMPHENICOL				
CIPROFLOXACIN				
LEVOFLOXACIN				
OFLOXACIN				
GATIFLOXACIN				
QUINUPRISTIN+DALFOPRISTIN				
GENTAMICIN				
RIFAMPIN				
TETRACYCLINE				
OTHER 1 (Specify Below)				
OTHER 2 (Specify Below)				

Record Other Antimicrobial Agent 1

Record Other Antimicrobial Agent 2

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

Clinical Information

Specify clinical diagnosis:
(Check all that apply)

☐ *Boil*	☐ *Cellulitis*	☐ *Colonization*	☐ *Endocarditis*	☐ *Folliculitis*
☐ *Impetigo*	☐ *Infected burn*	☐ *Infected decubitus*	☐ *Infected foot or leg ulcer*	☐ *Infected Wound*
☐ *Meningitis*	☐ *Osteomyelitis*	☐ *Paronychia*	☐ *Pericarditis*	☐ *Pneumonia*
☐ *Sepsis*	☐ *Septic pleural effusion*	☐ *Thrombophlebitis*	☐ *Other:*_____	

Specify treatment for this infection:

Antibiotic	Start date	Stop date
	mm/dd/yyyy	mm/dd/yyyy

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*

Public Health Investigation cont.

○ *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

Underlying Disease and Risk Factors

Indicate underlying disease and risk factors present in the one year prior to onset:

(Check all that apply)

☐ *Burn or wound* ☐ *Cancer* ☐ *Daycare attendance* ☐ *Diabetes* ☐ *HIV infection* ☐ *Indwelling line*
☐ *Injection drug use* ☐ *Peritoneal dialysis* ☐ *Renal dialysis* ☐ *Surgery* ☐ *Tattoo* ☐ *Participation in team sports*
☐ *Household/close contacts* ☐ *Health care worker* ☐ *Day care worker* ☐ *None* ☐ *Unknown* ☐ *Other*_____

Elaborate:

Did the patient have a hospital or nursing home stay in the year prior to onset?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, give locations and dates below

Facility Name	**Date admitted**	**Date discharged**	**Reason for admission**
	mm/dd/yyyy	mm/dd/yyyy	

Did the patient stay in DOC or regional jail in the year prior to onset?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, give locations and dates below

Facility Name	**Date admitted**	**Date released/transferred**
	mm/dd/yyyy	mm/dd/yyyy

OLS PFGE Data

PFGE pattern

Public Health Action

Describe public health action taken