Toxic Shock Syndrome

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

Investigation Information

*indicates required fields

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○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*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

Patient Demographic Information cont.

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 patient hospitalized for this 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

Clinical Findings (Major Criteria)

Fever (highest - if not recorded, leave blank) Fahrenheit	Hypertension (lowest)			
	Systolic:	**Diastolic:**	**Syncope?** ○ *Yes* ○ *No*	**Orthostatic dizziness?** ○ *Yes* ○ *No*

Rash? ○ *Yes* ○ *No* ○ *Unknown*	**If yes,** ○ *Generalized* ○ *Focal*	**Describe:**

Desquamation? ○ *Yes* ○ *No* ○ *Unknown*	**If yes, describe:**

SIGNS AND SYMPTOMS (First 4 Days of Illness)

Vomiting? ○ *Yes* ○ *No* ○ *Unknown*	**Diarrhea?** ○ *Yes* ○ *No* ○ *Unknown*	**Abdominal Pain?** ○ *Yes* ○ *No* ○ *Unknown*	**Myalgia?** ○ *Yes* ○ *No* ○ *Unknown*
Sore Throat? ○ *Yes* ○ *No* ○ *Unknown*	**Conjunctival hyperemia?** ○ *Yes* ○ *No* ○ *Unknown*	**Oropharyngeal hyperemia?** ○ *Yes* ○ *No* ○ *Unknown*	**Injected tongue?** ○ *Yes* ○ *No* ○ *Unknown*
Vaginal hyperemia? ○ *Yes* ○ *No* ○ *Unknown*	**Vaginal discharge?** ○ *Yes* ○ *No* ○ *Unknown*	**Vaginal ulceration?** ○ *Yes* ○ *No* ○ *Unknown*	**Disorientation?** ○ *Yes* ○ *No* ○ *Unknown*

Seizures? ○ *Yes* ○ *No* ○ *Unknown*	**Cardiac Arythmia?** ○ *Yes* ○ *No* ○ *Unknown*	**If yes, describe:**

Outcome and Clinical Information cont.

LABORATORY DATA (Most Abnormal Values in First 4 Days of Illness)

WBC Count (000/mm3)	Neutrophil (%)	Bands (%)	Metamyelocytes (%)

Myelocytes (%)	Platelets (000/mm3)	Highest Platelet value after 7 days of illness (000/mm3)

Urinalysis

WBC/HPF ("Many"=99)	RBC/HPF ("Many"=99)	Protein (0-4+)

SGOT (IU/L)	SGPT (IU/L)	Alkaline phosphatase (IU/L)

Bilirubin (mg/dl)	Amylase (Somogyi Units/dl)

BUN (mg/dl)	Creatnine (mg/dl)	Calcium (mg/dl)	Phosphorus (mg/dl)

Albumin (g/dl)	Creatnine phosphokinase (CPK) (IU/L)	CPK - myocardial band?
		○ *Yes* ○ *No* ○ *Unknown*

Outcome and Clinical Information cont.

CULTURES

Blood:
○ *Positive* ○ *Negative* ○ *Not Done* ○ *Unknown*

If Positive, what organism(s):

#	Organism
1	
2	

Urine:
○ *Positive* ○ *Negative* ○ *Not Done* ○ *Unknown*

If Positive, what organism(s):

#	Organism	Colony Count
		000/ml
1		
2		

Throat:
○ *Normal Flora* ○ *Abnormal* ○ *Not Done* ○ *Unknown*

If Abnormal, what organism(s):

#	Organism
1	
2	

Nares:
○ *Done* ○ *Not Done* ○ *Unknown*

If Done, what organism(s):

#	Organism
1	
2	

Vagina:
○ *Done* ○ *Not Done* ○ *Unknown*

If Done, what organism(s):

#	Organism
1	
2	

Was Staphylococcus aureus present in the vagina?
○ *Yes* ○ *No* ○ *Unknown*

If S. aureus present in vagina, is it resistant to penicillin and ampicillin only?
○ *Yes* ○ *No* ○ *Unknown*

Other site(s):

Organism(s):

#	Organism
1	
2	

Was patient taking antibiotics when culture(s) performed?
○ *Yes* ○ *No* ○ *Unknown*

If Yes, which sites?

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

Address

State: West Virginia

Zip:

Reporting Source

Last Name	**First Name**

Phone ###-###-####	**Ext.**	**Fax** ###-###-####

Reporting Source cont.

Facility

Address

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

E-mail

Provider with Further Patient Information

Last Name	**First Name**

Phone ###-###-####	**Ext.**	**Fax** ###-###-####

Address

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

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*

Tampon/Napkin/Minipad Use-If applicable (during period when patient became ill)

Products Used

○ *Tampons only* ○ *Napkins only* ○ *Minipads only* ○ *Tampons and Napkins*
○ *Tampons and Minipads* ○ *Napkins and Minipads* ○ *Tampons, Napkins, and Minipads* ○ *Sea Sponge*
○ *Unknown* ○ *Other (specify)*_____

Tampon Brand No. 1 (Most frequently used, judged by time. If only one brand was used before onset of symptoms, list only that brand)

Assure	**Kotex**	**If Yes, what type:**
○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	○ *Plastic Inserter* ○ *Stick Inserter* ○ *Inserter Unknown*

o.b.	**Playtex**	**If Yes, What type:**	**Pursetts**
○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	○ *Deodorized* ○ *Non-deodorized*	○ *Yes* ○ *No* ○ *Unknown*

Rely	**Tampax**	**Other**
○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *If Yes, specify*

Style (absorbency)

○ *Super-plus* ○ *Super* ○ *Regular* ○ *Junior* ○ *Unknown*

Public Health Investigation cont.

Tampon Brand No. 2 (Most frequently used, judged by time. If only one brand was used before onset of symptoms, list only that brand)

Assure ○ *Yes* ○ *No* ○ *Unknown*	**Kotex** ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, what type:** ○ *Plastic Inserter* ○ *Stick Inserter* ○ *Inserter Unknown*
o.b. ○ *Yes* ○ *No* ○ *Unknown*	**Playtex** ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, What type:** ○ *Deodarized* ○ *Non-deodarized*
Pursetts ○ *Yes* ○ *No* ○ *Unknown*		
Rely ○ *Yes* ○ *No* ○ *Unknown*	**Tampax** ○ *Yes* ○ *No* ○ *Unknown*	**Other** ○ *Yes* ○ *No* ○ *If Yes, specify*
Style (absorbency) ○ *Super-plus* ○ *Super* ○ *Regular* ○ *Junior* ○ *Unknown*		
Was Brand No. 1 the only tampon brand used during period when patient became ill? ○ *Yes* ○ *No* ○ *Unknown*	**Napkin brand**	**Minipad brand**
How was information in this section verified? ○ *Patient's Memory* ○ *Patient viewing product box* ○ *Interviewer viewing product box* ○ *Other (describe)*_____		
Has Patient had similar illness in past during menstrual period? ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, How many episodes** ○ *One* ○ *Two* ○ *Three* ○ *More than three*	
Describe Public Health Action Taken		