

Antibiotic Resistant Staphylococcus aureus (VISA/VRSA)

PATIENT DEMOGRAPHICS

Name (last, first): _____	Birth date: __/__/____ Age: _____
Address: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
City/State/Zip: _____	Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
Phone (home): _____ Phone (work) : _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native (Mark all that apply) <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk
Occupation/grade: _____ Employer/School: _____	
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____	

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigator : _____	WVEDSS ID: _____
Investigator phone: _____	Case Classification: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
Investigation Start Date: __/__/____	

REPORTING SOURCE

Date of report: __/__/____ Report Source: Laboratory Hospital Physician Public Health Agency Other

Report Source Name: _____ Address: _____ Phone: _____

Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____

Reporter Name: _____ Address: _____ Phone: _____

CLINICAL

Physician Name: _____ Physician Facility : _____

Physician Address: _____ Phone: _____

Hospital Was patient hospitalized for this illness? Y N U If yes, Admit date: __/__/____ Discharge date: __/__/____
Hospital name: _____

Condition Vancomycin intermediate resistant staphylococcus aureus (VISA)
 Vancomycin resistant staphylococcus aureus (VRSA)

Diagnosis date: __/__/____
Illness onset date: __/__/____
Illness end date: __/__/____

Did patient die from this disease? Y N U If yes, date of death: __/__/____

Specify clinical diagnosis:

- | | | | | |
|-------------------------------------|---|--|---|---|
| <input type="checkbox"/> Boil | <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Colonization | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Folliculitis |
| <input type="checkbox"/> Impetigo | <input type="checkbox"/> Infected burn | <input type="checkbox"/> Infected foot/leg ulcer | <input type="checkbox"/> Infected decubitus | <input type="checkbox"/> Infected wound |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Paronychia | <input type="checkbox"/> Pericarditis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Sepsis | <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> Septic pleural effusion | <input type="checkbox"/> Other (specify): _____ | |

Specify treatment for this infection:

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

Indicate underlying disease and risk factors present in the one year prior to onset (check all that apply):

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Burn or wound | <input type="checkbox"/> Cancer | <input type="checkbox"/> Daycare attendance | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV infection |
| <input type="checkbox"/> Indwelling line | <input type="checkbox"/> Injection drug use | <input type="checkbox"/> Peritoneal dialysis | <input type="checkbox"/> Renal dialysis | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Tattoo | <input type="checkbox"/> Participation in team sports | <input type="checkbox"/> Household/close contacts | <input type="checkbox"/> Healthcare worker | <input type="checkbox"/> Daycare worker |
| <input type="checkbox"/> None | <input type="checkbox"/> Unknown | <input type="checkbox"/> Other (specify): _____ | | |

Describe underlying disease/risk factors:

ANTIBIOTIC USE HISTORY

Did the patient use antibiotics in the year prior to onset? Y N U If yes, indicate treatment history below

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

LABORATORY (Please submit copies of all labs to DIDE)

Specify site of positive culture:

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Axilla | <input type="checkbox"/> Blood | <input type="checkbox"/> CSF | <input type="checkbox"/> Groin | <input type="checkbox"/> Nares |
| <input type="checkbox"/> Pericardial Fluid | <input type="checkbox"/> Peritoneal Fluid | <input type="checkbox"/> Pleural Fluid | <input type="checkbox"/> Sputum | <input type="checkbox"/> Synovial Fluid |
| <input type="checkbox"/> Tympanocentesis | <input type="checkbox"/> Urine | <input type="checkbox"/> Skin Lesion (specify site): _____ | <input type="checkbox"/> Wound/Burn (specify site): _____ | <input type="checkbox"/> Other (specify): _____ |

RESISTANCE TESTING RESULTS

Data entered on the Lab Reports page in WVEDSS are not transmitted to CDC. These data must be reentered on the Investigation page. Please enter data from the lab report in the appropriate place.

OLS PFGE DATA

PFGE pattern:

EPIDEMIOLOGICTransmission Setting (where did this case acquire MRSA/VISA/VRSA?): Other (specify): _____

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Athletics | <input type="checkbox"/> College | <input type="checkbox"/> Community | <input type="checkbox"/> Correctional facility |
| <input type="checkbox"/> Daycare | <input type="checkbox"/> Doctor's office | <input type="checkbox"/> Home | <input type="checkbox"/> Hospital ER |
| <input type="checkbox"/> Hospital outpatient clinic | <input type="checkbox"/> Hospital ward | <input type="checkbox"/> International travel | <input type="checkbox"/> Military |
| <input type="checkbox"/> Place of worship | <input type="checkbox"/> School | <input type="checkbox"/> Work | <input type="checkbox"/> Unknown |

Y N U

Is this case epi-linked to a case or carrier? If yes, complete info below on epi-linked case: Onset date: __/__/____
Name (Last, First): _____ Date of birth: __/__/____ County: _____

Is this case part of a cluster or outbreak? If yes, name of outbreak? _____

Did the patient have a hospital or nursing home stay in the year prior to onset? If yes, give locations and dates below

Facility Name	Date Admitted (mm/dd/yyyy)	Date Discharged (mm/dd/yyyy)	Reason for admission

Did the patient stay in DOC or regional jail in the year prior to onset? If yes, give locations and dates below

Facility name	Date Admitted (mm/dd/yyyy)	Release/Transfer Date (mm/dd/yyyy)

PUBLIC HEALTH ISSUES

Y N U

- Case knows someone who had shared exposure and is currently having similar symptoms
- Epi link to another confirmed case of same condition
- Case is part of an outbreak
- Other:

PUBLIC HEALTH ACTIONS

Y N U

- Disease education and prevention information provided to patient and/or family/guardian
- Initiate contact precautions for patient
- Facilitate laboratory testing of other symptomatic persons who have a shared exposure
- Patient is lost to follow-up
- Other:

NOTES