State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

Local ID Number _____

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)

☐ Preliminary ☐ Final

SEVERE *STAPHYLOCOCCUS AUREUS* INFECTION (COMMUNITY-ASSOCIATED) CASE REPORT

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ *Years* ☐ *Months* ☐ *Days*

Address Number & Street - Residence	*Apartment/Unit Number*

City/Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone/Pager*	*Work/School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work/School Location	*Work/School Contact*

Gender
☐ Male ☐ Female ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 7)	*Other Describe/Specify*

Occupation (see list on page 7)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other:_____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unk

*Race**
(check all that apply, race descriptions on page 7)
☐ African-American/Black
☐ American Indian or Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ Other:_____

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian
- ☐ Other:_____

☐ White
☐ Other:_____
☐ Unk

*Comment: self-identity or self-reporting
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

First three letters of patient's last name: | | | |

VERIFICATION OF CASE STATUS

Please see case definition on page 5. All three questions in this section MUST be answered to confirm that patient meets the case definition.

1. Did the patient's S. aureus infection result in admission to an Intensive Care Unit (ICU)?
☐ Yes ☐ No

2. Did the S. aureus patient's infection result in death?
☐ Yes ☐ No

If "No" to BOTH questions 1 and 2, patient does NOT meet the case definition. DO NOT COMPLETE OR SUBMIT THIS FORM.

3. Did the patient have EITHER of the risk factors listed below?
☐ Yes ☐ No ☐ Unk

If Yes, check all that apply
☐ A history of hospitalization, surgery, dialysis, or residence in a long-term care facility in the previous year
☐ The presence of a central vascular catheter or long-term percutaneous device, including Foley catheter, tracheostomy or gastrostomy tubes

If EITHER risk factor in question 3 is checked, patient does NOT meet the case definition. DO NOT COMPLETE OR SUBMIT THIS FORM.

If patient meets case definition, please attach discharge or death summary, if available.

CLINICAL CONDITIONS ASSOCIATED WITH POSITIVE CULTURE

Onset Date (mm/dd/yyyy)	*Date First Sought Medical Care (mm/dd/yyyy)*

Indicate type(s) of *S. aureus* infection diagnosed in this patient in the table below.

Infection	Yes	No	If Yes, Specify as Noted
Bacteremia			*Check one* ☐ Bacteremia only ☐ Bacteremia with other identified infection (e.g., pneumonia or SSTI - indicate below)
Endocarditis			*Did patient have septic emboli?* ☐ Yes ☐ No ☐ Unk
Meningitis			
Osteomyelitis			
Pneumonia			*Was it necrotizing (syndrome with hemoptysis, leukopenia, high fever, and cavitary lung lesions)?* ☐ Yes ☐ No ☐ Unk *Was it hemorrhagic?* ☐ Yes ☐ No ☐ Unk
Septic arthritis			
Septic shock			
Skin or soft tissue infection (SSTI)			*Specify location, if known* *Type of SSTI* ☐ Necrotizing fasciitis ☐ Pyomyositis ☐ Other: _____
Toxic shock syndrome			If Yes, please complete the Toxic Shock Syndrome Case Report (CDPH 8599) instead of this form.

Other infection (specify):

IMAGING RESULTS

Chest X-ray	*Interpretation*
☐ Yes ☐ No ☐ Unk	☐ Normal ☐ Pneumonia ☐ Other (describe):_____

First three letters of patient's last name: | | | |

PAST MEDICAL HISTORY

Did patient have any of the following underlying conditions? (check all that apply)

☐ Alcohol abuse
☐ Asthma
☐ Chronic dermatologic condition (e.g., eczema, psoriasis) (specify):_____
☐ Injection drug use (IDU)
☐ Diabetes mellitus
☐ Emphysema/chronic obstructive pulmonary disease (COPD)
☐ Other chronic pulmonary disease (e.g., cystic fibrosis)
☐ Congestive heart failure
☐ Immunosuppressive therapy
☐ Liver disease
☐ Malignancy (specify):_____
☐ Obesity (weight or BMI, if known: _____)
☐ Chronic renal insufficiency
☐ Current smoker
☐ Other chronic illness (specify):_____
☐ None

Did patient have a history of S. aureus infection? ☐ Yes ☐ No ☐ Unk	*Antibiotic Profile* ☐ MRSA ☐ MSSA	*Details*
Did patient have a history of S. aureus colonization? ☐ Yes ☐ No ☐ Unk	*Antibiotic Profile* ☐ MRSA ☐ MSSA	*Details*

HOSPITALIZATION

Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unk	*Was patient hospitalized?* ☐ Yes ☐ No ☐ Unk	*If Yes, how many total hospital nights?*

If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION - DETAILS

Hospital Name 1	*Street Address*			*Admit Date (mm/dd/yyyy)*
	City			*Discharge / Transfer Date (mm/dd/yyyy)*
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*
	Discharge Diagnoses (or causes of death)			
Hospital Name 2	*Street Address*			*Admit Date (mm/dd/yyyy)*
	City			*Discharge / Transfer Date (mm/dd/yyyy)*
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*
	Discharge Diagnoses (or causes of death)			

ICU COURSE

How many nights did the patient spend in the ICU?	*Did the patient require mechanical ventilation?* ☐ Yes ☐ No ☐ Unk

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unk	*If Survived, Survived as of* _____*(mm/dd/yyyy)*	*Date of Death (mm/dd/yyyy)*

First three letters of patient's last name: | | | |

LABORATORY INFORMATION

LABORATORY RESULTS - CULTURE

Note: First positive culture must have been collected within 48 hours of hospital admission, and NOT be a surveillance culture.

Is the isolate MRSA or MSSA?	*Collection Date (mm/dd/yyyy)*	*Laboratory Name*
☐ MRSA (Oxacillin resistant) ☐ MSSA (Oxacillin susceptible)		

Site(s) from which S. aureus was Isolated (check all that apply)

☐ Blood ☐ Nares ☐ Urine
☐ Bone ☐ Pleural fluid ☐ Wound
☐ Cerebrospinal fluid ☐ Sputum/tracheostomy/bronchial wash ☐ Other site (specify):_____
☐ Joint aspirate ☐ Surgical specimen (specify):_____

LABORATORY RESULTS - ANTIBIOTIC SUSCEPTIBILITY

Please complete the antibiotic susceptibility profile for the *S. aureus* isolate; S=Susceptible, I=Intermediate, R=Resistant, NT=Not tested, U=Unknown.

Antibiotic	S	I	R	NT	U	Antibiotic	S	I	R	NT	U
Ciprofloxacin						Quinupristin/dalfopristin (Synercid)					
Clindamycin						Rifampin					
Daptomycin						Telithromycin					
Erythromycin (or other macrolide)						Tetracycline					
Gentamicin						Trimethoprim-sulfamethoxazole					
Linezolid						Vancomycin					
Oxacillin / methicillin						Other antibiotic (specify):_____					

LABORATORY RESULTS - RESPIRATORY VIRUS TESTING

Tested for Influenza? ☐ Yes ☐ No ☐ Unk	*Type of Test (e.g., culture, rapid test)*		*Date Collected (mm/dd/yyyy)*
	Result		*Hospital or Laboratory Name*
Tested for other viral respiratory pathogens? ☐ Yes ☐ No ☐ Unk	*Pathogen*	*Type of Test*	*Date Collected (mm/dd/yyyy)*
	Result		*Hospital or Laboratory Name*

EPIDEMIOLOGIC INFORMATION

EXPOSURES / RISK FACTORS

Did the patient reside in any of the following settings in the year prior to illness onset?

☐ Correctional facility (including jail, prison, penitentiary) ☐ Military base ☐ Homeless
☐ Residential care facility (including rehabilitation) ☐ Indian reservation ☐ Other (specify):_____

Did the patient participate in any of the following in the year prior to illness onset?

☐ Pre-school/child care ☐ Team sports (specify): _____

Did the patient use any antibiotics in the year prior to illness onset?	*If Yes, types of antibiotics*
☐ Yes ☐ No ☐ Unk	

First three letters of patient's last name: | | | |

ASSOCIATION WITH OTHER CASES

Was the patient's illness associated with other cases of S. aureus illness? ☐ Yes ☐ No ☐ Unk	*Contact Name / Case Number*	*Specify Nature of Other Illness*
	Specify Nature of Association with Other Cases ☐ Household ☐Sexual ☐ Other (specify):_____	

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*

First Reported By
☐ Clinician ☐ Laboratory ☐ Other (specify):_____

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐ Confirmed ☐ Not a case

STATE USE ONLY

State Case Classification
☐ Confirmed ☐ Not a case ☐ Need additional information

CASE DEFINITION

SEVERE *STAPHYLOCOCCUS AUREUS* INFECTION, COMMUNITY-ASSOCIATED (CDPH working definition, 2012)

CLINICAL DESCRIPTION

An invasive *Staphylococcus aureus* (SA) infection which results in admission to an Intensive Care Unit (ICU) or death; SA infection should be the diagnostic criteria for the ICU stay or the primary cause of death.

LABORATORY CRITERIA FOR DIAGNOSIS

- Isolation of *S. aureus*, either methicillin-resistant or methicillin-sensitive, from a clinically relevant site (e.g., wound for necrotizing fasciitis, bronchial washings for pneumonia, blood for bacteremia/sepsis, etc.), AND
- Specimen obtained within 48 hours of hospital admission, AND
- Specimen NOT collected for screening or surveillance purposes

CASE CLASSIFICATION

Confirmed: A patient with illness compatible with the clinical description, who meets the laboratory criteria for diagnosis, AND who:

- Was NOT hospitalized in the year prior to onset of illness, AND
- Did NOT have surgery, dialysis, or residency in a long-term care facility in the year prior to onset of illness, AND
- Did NOT have an indwelling catheter or percutaneous medical device at the onset of illness

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Adult film actor/actress
- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - server
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - nurse
- Medical - other/unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent/guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Volunteer
- Other
- Refused
- Unknown