Streptococcus pneumoniae Surveillance Worksheet

NAME (Last, First)				Hospital Record No.
Address (Street and No.)	City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/LabPhone	Address			Phone

DETACH HERE and transmit only lower portion if sent to CDC

Streptococcus pneumoniae Surveillance Worksheet

(Invasive pneumococcal disease and drug-resistant *S. pneumoniae*)

THROUGHOUT: Y=YES N=NO U=UNKNOWN

1. Are you reporting:
   - Drug Resistant *S. pneumoniae* Y ☐ N ☐ U ☐
   - Invasive Disease Y ☐ N ☐ U ☐
2. Date of Birth ☐☐-☐☐-☐☐☐☐ (MONTH DAY YEAR)
3a. Age ☐☐☐
3b. Is age in years / months / weeks / days?
   ☐ years ☐ months ☐ weeks ☐ days
4. Sex ☐ Male ☐ Female ☐ Unknown
5. Race: *(check all that apply)*
   - ☐ American Indian / Alaska native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Pacific Islander
   - ☐ White
   - ☐ Other race (specify) _____
6. Ethnicity: is patient Hispanic or Latino? Y ☐ N ☐ U ☐
7. State in which patient resided at time of diagnosis: ☐☐
8. Zip code at which patient resided at time of diagnosis: ☐☐☐☐☐
9a. Hospitalized? Y ☐ N ☐ U ☐
9b. If hospitalized for this condition, how many days total was the patient hospitalized? *(Include days from multiple hospitals if relevant)*
   ☐☐☐ NUMBER OF DAYS: 0-998; 999=UNKNOWN
10. Does this patient: *(check all that apply)*
   - Attend a day care* facility? Y ☐ N ☐ U ☐
     Facility Name _____
     *DAY CARE IS DEFINED AS AS SUPERVISED GROUP OF 2 OR MORE UNRELATED CHILDREN FOR >4 HOURS PER WEEK.
   - Reside in a long term care facility? Y ☐ N ☐ U ☐
     Facility Name _____
11. Did patient die from this illness? Y ☐ N ☐ U ☐
12. Onset Date ☐☐-☐☐-☐☐☐☐ (MONTH DAY YEAR)
13. Type of infection caused by organism *(check all that apply)*
   - Bacteremia without focus ☐
   - Cellulitis ☐
   - Epiglottitis ☐
   - Hemolytic uremic syndrome ☐
   - Meningitis ☐
   - Osteomyelitis ☐
   - Otitis media ☐
   - Peritonitis ☐
   - Pericarditis ☐
   - Pneumonia ☐
   - Septic arthritis ☐
   - Other *(specify)* _____ ☐
14. Sterile site from which organism isolated: *(check all that apply)*
   - Blood ☐
   - CSF ☐
   - Pleural fluid ☐
   - Peritoneal fluid ☐
   - Pericardial fluid ☐
   - Joint ☐
   - Bone ☐
   - Internal body site ☐
   - Muscle ☐
   - Other normally sterile site ☐
     (specify) _____
15. Date first positive culture obtained
   DATE SPECIMIN TAKEN ☐☐-☐☐-☐☐☐☐ (MONTH DAY YEAR)
16. Nonsterile sites from which organism isolated, if any:
   Middle ear ☐ Sinus ☐ Other *(specify)* _____ ☐
17a. Does the patient have any underlying medical conditions or prior illness?
   - Y ☐ Yes. If yes fill out 17b.
   - N ☐ No. If no skip to 18.
   - U ☐ Unknown. Skip to 18.
17b. What underlying medical conditions does the patient have? *(check all that apply)*
   - Current smoker ☐
   - Multiple myeloma ☐
   - Sickle cell anemia ☐
   - Splenectomy / asplenia ☐
   - Immunoglobulin deficiency ☐
   - Immunosuppressive therapy (steroids, chemotherapy, radiation) ☐
   - Leukemia ☐
   - Hodgkin's disease ☐
   - Asthma ☐
   - Emphysema / COPD ☐
   - Systemic lupus erythematosus ☐
   - Diabetes mellitus ☐
   - Nephrotic syndrome ☐
   - Renal failure / dialysis ☐
   - HIV infection ☐

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AIDS (CD4 <200)	☐	CSF leak	☐
Cirrhosis / liver failure	☐	Intraveinous drug use	☐
Alcohol abuse	☐	Other malignancy *(specify)* _____	☐
Cardiovascular disease (ASCVD) / CAD	☐	Organ / bone marrow transplant	☐
Heart failure / CHF	☐	Other prior illness *(specify)* _____	☐

VACCINATION HISTORY

18. Did patient receive **POLYSACCHARIDE** pneumococcal vaccine? Y ☐ N ☐ U ☐ If **YES**, please complete the list below.

DOSE	DATE GIVEN (MONTH/DAY/YEAR)	VACCINE NAME	LOT NUMBER
1	☐☐-☐☐-☐☐☐☐	☐ Pneumovax 23 (Merck) ☐ Pnu-Imune23 (Wyeth) Other_____	
2	☐☐-☐☐-☐☐☐☐	☐ Pneumovax 23 (Merck) ☐ Pnu-Imune23 (Wyeth) Other_____	
3	☐☐-☐☐-☐☐☐☐	☐ Pneumovax 23 (Merck) ☐ Pnu-Imune23 (Wyeth) Other_____	

19. Did patient receive **CONJUGATE** pneumococcal vaccine? Y ☐ N ☐ U ☐ If **YES**, please complete the list below.

DOSE	DATE GIVEN (MONTH/DAY/YEAR)	VACCINE NAME	MANUFACTURER	LOT NUMBER
1	☐☐-☐☐-☐☐☐☐			
2	☐☐-☐☐-☐☐☐☐			
3	☐☐-☐☐-☐☐☐☐			
4	☐☐-☐☐-☐☐☐☐			

20. Resistance Testing Results

Oxacillin zone size: **(valid 00-30)** ☐☐ mm **Oxacillin interpretation:** ☐ R < 20mm (possibly resistant) ☐ S ≥20mm (susceptible) ☐ Unknown/not tested

SUSCEPTIBILITY METHOD CODES	S/I/R RESULT CODES	SIGN CODES	MIC VALUE
A- AGAR: Agar dilution method **B-** BROTH: Broth dilution **C-** DISK: Disk diffusion (Kirby Bauer) **S-** STRIP: Antimicrobial gradient strip (E-test)	**S-** SUSCEPTIBLE **B-** INTERMEDIATE **C-** RESISTANT **S-** UNK. / NOT TESTED Result indicates whether the microorganism is susceptible or not susceptible (intetrmediate or resistant) to the antimicrobial being tested	Indicate whether the MIC is <, >, ≤, ≥, = to the numerical MIC value in the last column	Valid range for data value 0.000 - 999.999
		MIC = minimum inhibitory concentration	

21.

ANTIMICROBIAL AGENT	SUSCEPTIBILITY METHOD A/B/D/S	S/I/R/U RESULT	SIGN < / > / ≤ / ≥ / =	MIC VALUE (e.g., 0.06 µg/ml)
Penicilin				
Amoxicillin				
Amoxicillin/clavulanic acid				
Cefotaxime				
Ceftriaxone				
Cefuroxime				
Vancomycin				
Erythromycin				
Azithromycin				
Tetracycline				
Levofloxacin				
Sparfloxacin				
Gatifloxacin				
Moxifloxacinn				
Trimethoprim/sulfamethoxazole				
Clindamycin				
Quinupristin/dalfopristin				
Linazolid				
Other: (list)				

Submitted by:_____ Phone (_____)_____ Date: ☐☐-☐☐-☐☐☐☐
MONTH DAY YEAR