County of Los Angeles
Public Health

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
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www.publichealth.lacounty.gov

SEVERE *STAPHYLOCOCCUS AUREUS* INFECTION IN A PREVIOUSLY HEALTHY PERSON* CASE REPORT

Census tract: _____ VCMR ID: _____

INITIAL SCREENING FOR CASE DEFINITION

Did the patient's infection result in: **ICU admission** ☐Yes ☐No
AND/OR
Death ☐Yes ☐No

If **NO TO BOTH** of the above, patient does **NOT** meet the case definition. Do **NOT** complete or submit this form.

Does the patient have ANY of the following? ☐Yes ☐No ☐Unknown

Check all that applies to determine who is NOT a previously healthy person.

- ☐ Hospitalized within the past year (including >48 hours prior to first *S. aureus* positive culture)
- ☐ Surgery within past year
- ☐ Dialysis (hemo or peritoneal) within past year
- ☐ Residence in long-term care within the past year
- ☐ Percutaneous device or indwelling catheter (e.g. BROVIAC®, foley, tracheostomy, gastrostomy)

If **ANY** checked, patient does **NOT** meet the case definition. Do **NOT** complete or submit this form.

DEMOGRAPHIC INFORMATION

Patient Name – Last First Middle Initial	Date of Birth _____/_____/_____	Age _____ years	Sex ☐Male ☐Female
Address (number, street) City State	ZIP code	County	

Home Telephone	Cellular Telephone/Pager	Work Telephone

Race (check all that apply)
☐African-American ☐Native American ☐Asian/Pacific Islander ☐White ☐Other_____

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

If Asian/Pacific Islander, check all that apply: ☐Asian Indian ☐Cambodian ☐Chinese ☐Filipino ☐Guamanian ☐Hawaiian ☐Hmong ☐Japanese ☐Korean ☐Laotian ☐Samoan ☐Thai ☐Vietnamese ☐Other_____

Pregnant? ☐Yes ☐No ☐Unknown	If Yes, Estimate Delivery Date
Occupation Setting	Occupation

CLINICAL INFORMATION

Illness Onset Date _____/_____/_____	Date First Sought Medical Care _____/_____/_____	Did patient visit emergency room for illness? ☐Yes ☐No ☐Unk

Patient hospitalized? ☐Yes ☐No ☐Unk If Yes, how many total hospital nights? _____ ICU nights? _____

HOSPITAL 1	Hospital Name	City	ZIP code

Admit Date _____/_____/_____	Discharge/Transfer Date _____/_____/_____	Medical Record #	Discharge Diagnoses (or cause of death)

HOSPITAL 2	Hospital Name	City	ZIP code

Admit Date _____/_____/_____	Discharge/Transfer Date _____/_____/_____	Medical Record #	Discharge Diagnoses (or cause of death)

Did the patient require mechanical ventilation? ☐Yes ☐No ☐Unk	Chest X-ray ☐Yes ☐No ☐Unk If Yes, ☐Normal ☐Abnormal Describe. _____

Was a clinically-relevant infection associated with the positive culture? ☐Yes ☐No ☐Unknown

If Yes, type of infection (check all that apply).

☐Bacteremia ☐Pneumonia: ☐Necrotizing ☐Hemorrhagic ☐Skin or soft tissue infection:
☐Endocarditis ☐Septic arthritis ☐Necrotizing fasciitis ☐Pyomyositis ☐Other _____
☐Meningitis ☐Septic emboli ☐Toxic shock syndrome (See Instructions)
☐Osteomyelitis ☐Septic shock ☐Other infection Specify. _____

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

Underlying condition(s) (check all that apply):

- ☐Alcohol abuse
- ☐Asthma
- ☐Chronic dermatologic condition Specify. _____
- ☐Diabetes mellitus
- ☐Emphysema/COPD
- ☐Other chronic pulmonary disease Specify. _____
- ☐Heart failure/CHF
- ☐HIV/AIDS
- ☐Immunosuppressive therapy
- ☐Liver disease
- ☐Malignancy Specify. _____
- ☐Chronic renal insufficiency
- ☐Other Specify. _____
- ☐None
- ☐Current smoker
- ☐Injecting drug use
- ☐Obesity Specify weight or BMI if known. _____

	Yes	No	Unk	Antibiotic Profile	Details
History of *S. aureus* infection?	☐	☐	☐	☐MRSA ☐MSSA	
History of *S. aureus* colonization?	☐	☐	☐	☐MRSA ☐MSSA	

Outcome ☐Survived (as of _____/_____/_____) ☐Died (Date _____/_____/_____) ☐Unknown

LABORATORY INFORMATION

Is the isolate: ☐MRSA ☐MSSA	Culture date: _____/_____/_____	Hospital/clinic where culture obtained:

Site from which *S. aureus* was isolated (check all that apply).

- ☐Blood
- ☐Bone
- ☐Cerebrospinal fluid
- ☐Ear (drainage/aspirate)
- ☐Eye
- ☐Joint aspirate
- ☐Nares
- ☐Peritoneal fluid
- ☐Pleural fluid
- ☐Skin (swab/aspirate)
- ☐Sputum/tracheostomy/bronchial wash
- ☐Surgical specimen Specify. _____
- ☐Urine
- ☐Wound
- ☐Other Specify. _____

Susceptibility Results (or attach laboratory report of antibiotic susceptibilities)	**Susceptible**	**Intermediate**	**Resistant**	**Not tested or unknown**
Ciprofloxacin	☐	☐	☐	☐
Clindamycin	☐	☐	☐	☐
Daptomycin	☐	☐	☐	☐
Erythromycin (or other macrolide)	☐	☐	☐	☐
Gentamicin	☐	☐	☐	☐
Linezolid	☐	☐	☐	☐
Oxacillin/methicillin	☐	☐	☐	☐
Quinupristin/dalfopristin (Synercid)	☐	☐	☐	☐
Rifampin	☐	☐	☐	☐
Tetracycline	☐	☐	☐	☐
Trimethoprim-sulfamethoxazole	☐	☐	☐	☐
Telithromycin	☐	☐	☐	☐
Vancomycin	☐	☐	☐	☐
Other Specify. _____	☐	☐	☐	☐

Respiratory Virus Testing	**Type of Test**	**Date Collected**	**Result**
Influenza			
Specify Other _____			

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

REPORTING INFECTION CONTROL PRACTITIONER

Name	Hospital Name	Telephone Number	E-mail Address	Date

EPIDEMIOLOGIC INFORMATION

Did the patient reside in or participate in any of the following in the year prior to the culture? (Check all that apply.)

☐Correctional facility ☐Homeless ☐Indian reservation ☐Military Base ☐Pre-school/child care

☐Residential care facility (including rehabilitation) ☐Team sports ☐Other Specify. _____

Did the patient use any antibiotics in the year prior to illness onset? ☐Yes ☐No ☐Unk If Yes, Specify type(s) of antibiotic._____

ASSOCIATION WITH OTHER CASES

Was this patient's illness associated with other cases of *S. aureus* illness? ☐Yes ☐No ☐Unknown

If Yes, Specify nature of other illness. _____

Specify nature of association with other case(s). ☐Household ☐Sexual ☐Other Specify._____

ADDITIONAL INFORMATION

Comments/Remarks:

PUBLIC HEALTH REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date
	Los Angeles County Department of Public Health	**(213) 240-7941**	

STATE USE ONLY

Case Counted ☐Yes ☐No	Reason for case classification