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) _____
15a. Date first positive culture obtained
   DATE SPECIMEN TAKEN ☐☐-☐☐-☐☐☐☐ (MONTH DAY YEAR)
15b. If known, indicate the serotype* ☐☐☐
   If unknown, enter UNK above

* As of 4/7/17, the serotypes contained in the PCV7 - Prevnar 7 conjugate vaccine are 4, 6B, 9V, 14, 18C, 19F, 23F; the serotypes contained in the PCV13 - Prevnar 13 conjugate vaccine are 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, 23F; and the serotypes contained the PPSV23 - Pneumovax polysaccharide vaccine are 1, 2, 3, 4, 5, 6B, 7F, 8, 9N, 9V, 10A, 11A, 12F, 14, 15B, 17F, 18C, 19F, 19A, 20, 22F, 23F, 33F.

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 ☐

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Asthma	☐	Alcohol abuse	☐
Emphysema/COPD	☐	Cardiovascular disease (ASCVD)/CAD	☐
Systemic lupus erythematosus	☐	Heart failure/CHF	☐
Diabetes mellitus	☐	CSF leak	☐
Nephrotic syndrome	☐	Intraveinous drug use	☐
Renal failure/dialysis	☐	Other malignancy *(specify)* _____	☐
HIV infection	☐	Organ/bone marrow transplant	☐
AIDS (CD4 <200)	☐	Other prior illness *(specify)* _____	☐
Cirrhosis/liver failure	☐		

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