COUNTY OF LOS ANGELES
Public Health

Acute Communicable Disease Control
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SEVERE *STAPHYLOCOCCUS AUREUS* INFECTION IN A PREVIOUSLY HEALTHY PERSON* CASE REPORT

Census tract: _______________ VCMR ID: _____________________

*A **Previously Healthy Person** is defined as a person "who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or cutaneous medical device at the time of culture."

INITIAL SCREENING FOR CASE DEFINITION

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

If No to both of the above, patient does not meet the case definition. Please do not complete or submit this form.

Does the patient have ANY of the following? ☐**Yes** ☐**No** ☐**Unknown**
If yes, check all that apply

☐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 risk factor is checked, patient does not meet the case definition. Please do not complete or submit this form.

SECTION 1. DEMOGRAPHIC INFORMATION

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

Race (check all that apply)
☐African-American ☐White ☐Native American ☐Asian/Pacific Islander ☐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 ☐Japanese ☐Korean ☐Laotian ☐Samoan ☐Vietnamese ☐Other______________

Occupation

SECTION 2. CLINICAL INFORMATION

Patient Hospitalized? ☐Yes ☐No ☐Unk	If Yes, Hospital Name	City	ZIP code

Admit Date _____/_____/__________	Medical Record #

Illness Onset Date _____/_____/__________	Physician Name – Last	First	Telephone Number

Chest X-ray ☐Yes ☐No ☐Unknown 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
☐Bursitis
☐Pyomyositis
☐Meningitis
☐Septic arthritis
☐Septic emboli
☐Wound infection
☐Osteomyelitis
☐Pneumonia
  ☐Necrotizing ☐Hemorrhagic
☐Endocarditis
☐Skin or soft tissue infection (specify if known) __________________________
  ☐Necrotizing fasciitis
☐Other infection (specify)________________________________
☐Toxic shock syndrome (see Instructions)

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

☐Alcohol abuse
☐Asthma
☐Eczema
☐Psoriasis
☐Folliculitis
☐Other chronic dermatologic condition (specify) ______________________________
☐HIV/AIDS
☐Injecting drug use
☐Diabetes mellitus
☐Emphysema/COPD
☐Heart failure/CHF
☐Immunosuppressive therapy
☐Liver disease
☐Malignancy – hematologic
☐Malignancy – solid organ
☐Chronic renal insufficiency
☐Current smoker
☐Other (specify) _________________________________
☐**None**

Past Medical History ☐Staphylococcal disease ☐MRSA infection or colonization

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

Patient name (last, first) ____________________ Date of Birth ____________ VCMR ID: __________

SECTION 3. 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	Joint	Skin (swab/aspirate)	Urine	Cerebrospinal fluid
Bone	Sputum/trach	Ear (drainage/aspirate)	Pleural fluid	Surgical specimen
Nares	Eye	Peritoneal fluid	Wound	specify ____________

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	☐	☐	☐	☐
Oxacillin	☐	☐	☐	☐
Linezolid	☐	☐	☐	☐
Rifampin	☐	☐	☐	☐
Synercid	☐	☐	☐	☐
Tetracycline	☐	☐	☐	☐
Trimethoprim-sulfamethoxazole	☐	☐	☐	☐
Telithromycin	☐	☐	☐	☐
Vancomycin	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐

Laboratory-confirmed influenza? ☐A ☐B ☐ A/B Type of test ______________ Date _____/_____/__________

REPORTING INFECTION CONTROL PRACTITIONER

Name	Hospital Name	Telephone Number	E-mail Address	Date

SECTION 4. 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 ☐Residential care facility ☐Indian reservation ☐Pre-school/child care ☐Team sports

SECTION 5. 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 ______________

ADDITIONAL INFORMATION

Comments/Remarks:

Attachments/Reports:
Please attach laboratory report of antibiotic susceptibilities unless Susceptibility Results have been provided above.

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