

Patient's Name _____ Phone Number _____
Current Address _____ Hospital _____
Address _____ Hospital _____
NUMBER / STREET / APT. NUMBER / CITY / STATE ZIP CODE Patient Chart Number _____

Detach here — Patient identifier information is not transmitted 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 Invasive Disease
2. Date of birth: MONTH DAY YEAR
3a. Age:
3b. Is age in years/months/weeks/days?
4. Sex: M Male F Female U Unknown
5. Race: (check all that apply)
6. Ethnicity: Is patient Hispanic or Latino?
7. State in which patient resided at time of diagnosis:
8. ZIP code at which patient resided at time of diagnosis:

- 13. Type of infection caused by organism (cont.): Epiglottitis Hemolytic uremic syndrome Meningitis Osteomyelitis Otitis media Peritonitis Pericarditis Pneumonia Septic arthritis Other
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 SPECIMEN TAKEN MONTH DAY YEAR
16. Nonsterile sites from which organism isolated, if any: Middle Ear Sinus Other (specify)

- 9a. Hospitalized?
9b. If hospitalized for this condition, how many days total was the patient hospitalized?
10. Does this patient: (check all that apply) Attend a day care* facility? Reside in a long-term care facility?
11. Did patient die from this illness?
12. Onset date: MONTH DAY YEAR
13. Type of infection caused by organism: (check all that apply) Bacteremia without focus Cellulitis

- 17a. Does the patient have any underlying medical conditions or prior illness?
17b. What underlying medical conditions does the patient have? (check all that apply) Current smoker Multiple myeloma Sick cell anemia Splenectomy/asplenia Immunoglobulin deficiency Immunosuppressive therapy (steroids, chemotherapy, radiation) Leukemia

Item 13 continues next column

Item 17b continues on back

17b. What underlying medical conditions does the patient have (cont.)?

Hodgkin's disease	<input type="checkbox"/>	Cirrhosis/liver failure	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Alcohol abuse	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	Cardiovascular disease (ASCVD)/CAD	<input type="checkbox"/>
Systemic lupus erythematosus	<input type="checkbox"/>	Heart failure/CHF	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	CSF leak	<input type="checkbox"/>
Nephrotic syndrome	<input type="checkbox"/>	Intravenous Drug Use	<input type="checkbox"/>
Renal failure/dialysis	<input type="checkbox"/>	Other malignancy (specify) _____	<input type="checkbox"/>
HIV infection	<input type="checkbox"/>	Organ/bone marrow transplant	<input type="checkbox"/>
AIDS (CD4<200)	<input type="checkbox"/>	Other prior illness (specify) _____	<input type="checkbox"/>

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	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Pneumovax 23 (Merck) <input type="checkbox"/> Pnu-Imune23 (Wyeth) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	
2	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Pneumovax 23 (Merck) <input type="checkbox"/> Pnu-Imune23 (Wyeth) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	
3	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Pneumovax 23 (Merck) <input type="checkbox"/> Pnu-Imune23 (Wyeth) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	

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	<input type="text"/> - <input type="text"/> - <input type="text"/>			
2	<input type="text"/> - <input type="text"/> - <input type="text"/>			
3	<input type="text"/> - <input type="text"/> - <input type="text"/>			
4	<input type="text"/> - <input type="text"/> - <input type="text"/>			

20. **RESISTANCE TESTING RESULTS**

Oxacillin zone size: 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 D - DISK: Disk diffusion (Kirby Bauer) S - STRIP: Antimicrobial gradient strip (E-test)	S - SUSCEPTIBLE I - INTERMEDIATE R - RESISTANT U - UNK./NOT TESTED	Result indicates whether the micro-organism is susceptible or not susceptible (intermediate or resistant) to the antimicrobial being tested.	Indicate whether the MIC is <, >, ≥, ≤, or = to the numerical MIC value in the last column. <small>MIC=minimum inhibitory concentration</small> Valid range for data value 0.000-999.999

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

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