Community-Associated *Staphylococcus aureus* Mortality Case Report Form

Case's county of residence: _____ Date reported to CHD: _____ Merlin case number: _____

Reporter type: _____ Reporter's name: _____

Investigator's name: _____ Phone number: _____ Extension: _____

BASIC INFORMATION

Patient's name (last, first): _____ Social security number: _____

Date of birth (mm/dd/yyyy): _____ Gender: _____ Race: _____ Ethnicity: _____

Address: _____ City: _____ State: _____ Zip code: _____

Date of death (mm/dd/yyyy): _____

Did the patient have health insurance at the time of illness onset? ☐ Yes ☐ No ☐ Unk

If yes, what kind? ☐ Medicaid ☐ Medicare ☐ Military/VA ☐ Private insurance ☐ Other (specify): _____

ELIGIBILITY CRITERIA

1. Please respond to each of the following statements.

True	False	
☐	☐	Patient died.
☐	☐	Laboratory culture from a sterile or respiratory site was positive for *Staphylococcus aureus*.
☐	☐	Culture specimen was obtained in outpatient setting or within 48 hours of admission to a hospital.
☐	☐	Patient was **NOT** hospitalized within the year prior to death (for children <1 year old, a hospitalization other than birth).
☐	☐	Patient was **NOT** admitted to a nursing home, skilled nursing facility, or hospice within the year prior to death.
☐	☐	Patient did **NOT** undergo dialysis within the year prior to death.
☐	☐	Patient did **NOT** undergo surgery within the year prior to death.
☐	☐	Patient did **NOT** have indwelling catheter/medical device that passed through skin within the year prior to death.

If you responded FALSE to ANY of the statements above, this case is not reportable.
You do NOT need to complete the Case Report Form.

2. How was the eligibility determined? Please check all that apply.

☐ Review of History and Physical for current admission

☐ Full chart/computer record review

☐ Interview with family or other close contact

☐ Other, please explain: _____

ELIGIBILITY COMMENTS

AUTOPSY INFORMATION

3. Was the case referred to a medical examiner? ☐ Yes ☐ No ☐ Unk

If yes, name of medical examiner: _____ Phone number: _____

Was an autopsy performed? ☐ Yes ☐ No ☐ Unk **If yes, attach a copy of autopsy report to case in Merlin.**

4. Death certificate cause of death: _____

LABORATORY INFORMATION

5. Please mark all sites from which *S. aureus* was isolated for the current illness (premortem or postmortem):

☐ Blood ☐ Nares ☐ Eye ☐ Joint ☐ CSF ☐ Peritoneal fluid ☐ Sputum, tracheostomy, bronchioalveolar lavage

☐ Urine ☐ Skin ☐ Bone ☐ Brain ☐ Lung ☐ Pleural fluid ☐ Other (specify): _____

6. Date first *S. aureus* culture-positive specimen for current illness was collected (mm/dd/yyyy): _____

7. Were any *S. aureus* isolates for the current illness reported as resistant to oxacillin (i.e. MRSA)? ☐ Yes ☐ No ☐ Unk

8. Were any other bacteria isolated for the current illness (premortem or postmortem)? ☐ Yes ☐ No ☐ Unk

Test type	Date specimen collected (mm/dd/yyyy):	Premortem or postmortem	Organism(s)

9. Was viral testing done during current illness or postmortem? ☐ Yes ☐ No ☐ Unk

If yes, please describe below (if additional space is needed, please use LABORATORY NOTES at the bottom of the page).

Test type		Influenza result	Other virus(es) identified
☐ Rapid antigen			
☐ Immunofluorescence			
☐ RT-PCR			
☐ Viral culture			
☐ Serology			

☐ Other (please describe): _____

Please note that the CDC Influenza-Associated Pediatric Deaths Case Report Form must be completed for all persons <18 years old that test positive for influenza (http://www.doh.state.fl.us/disease_ctrl/epi/surv/Influenza_Death_CRF.pdf).

AUTOPSY AND LABORATORY NOTES

CLINICAL INFORMATION

SIGNS AND SYMPTOMS

10. Date of symptom onset (mm/dd/yyyy): _____

11. Did the patient experience the following signs and symptoms? Check all that apply.

- ☐ Altered mental status
- ☐ Shortness of breath
- ☐ Hemoptysis
- ☐ Headache
- ☐ Fever >101 F
- ☐ Cardiac arrhythmia
- ☐ Cyanosis
- ☐ Rales
- ☐ Fatigue/malaise
- ☐ Chills
- ☐ Chest pain
- ☐ Cough
- ☐ Myalgia
- ☐ Sore throat
- ☐ Nausea/vomiting
- ☐ Other (specify): _____

MEDICAL HISTORY

12. Did the patient have a history of any of the following conditions? Check all that apply.

- ☐ Current smoker
- ☐ Neurologic disease
- ☐ Asthma
- ☐ Renal disease
- ☐ Alcohol abuse
- ☐ Neuromuscular disease
- ☐ Congestive heart failure
- ☐ Liver disease
- ☐ Injection drug use
- ☐ Neoplastic disease
- ☐ Cerebrovascular disease
- ☐ Splenectomy
- ☐ Other drug abuse
- ☐ COPD
- ☐ Diabetes mellitus
- ☐ Gastroesophageal reflux disease
- ☐ HIV/AIDS
- ☐ Cystic fibrosis
- ☐ Dialysis
- ☐ Therapy to decrease stomach acid
- ☐ Other (specify): _____

13. Did the patient have a history of *S. aureus* infection or colonization? ☐ Yes ☐ No ☐ Unk

If yes, date of last positive culture (mm/dd/yyyy): _____ Was it resistant to oxacillin (i.e. MRSA)? ☐ Yes ☐ No ☐ Unk

☐ Skin or soft tissue infection ☐ Nasal colonization ☐ Other (specify): _____

14. Did the patient have a history of a skin condition in the year prior to death? ☐ Yes ☐ No ☐ Unk

If yes, date of onset (mm/dd/yyyy): _____ Duration (in days): _____

☐ Eczema ☐ Atopic dermatitis ☐ Psoriasis ☐ Any non-MRSA infection ☐ Other (specify): _____

15. Did the patient have a history of cold or influenza-like illness (fever >100F and sore throat or cough) in the 2 weeks prior to death? ☐ Yes ☐ No ☐ Unk

If yes, diagnosis: _____ Date of onset (mm/dd/yyyy): _____ Duration (in days): _____

Treatment, if any (including home treatments): _____

Did the patient receive an influenza vaccination for the current influenza season? ☐ Yes ☐ No ☐ Unk

HEALTH CARE

16. Did the patient seek healthcare in the 2 weeks prior to death? ☐ Yes ☐ No ☐ Unk

IF PATIENT SOUGHT HEALTH CARE, ANSWER QUESTIONS 13-17. IF NOT, SKIP TO QUESTION 18 IN AUTOPSY INFORMATION.

17. Was the patient hospitalized (this does NOT include visits to the emergency department)? ☐ Yes ☐ No ☐ Unk

If yes, hospital name: _____ Infection control phone number: _____

Date admitted (mm/dd/yyyy): _____ Date discharged (mm/dd/yyyy): _____ ☐ Patient died while hospitalized

Was the patient admitted to an intensive care unit? ☐ Yes ☐ No ☐ Unk If yes, number of days in ICU: _____

Was the patient placed on mechanical ventilation? ☐ Yes ☐ No ☐ Unk If yes, number of days on ventilator: _____

18. Please describe all healthcare visits in the 2 weeks prior to death. Include name of provider, phone number, date of visit, reason for visit, tests performed, and treatments.

CLINICAL INFORMATION CONTINUED

CLINICAL FINDINGS

19. Please note the most abnormal clinical and laboratory findings observed on the day the first *S. aureus* positive specimen was collected (or 24 hours prior to death if specimens were collected postmortem):

		Not obtained
Temperature (F):	_____	☐
Respiratory rate (per minute):	_____	☐
Pulse rate (per minute):	_____	☐
Blood pressure (systole/diastole):	_____ / _____	☐
Arterial pH:	_____	☐
Sodium (mmol/liter):	_____	☐
Blood urea nitrogen (mg/dl):	_____	☐
Serum creatine (mg/dl):	_____	☐
Glucose (mg/dl):	_____	☐
Hematocrit:	_____	☐
Platelets (mm3):	_____	☐
White blood cell count (mm3):	_____	☐

Neutrophils (%): _____ Bands (%): _____

20. Was a chest X-ray obtained? ☐ Yes ☐ No ☐ Unk

If yes, date of initial X-ray (mm/dd/yyyy): _____

Result:
- ☐ Normal
- ☐ Singular lobar infiltrate
- ☐ Multiple lobar infiltrate
- ☐ Interstitial infiltrate
- ☐ Pleural effusion
- ☐ Empyema
- ☐ Cavitation
- ☐ Other (specify): _____

If a chest X-ray was obtained, please attach copy of report for the initial X-ray.

TREATMENT

21. Was the patient treated with antibiotics for the current illness? ☐ Yes ☐ No ☐ Unk

If yes, please list (if additional space is needed, please use CLINICAL AND AUTOPSY NOTES at the bottom of the page).

Antibiotic name	Start date (mm/dd/yyyy)	Stop date (mm/dd/yyyy)	Started before or after *S. aureus* diagnosed

CLINICAL NOTES

EPIDEMIOLOGY INFORMATION

22. Where was this case acquired? ☐ Florida ☐ In US, not in FL ☐ Outside US ☐ Unk

23. Does the patient attend or work at a day care? ☐ No ☐ Attendee ☐ Staff ☐ Unk

If yes, location: _____ Last date attended (mm/dd/yyyy): _____ Phone Number _____

Address: _____ City: _____ State: _____ Zip code: _____

24. Does the patient have sensitive occupation? ☐ No ☐ Food handler ☐ Healthcare worker ☐ Unk

If yes, location: _____ Last date attended (mm/dd/yyyy): _____ Phone Number _____

Address: _____ City: _____ State: _____ Zip code: _____

25. Does anyone in the patient's household work in the healthcare field? ☐ Yes ☐ No ☐ Unk

If yes, job description: _____

☐ Hospital ☐ Clinic/doctors office ☐ Nursing home ☐ Other (specify): _____

26. Did the patient have any contacts with MRSA or a history of MRSA in the last year? ☐ Yes ☐ No ☐ Unk

If yes, please explain in EPIDEMIOLOGY NOTES below.

27. Where was the patient living?

☐ Home/apartment

Number of occupants (in addition to the case): _____

Number of adults 18+ years: _____ Number of children 6-17 years: _____ Number of children < 6 years: _____

☐ County jail (date admitted [mm/dd/yyyy]): _____

☐ State/federal prison

☐ Group home (explain): _____

☐ Homeless shelter

☐ Homeless

☐ Other (specify): _____

☐ Unk

28. Did the patient participate in activities that may result in impaired skin integrity in the year prior to death? ☐ Yes ☐ No ☐ Unk

If yes, please mark all that apply:

☐ Health club/fitness gym

☐ Contact sports, such as football, wrestling, etc. (specify): _____

☐ Occupation, such as tree trimming, construction, etc. (specify): _____

☐ Hobbies, such as fishing, rock climbing, etc. (specify): _____

☐ Tattoo in 6 months prior to death (date [mm/dd/yyyy]): _____

If yes, did tattoo site become infected? ☐ Yes ☐ No ☐ Unk

If yes, was infection treated? ☐ Yes ☐ No ☐ Unk

If yes, list name of provider and other details as available in EPIDEMIOLOGY NOTES below.

☐ Injection drug use

☐ Sexual activities

If yes, sexual preference: ☐ Same sex ☐ Opposite sex ☐ Both sexes ☐ Unk

☐ Other (specify): _____

EPIDEMIOLOGY NOTES