For Local Use Only

STREPTOCOCCUS PNEUMONIAE SURVEILLANCE WORKSHEET

Patient's Name _____ Phone Number _____
LAST / FIRST / MIDDLE AREA CODE + 7 DIGITS

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

Detatch 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* 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?**
   ☐ Yrs. ☐ Mos. ☐ Wks. ☐ Days
4. **Sex:** M☐ Male F☐ Female U☐ Unknown
5. **Race:** *(check all that apply)*
   - ☐ American Indian/Alaskan 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 A 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** ☐

Item 13 continues next column

13. **Type of infection caused by organism (cont.):**
   - **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)* ☐

   _____
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) _____
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** ☐

Item 17b continues on back

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

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

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_____ ☐ Unknown	
2	☐☐-☐☐-☐☐☐☐	☐ Pneumovax 23 (Merck) ☐ Pnu-Imune23 (Wyeth) ☐ Other_____ ☐ Unknown	
3	☐☐-☐☐-☐☐☐☐	☐ Pneumovax 23 (Merck) ☐ Pnu-Imune23 (Wyeth) ☐ Other_____ ☐ 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	☐☐-☐☐-☐☐☐☐			
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 **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.	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 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