

CDC unique ID: _____

Multistate Fungal Infection Case Report Form, Florida Department of Health, October 2012, Version 2.0

CDC Unique ID (Contact CDC for unique identifier): _____

Investigation ID# (FL + County + sequence#; Ex. FLMarion1): _____

Investigator Last Name: _____ First name: _____

Investigator Phone Number: _____ Date form completed: __ __/__ __/2012

Date CHD notified: __ __/__ __/2012

Merlin Case # (if entered): _____

Patient Last Name: _____ First Name _____ Middle _____

Parent or Guardian First Name: _____

Gender Male Female Unknown

DOB __ __/__ __/__ __ Date of Death __ __/__ __/__ __

Race American Indian/Alaska Native Asian/Pacific Islander Black Unknown White Other

Ethnicity Hispanic Non-Hispanic Unknown _____

Address _____ City _____

Zip code _____ County _____

State _____ Home phone (_____) _____

Other phone (_____) _____ Emergency phone (_____) _____

Date of initial symptom onset: __ / __ / ____

Investigated? Yes No Date Investigated __ __/__ __/2012

Interviewed? Yes No Date Interviewed __ __/__ __/2012

Symptomatic at Interview? Yes No

Final Known Outcome? Died Ill at time of reporting Recovered Unknown

Emergency Department Visit? Yes No Inpatient Hospitalization? Yes No

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Patient initials: _____

Patient insurance carrier (if known): _____

Clinics:

Clinic Name Where Injected with Implicated Product	Date of injection

Hospitalizations:

Hospital Name	Admission Date	Discharge Date

Pages 2-12 will be forwarded to CDC, initial demographic data should be copied from page 1 to page 3

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Analytic data collection form

Abstractor Name: _____

Date abstracted: __ __/ __ __/2012

Case Definition – refer to current case definitions

Please **check** which case criterion the patient meets:

- [1] **Meningitis**
- [2] **Posterior Circulation Stroke**
- [3] **Spinal/para-spinal osteomyelitis/abscess**
- [4] **Osteomyelitis or worsening inflammatory arthritis of a peripheral joint**

Demographics and Past Medical History

Gender:	[1] Male	[2] Female	[3] Unknown	[9] Missing/Not documented
Date of Birth: __ / __ / ____	Age (years): ____	[] Unknown	[] Missing	
Race	[1] White	[2] Black	[3] Asian	[4] American Indian/Alaska Native
	[5] Pacific Islander	[6] Other	[7] Unknown	[9] Missing/Not documented
Ethnicity	[1] Hispanic	[2] Non-Hispanic	[3] Unknown	[9] Missing/Not documented
County of Residence: _____	Residence state	__ __		
Does the patient have any immunosuppressive conditions (e.g. cancer, chronic steroids)?				
	[1] Yes	[2] No	[7] Unknown	[9] Missing/Not documented
If yes, specify condition(s): _____				

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Initial Presentation

Date of initial symptom onset: ___ / ___ / _____

List all initial symptoms that prompted evaluation below, including onset date for each and estimated duration. (e.g., fever, headache, slurred speech, decreased vision, confusion, decreased concentration, seizure, sleepiness, photophobia, nausea, vomiting, back pain, numbness, vertigo, incontinence, warmth, redness or swelling at the site of injection, new or increasing effusion).

Symptom	Onset Date	Duration (days)
Altered Mental Status	___ / ___ / _____	
Back Pain	___ / ___ / _____	
Blurred Vision	___ / ___ / _____	
Confusion	___ / ___ / _____	
Decreased Vision	___ / ___ / _____	
Difficulty Moving Limbs	___ / ___ / _____	
Difficulty Walking	___ / ___ / _____	
Falling Down	___ / ___ / _____	
Fever	___ / ___ / _____	
Headache	___ / ___ / _____	
Incontinence	___ / ___ / _____	
Joint Pain	___ / ___ / _____	
Light Sensitivity	___ / ___ / _____	
Nausea	___ / ___ / _____	
Numbness	___ / ___ / _____	
Seizures	___ / ___ / _____	
Sleepiness	___ / ___ / _____	
Slurred Speech	___ / ___ / _____	
Stiff Neck	___ / ___ / _____	
Vertigo/Dizziness	___ / ___ / _____	
Vomiting	___ / ___ / _____	
Weakness	___ / ___ / _____	
Other:	___ / ___ / _____	

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Was the case-patient initially diagnosed with a different condition (i.e., a condition other than meningitis, posterior circulation stroke, spinal osteomyelitis/epidural abscess, or septic arthritis/osteomyelitis of a peripheral joint) at the time of initial presentation?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, what condition? _____

Was a **lumbar puncture (LP)** performed on the patient?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, complete the information below for the initial LP:

Date of initial LP: ___ / ___ / _____

Record initial LP results in the table below:

	Value / Result		Value / Result
Opening pressure		Glucose	
WBC (if more than one tube give maximum)		Protein	
RBC*		Gram stain	
Differential (%)	PMN: Mono: Lymph: Eos:	Fungal stain	

* use the RBC count from the same tube as reported WBC count

If yes, were antimicrobials (antibiotic or antifungal) given prior to LP?

If yes, please list names

Was any **spinal/para-spinal abscess (e.g. epidural abscess) aspirate** performed on the patient?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, complete the information below for the initial aspirate :

Date of initial aspiration: ___ / ___ / _____

Source of aspirate: _____

Record initial aspiration results in the table below:

	Value / Result		Value / Result
Gram stain		Fungal stain	

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If **yes**, were antimicrobials (antibiotic or antifungal) given prior to aspiration?

If yes, please list names

Was **synovial fluid** evaluated for this patient?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If **yes**, complete the information below for the initial synovial fluid analysis:

Joint affected: [1] Knee [2] Hip [3] Elbow [4] Ankle [5] Other _____

Side affected: [1] Right [2] Left

Date of initial synovial fluid analysis: ___ / ___ / _____

Record initial synovial fluid analysis results in the table below:

	Value / Result		Value / Result
WBC		RBC	
Differential	PMN: Mono: Lymph: Eos:	Gram stain	
Crystals (type, present or absent)		Fungal stain	

If **yes**, were antimicrobials (antibiotic or antifungal) given prior to the sampling of synovial fluid?

If yes, please list names

Diagnostic Tests

Was the **CSF** cultured or were any other diagnostic tests for pathogens performed from any LP?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

Was the **synovial fluid** cultured or were any other diagnostic tests for pathogens performed from any athrocentesis?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

Was the **spinal/para-spinal aspirate** cultured or were any other diagnostic tests for pathogens performed from any epidural abscess aspirate?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If **yes to any of the above**, list all results below,

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Source (e.g. CSF, synovial fluid, abscess aspirate)	Test Type (e.g., bacterial or fungal culture, virus, PCR, galactomannan)	Result (e.g., positive, negative, indeterminate, pending. If galactomannan please give level)	If positive , pathogen name or value	Collection Date
				___/___/____
				___/___/____
				___/___/____
				___/___/____
				___/___/____
				___/___/____

Was a pathogen identified by culture or other diagnostic test in this patient via any other specimen (**other than those listed above, including tissue culture or histopathology**)?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, list the results below (e.g., bacterial or fungal culture, AFB, virus, PCR, galactomannan)

Test Type	Specimen Source	Pathogen Name	Collection Date
			___/___/____
			___/___/____
			___/___/____
			___/___/____
			___/___/____

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Imaging Studies

Did the patient have any brain, spinal or peripheral joint imaging studies performed?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, document imaging results in the table below:

Imaging Study Type (CT/MRI)	Imaging Study Date	Location Imaged (please specify side (R/L) and body part)	Contrast Used (Y/N)	Results
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			

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Treatment and Patient Outcomes (This page should be updated after the patient has been on 2 weeks of treatment and resubmitted to FDOH)

Date Treatment/Outcomes filled out ___/___/_____

Was the case-patient treated for their illness?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, list all therapeutic agents (e.g., antifungals, antibiotics, steroids) in the table below, including any antimicrobials administered prior to any diagnostic procedure documented in the table above.

Therapeutic Agent Name	Daily dose (mg/day)	Route (IV, PO)	Start Date	Duration of Therapy	Therapy ongoing at time of abstraction	Discontinued due to toxicity. If yes, state toxicity
			___/___/_____	____ days	[1] Yes [2] No	[1] Yes [2] No ----- -----
			___/___/_____	____ days	[1] Yes [2] No	[1] Yes [2] No ----- -----
			___/___/_____	____ days	[1] Yes [2] No	[1] Yes [2] No ----- -----
			___/___/_____	____ days	[1] Yes [2] No	[1] Yes [2] No ----- -----
			___/___/_____	____ days	[1] Yes [2] No	[1] Yes [2] No ----- -----
			___/___/_____	____ days	[1] Yes [2] No	[1] Yes [2] No ----- -----
			___/___/_____	____ days	[1] Yes [2] No	[1] Yes [2] No ----- -----
			___/___/_____	____ days	[1] Yes [2] No	[1] Yes [2] No ----- -----

<p>Was the case-patient admitted to an intensive care unit? [1] Yes [2] No [7] Unknown [9] Missing/Not documented</p> <p>If yes, please complete the follow information:</p> <p>Duration of ICU stay: _____ days [7] Unknown [9] Missing/Not documented</p> <p>Patient still in the ICU as of the date of abstraction? [1] Yes [2] No [7] Unknown [9] Missing/Not documented</p>
<p>Did the case-patient have one or more strokes at any time? [1] Yes [2] No [7] Unknown [9] Missing/Not documented</p> <p>If yes, list the dates of onset for all strokes:</p> <p>Stroke 1: ___/___/___ Stroke 2: ___/___/___ Stroke 3: ___/___/___ Stroke 4: ___/___/___</p>
<p>Did the case-patient have an operative procedure <i>related to their infection</i> at any time? [1] Yes [2] No [7] Unknown [9] Missing/Not documented</p> <p>If yes, list the dates and procedure type</p> <p>[] Athroscopic debridement and/or washout ___/___/___ [] Joint replacement ___/___/___ [] Other surgical debridement ___/___/___ Please list site _____</p> <p>[] Other surgical procedure, not listed above Please describe _____</p>
<p>What is the case-patient's status as of the date of abstraction (List date: ___/___/___)?</p> <p>[1] Hospitalized [2] Discharged, date: ___/___/___ [3] Died, date: ___/___/___ [9] Other, specify: _____</p>

Exposure data

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Did the patient receive more than one injection with MPA since May 21st, 2012?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, number of injections: _____

Did the patient receive injections of MPA at more than one clinic?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, list the clinics: _____

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Please complete one procedure data sheet for *each* individual procedure event

Procedure data sheet

Clinic Name: _____ Clinic State: ____

Injection Type: Epidural
 Facet Joint
 Nerve Root Block
 Blood Patch
 Nerve Block
 Sacroiliac joint
 Joint Steroid Injection, specify joint: _____
 Other procedure, specify: _____

Injection location: Cervical Thoracic Caudal
 Lumbar Sacral
 Hip Knee
 Ankle Elbow
 Other, please specify: _____

Injection side: Right Left

Injection approach (epidural only): [1] Translaminar [2] Transforaminal [3] Caudal [4] N/A

Procedure date: ___ / ___ / _____ Procedure Duration: _____ minutes

Any evidence of dural puncture or other complication during the procedure documented in the procedure note (e.g., presence of radio-contrast material in the subarachnoid space, inadvertent aspiration of CSF)?

[1] Yes [2] No [7] Unknown [9] Missing/Not documented

If yes, specify: _____

Was methylprednisolone (MPA) from NECC used in this procedure?

[1] Yes [2] No [7] Unknown, if unknown list reason _____

Dose of MPA used: _____mg

Lot # of MPA used 05212012 06292012 08102012 not recorded other

**Completed reports should be scanned and uploaded
into Outbreak Module #1685**