West Virginia Bureau for Public Health — Your Health Your Safety Our Purpose
Department of Health & Human Resources

Antibiotic Resistant Staphylococcus aureus (VISA/VRSA)

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade:_____ Employer/School:_____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:*_____ *Phone:* _____

Birth date: __ / __ / ____ Age: _____
Gender: ☐Male ☐Female ☐Unk

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

REPORTING SOURCE

Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐Other
Report Source Name: _____ Address: _____ _____ Phone: _____
Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____
Reporter Name: _____ ____ Address: _____ Phone: _____

CLINICAL

Physician Name: _____ Physician Facility : _____
Physician Address: _____ Phone: _____

Hospital Was patient hospitalized for this illness? ☐ **Y** ☐ **N** ☐ **U** If yes, Admit date: __ / __ / ____ Discharge date: __ / __ / ____
Hospital name: _____

Condition
☐ Vancomycin intermediate resistant staphylococcus aureus (VISA)
☐ Vancomycin resistant staphylococcus aureus (VRSA)

Diagnosis date: __ / __ / ____
Illness onset date: __ / __ / ____
Illness end date: __/__/____

Did patient die from this disease? ☐ **Y** ☐ **N** ☐ **U** If yes, date of death: __ / __ / ____

Specify clinical diagnosis:

☐ Boil	☐ Cellulitis	☐ Colonization	☐ Endocarditis	☐ Folliculitis
☐ Impetigo	☐ Infected burn	☐ Infected foot/leg ulcer	☐ Infected decubitus	☐ Infected wound
☐ Meningitis	☐ Osteomyelitis	☐ Paronychia	☐ Pericarditis	☐ Pneumonia
☐ Sepsis	☐ Thrombophlebitis	☐ Septic pleural effusion	☐ Other (specify): _____	

Specify treatment for this infection:

Antibiotic	Start date (mm/dd/yyyy)	Stop date (mm/dd/yyyy)

Indicate underlying disease and risk factors present in the one year prior to onset (check all that apply):

☐ Burn or wound	☐ Cancer	☐ Daycare attendance	☐ Diabetes	☐ HIV infection
☐ Indwelling line	☐ Injection drug use	☐ Peritoneal dialysis	☐ Renal dialysis	☐ Surgery
☐ Tattoo	☐ Participation in team sports	☐ Household/close contacts	☐ Healthcare worker	☐ Daycare worker
☐ None	☐ Unknown	☐ Other (specify): _____		

Describe underlying disease/risk factors:

ANTIBIOTIC USE HISTORY

Did the patient use antibiotics in the year prior to onset? ☐ **Y** ☐ **N** ☐ **U** If yes, indicate treatment history below

Antibiotic	Start date (mm/dd/yyyy)	Stop date (mm/dd/yyyy)	Reason prescribed

Y=Yes N=No U=Unknown

LABORATORY *(Please submit copies of all labs to DIDE)*

Specify site of positive culture:

☐ Axilla	☐ Blood	☐ CSF	☐ Groin	☐ Nares
☐ Pericardial Fluid	☐ Peritoneal Fluid	☐ Pleural Fluid	☐ Sputum	☐ Synovial Fluid
☐ Tympanocentesis	☐ Urine	☐ Skin Lesion (specify site): _____	☐ Wound/Burn (specify site): _____	☐ Other (specify): ____ _____

RESISTANCE TESTING RESULTS

Data entered on the Lab Reports page in WVEDSS are not transmitted to CDC. These data must be reentered on the Investigation page. Please enter data from the lab report in the appropriate place.

OLS PFGE DATA

PFGE pattern:

EPIDEMIOLOGIC

Transmission Setting (where did this case acquire MRSA/VISA/VRSA?): ☐ Other (specify): _____

☐ Athletics	☐ College	☐ Community	☐ Correctional facility
☐ Daycare	☐ Doctor's office	☐ Home	☐ Hospital ER
☐ Hospital outpatient clinic	☐ Hospital ward	☐ International travel	☐ Military
☐ Place of worship	☐ School	☐ Work	☐ Unknown

Y	N	U	
☐	☐	☐	Is this case epi-linked to a case or carrier? If yes, complete info below on epi-linked case: Onset date: __/__/____ Name (Last, First): _____ Date of birth: __/__/____ County: _____
☐	☐	☐	Is this case part of a cluster or outbreak? If yes, name of outbreak? _____
☐	☐	☐	Did the patient have a hospital or nursing home stay in the year prior to onset? If yes, give locations and dates below

Facility Name	Date Admitted (mm/dd/yyyy)	Date Discharged (mm/dd/yyyy)	Reason for admission

☐ ☐ ☐ Did the patient stay in DOC or regional jail in the year prior to onset? If yes, give locations and dates below

Facility name	Date Admitted (mm/dd/yyyy)	Release/Transfer Date (mm/dd/yyyy)

PUBLIC HEALTH ISSUES

Y	N	U	
☐	☐	☐	Case knows someone who had shared exposure and is currently having similar symptoms
☐	☐	☐	Epi link to another confirmed case of same condition
☐	☐	☐	Case is part of an outbreak
☐	☐	☐	Other:

PUBLIC HEALTH ACTIONS

Y	N	U	
☐	☐	☐	Disease education and prevention information provided to patient and/or family/guardian
☐	☐	☐	Initiate contact precautions for patient
☐	☐	☐	Facilitate laboratory testing of other symptomatic persons who have a shared exposure
☐	☐	☐	Patient is lost to follow-up
☐	☐	☐	Other:

NOTES