

Staphylococcal Toxic-Shock Syndrome

PATIENT DEMOGRAPHICS

Name (last, first): _____	Birth date: __/__/____ Age: _____
Address: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
City/State/Zip: _____	Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
Phone (home): _____ Phone (work): _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk
Occupation/grade: _____ Employer/School: _____	(Mark all that apply)
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____	

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigator: _____	WVEDSS ID: _____
Investigator phone: _____	Case Classification: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unk
Investigation Start Date: __/__/_____	

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 Y N U If yes: Hospital name: _____

Hospitalized for this illness? Admit date: __/__/____ Discharge date: __/__/____

Did patient die from this illness? If yes, date of death: __/__/____

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

Symptoms

Clinical Findings (Major Criteria)

Y N U

Fever If yes, highest recorded temperature: _____° Fahrenheit Celsius

Hypotension If yes, lowest Systolic: _____ Diastolic: _____

Syncope

Orthostatic dizziness

Rash If yes: Generalized Focal Describe: _____

Desquamation If yes, describe: _____

Signs and Symptoms during first 4 days of illness

Y	N	U	Y	N	U	Y	N	U
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cardiac arrhythmia If yes, describe: _____

LABORATORY (Please submit copies of all labs to DIDE)

Record most abnormal values during first 4 days of illness

WBC count (000/mm³): _____ Neutrophil (%): _____ Bands (%): _____ Metamyelocytes (%): _____

Myelocytes (%): _____ Platelets (000/mm³): _____ Highest platelet value after 7 days of illness (000/mm³): _____

Urinalysis Creatinine phosphokinase (CPK) (IU/L): _____ CPK – myocardial band? Y N U

WBC/HPF ("many"=99): _____ RBC/HPF ("many"=99): _____ Protein (0-4+): _____ SGOT (IU/L): _____ SGPT (IU/L): _____

Alkaline phosphatase (IU/L): _____ Bilirubin (mg/dl): _____ Amylase (Somogyi Units/dl): _____ BUN (mg/dl): _____

Creatinine (mg/dl): _____ Calcium (mg/dl): _____ Phosphorus (mg/dl): _____ Albumin (g/dl): _____

LABORATORY (cont.) (Please submit copies of all labs to DIDE)**Cultures**Blood – Result: Positive Negative Not Done Unknown

If positive, what organism: 1. _____ 2. _____

Urine – Result: Positive Negative Not Done Unknown

If positive, what organism: 1. _____ 2. _____

Colony count (000/ml): 1. _____ 2. _____

Throat – Result: Normal Flora Abnormal Not Done Unknown

If abnormal, what organism: 1. _____ 2. _____

Nares – Result: Done Not Done Unknown

If done, what organism: 1. _____ 2. _____

Vagina – Result: Done Not Done Unknown

If done, what organism: 1. _____ 2. _____

Was Staphylococcus aureus present in the vagina? Y N UIf S. aureus present in vagina, is it resistant to penicillin and ampicillin only? Y N UOther sites cultured? Y N U If yes, specify site: _____

If done, what organism: 1. _____ 2. _____

Was patient taking antibiotics when culture(s) performed? Y N U

If yes, which sites: _____

EXPOSURE ASSESSMENT**Tampon/Napkin/Minipad Use – If applicable during period when patient became ill**

Products used:

- Tampons only Napkins only Minipads only Tampons and Napkins
 Tampons and Minipads Napkins and Minipads Tampons, Napkins and Minipads Sea Sponge
 unknown Other (specify): _____

Tampon brand #1 (Most frequently used, judged by time. If only one brand was used before onset of symptoms, list only that brand)

- | | | | |
|---|--|---|---|
| Y N U | Y N U | Y N U | Y N U |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Assure | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> o.b. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pursetts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tampax |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kotex | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Playtex | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rely | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify): _____ |

If yes to any, what type: Plastic Inserter Stick Inserter Inserter UnknownIf yes to any, what type: Deodorized Non-deodorizedIf yes to any, style (absorbency): Super-plus Super Regular Junior Unknown

Tampon brand #2 (Most frequently used, judged by time. If only one brand was used before onset of symptoms, list only that brand)

- | | | | |
|---|--|---|---|
| Y N U | Y N U | Y N U | Y N U |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Assure | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> o.b. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pursetts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tampax |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kotex | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Playtex | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rely | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify): _____ |

If yes to any, what type: Plastic Inserter Stick Inserter Inserter UnknownIf yes to any, what type: Deodorized Non-deodorizedIf yes to any, style (absorbency): Super-plus Super Regular Junior UnknownWas Brand #1 the only tampon brand used during period when patient became ill? Y N U

Name Napkin brand used: _____ Name Minipad brand used: _____

How was information in this section verified?

-
- Patient memory
-
- Patient viewing product box
-
- Interviewer viewing product box
-
- Other (describe): _____

Has patient had similar illness in past during menstrual period? Y N UIf yes, how many episodes: 1 2 3 ≥ 4

If no tampon use reported, does the patient have meet any of the following criteria:

-
- Childbirth
-
- Abortion
-
- Recent surgical procedure
-
- Presence of cutaneous lesion
-
- Other (specify): _____
-
- N/A

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
 Patient is lost to follow-up
 Other: