WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Streptococcus Pneumoniae

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

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 ☐ Unk

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 Number: _____

Hospital Y N U
☐ ☐ ☐ Hospitalized for this illness? If yes: Hospital name: _____
Admit date: __ / __ /_____ Discharge date: / / _____

Condition * Illness onset date: ___/ ___/_____ Diagnosis date: ___/ ___/_____ Illness end date: / / _____

*Types of infection caused by organism:

☐ Abscess (not skin)	☐ Bacteremia without focus	☐ Cellulitis	☐ Chorioamnionitis
☐ Conjunctivitis	☐ Empyema	☐ Endocarditis	☐ Endometritis
☐ Epiglottitis	☐ Hemolytic uremic syndrome (HUS)	☐ Meningitis	☐ Necrotizing fasciitis
☐ Osteomyelitis	☐ Otitis media	☐ Pericarditis	☐ Peritonitis
☐ Pneumonia	☐ Puerperal sepsis	☐ Septic abortion	☐ Septic arthritis
☐ Streptococcal toxic-shock syndrome (STSS)		☐ Other (specify) _____	☐ Unknown

Date first positive culture obtained: / / _____

*Sterile sites from which organism was isolated: ☐ Blood ☐ Bone ☐ Cerebral Spinal Fluid ☐ Internal body site ☐ Joint ☐ Muscle ☐ Pericardial Fluid ☐ Peritoneal Fluid ☐ Pleural Fluid ☐ Other normally sterile site (specify) _____

Nonsterile sites from which organism was isolated:
☐ Amniotic fluid ☐ Middle ear ☐ Placenta ☐ Sinus ☐ Wound ☐ Other (specify) _____

Did patient have any underlying medical conditions? ☐ **Y** ☐ **N** ☐ **U** If yes, specify:

☐ AIDS	☐ Alcohol abuse	☐ Asthma
☐ Atherosclerotic Cardiovascular Disease	☐ Burns	☐ Cerebral vascular accident (CVA)/Stroke
☐ Cirrhosis/liver failure	☐ Cochlear implant	☐ Complement deficiency
☐ CSF leak (2 deg trauma/surgery)	☐ Current smoker	☐ Deaf/profound hearing loss
☐ Diabetes mellitus	☐ Emphysema/COPD	☐ Heart failure/CHF
☐ HIV	☐ Hodgkin's disease	☐ Immunoglobulin deficiency
☐ Immunosuppressive therapy (steroids, chemo)	☐ IVDU	☐ Leukemia
☐ Multiple myeloma	☐ Nephrotic syndrome	☐ Obesity
☐ Renal failure/dialysis	☐ Sickle cell anemia	☐ Splenectomy/Asplenia
☐ Systemic lupus erythematosus (SLE)	☐ Unknown	☐ Other prior illness (specify)_____
☐ Other malignancy (specify) _____	☐ Organ transplant (specify)_____	

Did patient die from this illness? ☐ **Y** ☐ **N** ☐ **U** If yes, date of death: / / _____

*RESISTANCE TESTING RESULTS *(Please submit copies of all labs to DIDE)*

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.

VACCINE INFORMATION

☐ **Y** ☐ **N** ☐ **U** Has patient received the 23-valent pneumococcal POLYSACCHARIDE vaccine? If yes, enter data in Vaccination Record

☐ **Y** ☐ **N** ☐ **U** If <15 years of age, did patient receive pneumococcal CONJUGATE vaccine? If yes, enter data in Vaccination Record

*VACCINATION RECORD

Date received:_/_/_ Anatomical site: ____________________ Vaccine administered:______________Vaccine ID: __________ Manufacturer:________________Organization ID: __________ Lot #: _________________ Expiration Date:_/_/________	**Given by:** Last Name: _________________________ First Name:______________________Provider ID: __________ Organization Name: __________________________________ Organization ID: _________________
Date received:_/_/_ Anatomical site: ____________________ Vaccine administered:______________Vaccine ID: __________ Manufacturer:________________Organization ID: __________ Lot #: _________________ Expiration Date:_/_/________	**Given by:** Last Name: _________________________ First Name:______________________Provider ID: __________ Organization Name: __________________________________ Organization ID: _________________
Date received:_/_/_ Anatomical site: ____________________ Vaccine administered:______________Vaccine ID: __________ Manufacturer:________________Organization ID: __________ Lot #: _________________ Expiration Date:_/_/________	**Given by:** Last Name: _________________________ First Name:______________________Provider ID: __________ Organization Name: __________________________________ Organization ID: _________________
Date received:_/_/_ Anatomical site: ____________________ Vaccine administered:______________Vaccine ID: __________ Manufacturer:________________Organization ID: __________ Lot #: _________________ Expiration Date:_/_/________	**Given by:** Last Name: _________________________ First Name:______________________Provider ID: __________ Organization Name: __________________________________ Organization ID: _________________
Date received:_/_/_ Anatomical site: ____________________ Vaccine administered:______________Vaccine ID: __________ Manufacturer:________________Organization ID: __________ Lot #: _________________ Expiration Date:_/_/________	**Given by:** Last Name: _________________________ First Name:______________________Provider ID: __________ Organization Name: __________________________________ Organization ID: _________________

EPIDEMIOLOGIC

Y N U

☐ ☐ ☐ If <6 years of age, is the patient in daycare?
If yes, name of day care facility: ________________________________

☐ ☐ ☐ Was the patient a resident of a nursing home or other chronic care facility at time of first positive culture?
If yes, name of chronic care facility? ____________________________

☐ ☐ ☐ Is this case part of an outbreak?
If yes, name of outbreak? _____________________________________

Where was the disease acquired?

☐ Indigenous, within jurisdiction ☐ Out of country ☐ Out of jurisdiction, from another jurisdiction
☐ Out of state ☐ Unknown

Confirmation method:

☐ Active surveillance ☐ Case/Outbreak management ☐ Clinical diagnosis (not lab confirmed) ☐ Epidemiologically linked
☐ Lab confirmed ☐ Lab report ☐ Local/State specified ☐ Medical record review
☐ No information given ☐ Occupational disease surveillance ☐ Provider certified ☐ Other (specify): ______________________

*Serotype:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6B ☐ 7F ☐ 8 ☐ 9N ☐ 9V ☐ 10A ☐ 11A ☐ 12F ☐ 14
☐ 15B ☐ 17F ☐ 18C ☐ 19A ☐ 19F ☐ 20 ☐ 22F ☐ 23F ☐ 33F ☐ not done ☐ other (specify)_________

Are you reporting drug resistant strep pneumo? ☐ **Y** ☐ **N** ☐ **U**

PUBLIC HEALTH ACTIONS/NOTES

☐ Lost to follow-up