

Streptococcus pneumoniae Surveillance Worksheet

NAME (Last, First)		Hospital Record No.		
Address (Street and No.)	City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/Lab/Phone	Address		Phone	

DETACH HERE and transmit only lower portion if sent 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

MONTH

3b. Is age in years / months / weeks / days?

☐ years ☐ months ☐ weeks ☐ days

4. Sex

☐ Male ☐ Female ☐ Unknown

5. Race: (check all that apply)

- ☐ American Indian / Alaska 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 AS 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 ☐
 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 ☐ Joint ☐
 CSF ☐ Bone ☐
 Pleural fluid ☐ Internal body site ☐
 Peritoneal fluid ☐ Muscle ☐
 Pericardial fluid ☐ Other normally sterile site ☐
 (specify) _____

15. Date first positive culture obtained

DATE SPECIMIN 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 ☐
 Hodgkin's disease ☐
 Asthma ☐
 Emphysema / COPD ☐
 Systemic lupus erythematosus ☐
 Diabetes mellitus ☐
 Nephrotic syndrome ☐
 Renal failure / dialysis ☐
 HIV infection ☐

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AIDS (CD4 <200) ☐

Cirrhosis / liver failure ☐

Alcohol abuse ☐

Cardiovascular disease (ASCVD) / CAD ☐

Heart failure / CHF ☐

CSF leak ☐

Intravenous drug use ☐

Other malignancy (specify) ☐

Organ / bone marrow transplant ☐

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	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Pneumovax 23 (Merck) <input type="checkbox"/> Pnu-Imune23 (Wyeth) Other <input type="text"/>	
2	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Pneumovax 23 (Merck) <input type="checkbox"/> Pnu-Imune23 (Wyeth) Other <input type="text"/>	
3	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Pneumovax 23 (Merck) <input type="checkbox"/> Pnu-Imune23 (Wyeth) Other <input type="text"/>	

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	<input type="text"/> - <input type="text"/> - <input type="text"/>			
2	<input type="text"/> - <input type="text"/> - <input type="text"/>			
3	<input type="text"/> - <input type="text"/> - <input type="text"/>			
4	<input type="text"/> - <input type="text"/> - <input type="text"/>			

20. Resistance Testing Results

Oxacillin zone size: mm **Oxacillin interpretation:** ☐ R < 20mm (possibly resistant) ☐ S ≥20mm (susceptible) ☐ Unknown/not tested (valid 00-30)

SUSCEPTIBILITY METHOD CODES	S/I/R RESULT CODES	SIGN CODES	MIC VALUE
A- AGAR: Agar dilution method B- BROTH: Broth dilution C- DISK: Disk diffusion (Kirby Bauer) S- STRIP: Antimicrobial gradient strip (E-test)	S- SUSCEPTIBLE B- INTERMEDIATE C- RESISTANT S- UNK. / NOT TESTED Result indicates whether the microorganism is susceptible or not susceptible (intermediate or resistant) to the antimicrobial being tested	Indicate whether the MIC is <, >, ≤, ≥, = to the numerical MIC value in the last column MIC = minimum inhibitory concentration	Valid range for data value 0.000 - 999.999

ANTIMICROBIAL AGENT	SUSCEPTIBILITY METHOD A/B/D/S	S/I/R/U RESULT	SIGN </>/≤/≥/=	MIC VALUE (e.g., 0.06 µg/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: -- MONTH DAY YEAR