

# TOXIC SHOCK SYNDROME (TSS) INVESTIGATION FORM

## BASIC DEMOGRAPHIC DATA

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  years  months Current Sex:  Female  Male  Unknown

Is the patient deceased?  No  Unknown  Yes Date of Death: \_\_\_/\_\_\_/\_\_\_\_

Street Address 1: \_\_\_\_\_ Street Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

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

## INVESTIGATION SUMMARY

Investigation Start Date: \_\_\_/\_\_\_/\_\_\_\_ Investigation Status:  Open  Closed Investigator: \_\_\_\_\_

## REPORTING SOURCE

Date of Report: \_\_\_/\_\_\_/\_\_\_\_ Reporting Source: \_\_\_\_\_

Reporting Source Name: \_\_\_\_\_

## CLINICAL

Physician's Name: \_\_\_\_\_ Phone Number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Was patient hospitalized for this illness?  No  Unknown  Yes If yes: Hospital Name: \_\_\_\_\_

Admission Date: \_\_\_/\_\_\_/\_\_\_\_ Discharge Date: \_\_\_/\_\_\_/\_\_\_\_ Duration of Stay \_\_\_\_\_ day(s)

Diagnosis Date: \_\_\_/\_\_\_/\_\_\_\_ Illness Onset Date: \_\_\_/\_\_\_/\_\_\_\_ Illness End Date: \_\_\_/\_\_\_/\_\_\_\_

Age at Onset: \_\_\_\_\_  days  hours  minutes  months  unknown  weeks  years

Is the patient pregnant?  No  Unknown  Yes

Does the patient have pelvic inflammatory disease?  No  Unknown  Yes

Did the patient die from this illness?  No  Unknown  Yes Date of Death: \_\_\_/\_\_\_/\_\_\_\_

## EPIDEMIOLOGIC

Is this patient associated with a day care facility?  No  Unknown  Yes

Is this patient a food handler?  No  Unknown  Yes

Is this case part of an outbreak?  No  Unknown  Yes If yes, outbreak name: \_\_\_\_\_

Where was the disease acquired?  Indigenous within jurisdiction  Out of Country  Out of jurisdiction, from another jurisdiction  
 Out of State  Unknown

If selection is out of country, state, or jurisdiction, where was the disease acquired?

Country: \_\_\_\_\_ State: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

Transmission Mode:  Airborne  Bloodborne  Dermal  Foodborne  Indeterminate  Mechanical  Nosocomial  Sexually Transmitted  
 Transplacental transmission  Vectorborne  Waterborne  Zoonotic  Unknown

Detection Method:  Patient self-referral  Prenatal testing  Prison entry screening  Provider reported  Routine physical  Other  
Confirmation Method:  Active Surveillance  Case/Outbreak Investigation  Clinical diagnosis (non-laboratory confirmed)  
 Epidemiologically linked  Laboratory confirmed  Laboratory report  Local/State specified  Medical record review  
 No information given  Occupational disease surveillance  Provider certified  Other

Confirmation Date: \_\_\_/\_\_\_/\_\_\_\_\_

Case Status:  Confirmed  Probable  Not a Case  Unknown MMWR Week: \_\_\_\_\_ MMWR Year: \_\_\_\_\_

**ADMINISTRATIVE**

General Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHA4 SUPERVISOR REVIEW**

Date Due: \_\_\_/\_\_\_/\_\_\_\_\_ Investigation ready for supervisor review:  Reviewed (Complete)  Reviewed (Incomplete)

Date investigation ready for supervisor review: \_\_\_/\_\_\_/\_\_\_\_\_  Reviewed (Not a case)  Yes

Review comments (completed by supervisor): \_\_\_\_\_

**CONTACT ATTEMPTS**

Physician Contact Date(s):

1<sup>st</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_\_ 2<sup>nd</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_\_ 3<sup>rd</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_\_

Patient Contact Date(s):

1<sup>st</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_\_ Time: \_\_\_\_\_  AM  PM 2<sup>nd</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

3<sup>rd</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Regular Letter Mailed: \_\_\_/\_\_\_/\_\_\_\_\_ Certified Letter Mailed: \_\_\_/\_\_\_/\_\_\_\_\_

Was clinical information obtained from the physician or patient?  Yes  No

**IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.**

**CASE REQUIREMENTS**

**Hypotension, based on lowest systolic blood pressure (SBP):**

SBP ≤90 mmHg in adults:  No  Unknown  Yes **OR** SBP < 5<sup>th</sup> percentile for children < 16 years:  No  Unknown  Yes

**Rash:**

Generalized erythematous macular rash (may desquamate):  No  Unknown  Yes

**Coagulopathy:**

Platelets ≤ 100,000/mm<sup>3</sup>:  No  Unknown  Yes **OR** Disseminated Intravascular Coagulation (DIC):  No  Unknown  Yes

**Liver Involvement:**

ALT/AST/Total Bilirubin ≥ 2x upper limit of normal:  No  Unknown  Yes **OR**

Patients with existing renal disease > 2-fold elevation over baseline:  No  Unknown  Yes

**Renal Impairment:**

Blood Urea nitrogen (BUN) or Creatinine ≥ 2x upper limit of normal:  No  Unknown  Yes **OR**

Urinary sedimentation with pyuria (≥ 5 leukocytes/high-power field) in absence of urinary tract infection:  No  Unknown  Yes

**Gastrointestinal:**

Vomiting or diarrhea at illness onset:  No  Unknown  Yes

**Muscular:**

Severe myalgia:  No  Unknown  Yes      **OR**      Creatinine phosphokinase  $\geq$  2x upper limit of normal:  No  Unknown  Yes

**Mucous Membrane:**

Vaginal, oropharyngeal, or conjunctival hyperemia (redness):  No  Unknown  Yes

**High Fever:**

High Fever ( $\geq$ 102.0°F):  No  Unknown  Yes

**STAPHYLOCOCCAL TSS CULTURE INFORMATION**

Was *Staphylococcus aureus* present in the vagina:  No  Unknown  Yes

If *S. aureus* present in vagina, is it resistant to penicillin and ampicillin only:  No  Unknown  Yes

Was patient taking antibiotics when culture(s) performed:  No  Unknown  Yes

**STAPHYLOCOCCAL TSS MENSTRATION INFORMATION**

Does the patient use tampons:  No  Unknown  Yes      Brand Most Frequently Used: \_\_\_\_\_

Style of Brand Most Frequently Used:  Junior/Slender  Regular  Super  Super-Plus  Unknown

How was information in this section verified:  Interviewer Viewing Product Box  Patient Viewing Product Box  
 Patient's Memory  Other: \_\_\_\_\_

Has patient had similar illness in past during menstrual period:  No  Unknown  Yes      If yes, how many episodes of similar illness: \_\_\_\_\_

**CONTROL MEASURES**

Date ADPH Investigator verbally provided patient, or patient representative, with Control Measures: \_\_\_ / \_\_\_ / \_\_\_\_\_

If control measures were not verbally provided (or not provided within the recommended timeframe), explain:

\_\_\_\_\_

Educations case/contacts:  Yes  No  Not applicable