Vancomycin-Intermediate and Vancomycin-Resistant *Staphylococcis Aureus* (VISA/VRSA) 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: __ __ / __ __ /__ __ __ __

Marital Status: ☐Married ☐Single, never married ☐Widowed ☐Annulled
☐Domestic partner ☐Interlocutory ☐Legally separated ☐Divorced
☐Polygamous ☐Refused to answer ☐Unknown

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 ☐Not a Case ☐Probable ☐Suspect ☐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):____

EXPOSURES

In the previous 12 months, did the patient have dialysis, surgery, or invasive device or catheter (in place at least 1 day prior to *S. aureus* culture)?

If yes, please provide details, date, and location:

Date: __ __ / __ __ /__ __ __ __ Location: ____

Details:

____

____

In the previous 12 months, was the patient in a hospital or long-term care facility for at least one night?

If yes to overnight stay, provide details, date and location:

Date: __ __ / __ __ /__ __ __ __ Location: ____

Details:

____

____

Does the patient have prior history of Methacillin-Resistant *S. aureus* (MRSA)? ☐No ☐Unknown ☐Yes

If yes to previous MRSA, please provide culture site and date:

Date: __ __ / __ __ /__ __ __ __ Culture Site: ___________________

Does the patient have prior history of Vancomycin-Resistant *Enterococcus* (VRE)? ☐No ☐Unknown ☐Yes

If yes to previous VRE, please provide culture site and date:

Date: __ __ / __ __ /__ __ __ __ Culture Site: ___________________

Has the patient received vancomycin in the previous 12 months? ☐No ☐Unknown ☐Yes

If yes, please provide date range: __ __ / __ __ /__ __ __ __ to __ __ / __ __ /__ __ __ __

Is the patient a healthcare worker? ☐No ☐Unknown ☐Yes

If yes, enter location specifics: ____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐Alcohol Abuse ☐Current Smoker ☐HIV/AIDS ☐Neoplastic Disease ☐Renal Disease
☐Asthma ☐Cystic Fibrosis ☐Immunosuppressive Therapy ☐Neurologic/Neuromuscular Disease
☐Cerebrovascular Disease ☐Diabetes Mellitus ☐IVDU ☐Other Drug Use
☐Congestive Heart Failure ☐Emphysema/COPD ☐Liver Disease ☐Other, specify: _______________

LABORATORY TESTING

Was the isolate: ☐VISA (MIC = 4-8 µg/mL) ☐VRSA (MIC ≥ 16 µg/mL) If yes, vancomycin MIC ____________ µg/mL

Was VISA/VRSA confirmed by a State Public Health Laboratory (SPHL)? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

Was VISA/VRSA confirmed by the Centers for Disease Control & Prevention (CDC)? ☐Indeterminate ☐Negative ☐Not Tested ☐Positive

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:

____

____