

SEVERE STAPHYLOCOCCUS AUREUS INFECTION IN A PREVIOUSLY HEALTHY PERSON*

CASE INVESTIGATION – Page 2 of 2

Indiana State Department of Health
State Form 53653 (6-08)

SECTION 3. Diagnostic Tests

Is the isolate: <input type="radio"/> MRSA <input type="radio"/> MSSA	Culture date: ____/____/____	Hospital/clinic where culture obtained:
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Site from which *S. aureus* was isolated (check all that apply)

<input type="radio"/> Blood	<input type="radio"/> Joint	<input type="radio"/> Skin (swab/aspirate)	<input type="radio"/> Urine	<input type="radio"/> Cerebrospinal fluid
<input type="radio"/> Bone	<input type="radio"/> Sputum/trach	<input type="radio"/> Ear (drainage/aspirate)	<input type="radio"/> Pleural fluid	<input type="radio"/> Surgical specimen
<input type="radio"/> Nares	<input type="radio"/> Eye	<input type="radio"/> Peritoneal fluid	<input type="radio"/> Wound	(specify) _____

Other (specify) _____

Susceptibility Results (or attach laboratory report of antibiotic susceptibilities)	Susceptible	Intermediate	Resistant	Not tested or unknown
Amox/ K Clav	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amp/Sulbactam (Unasyn)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Azithromycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cefazolin (Kefzol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cefuroxime	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ciprofloxacin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clindamycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Erythromycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gentamicin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imipenem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Levofloxacin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Linezolid (Zyvox)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oxacillin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pip/Tazo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rifampin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Synercid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tetracycline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trimeth/Sulfa (Septra, Bactrim)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vancomycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (specify)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Laboratory-confirmed influenza? A B Type of test _____ Date ____/____/____

SECTION 4. EPIDEMIOLOGIC INFORMATION

Did the patient reside in or participate in any of the following in the year prior to the culture? (Check all that apply.)

Correctional facility Residential care facility Pre-school/child care Team sports

SECTION 5. ASSOCIATION WITH OTHER CASES

Was this patient's illness associated with other cases of *S. aureus* illness? Yes No Unknown

If Yes, specify nature of other illness _____

Specify nature of association with other case(s) Household Sexual Other _____

Section 6. Comments/Follow-up

Attachments/Reports:
Please attach laboratory report of antibiotic susceptibilities unless susceptibility results have been provided above.

Investigator Name	Agency	Telephone Number	Date (month, day, year)
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