

REPORTABLE DISEASES AND CONDITIONS

I. PURPOSE

- A. To comply with state law in reporting certain communicable diseases and other reportable conditions diagnosed or treated at Stanford Hospital and Clinics.
- B. To inform local health department personnel that a person has a reportable disease or condition. If necessary, health department personnel will conduct an epidemiological investigation.
- C. To contribute to county, state, national and international analysis of epidemiological trends. Persons responsible for reporting:
 - 1. Technologists in Microbiology Laboratory and Virology Laboratory
 - 2. Staff in the Infection Control and Department (ICED)
 - 3. Physicians and nurses in patient care areas in Hospital and Clinics

II. SUPPORTIVE INFORMATION

The California Administrative Code, Title 17, Section 2500, requires that certain diseases and conditions be reported by hospital personnel or the patient's physician to the Santa Clara County Health Department, and the health department of the county in which the patient resides, if not Santa Clara County.

III. POLICY

- A. Review list of reportable diseases and conditions to determine if the disease of concern is a reportable disease (refer to Attachment 1). Attachment.
- B. Refer to the instructions on Attachment 1 for “Urgency Reporting Requirements”.
- C. Reporting Addresses and Phone Numbers:
 - 1. Santa Clara County Health Department
(408) 885-4214, Fax (408) 885-4249
 - 2. San Mateo County Health Department
(650) 573-2346, Fax (650) 573-2919
 - 3. San Francisco County Health Department
(415) 554-2830, Fax (415) 554-2848
 - 4. Santa Clara County Health Department, Health Protection, 2220 Moorpark Avenue, San Jose, CA 95128, Fax: (408) 885-4249
 - 5. County of San Mateo, Public Health Division, Attn: Public Health Director, 225 W. 37th Avenue, San Mateo, CA 94403
- D. For any questions call the ICED at 5-1106 or pager 16167.

Appendices:

Appendix A: Confidential Morbidity Report

Appendix B: Sever *Staphylococcus Aureus* Infection in a Previously Healthy Person Case Report

Approved by: Infection Control Committee, 3/08

Quality Improvement and Patient Safety Committee, 5/08

Stanford Hospital and Clinics Medical Executive Committee, 5/08

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Revised Date: 6/97, 1/01, 8/03

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Direct inquiries to: Infection Control and Epidemiology -- (650) 725-1106

Stanford Hospital and Clinics

Stanford, CA 94305

Appendix A

State of California—Health and Human Services Agency

California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED: _____

Patient's Last Name <input style="width:100%;" type="text"/>		Social Security Number <input style="width:100%;" type="text"/>		Ethnicity (✓ one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
First Name/Middle Name (or initial) <input style="width:100%;" type="text"/>		Birth Date Month Day Year <input style="width:100%;" type="text"/>		Age <input style="width:100%;" type="text"/>	
Address: Number, Street <input style="width:100%;" type="text"/>			Apt./Unit Number <input style="width:100%;" type="text"/>		
City/Town <input style="width:100%;" type="text"/>		State <input style="width:100%;" type="text"/>	ZIP Code <input style="width:100%;" type="text"/>		
Area Code <input style="width:100%;" type="text"/>	Home Telephone <input style="width:100%;" type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	Estimated Delivery Date Month Day Year <input style="width:100%;" type="text"/>	
Area Code <input style="width:100%;" type="text"/>	Work Telephone <input style="width:100%;" type="text"/>	Patient's Occupation/Setting <input type="checkbox"/> Food service <input type="checkbox"/> Day care <input type="checkbox"/> Correctional facility <input type="checkbox"/> Health care <input type="checkbox"/> School <input type="checkbox"/> Other _____		Race (✓ one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander (✓ one): <input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White: _____ <input type="checkbox"/> Other: _____	

DATE OF ONSET Month Day Year <input style="width:100%;" type="text"/>	Reporting Health Care Provider <input style="width:100%;" type="text"/>
DATE DIAGNOSED Month Day Year <input style="width:100%;" type="text"/>	Reporting Health Care Facility <input style="width:100%;" type="text"/>
DATE OF DEATH Month Day Year <input style="width:100%;" type="text"/>	Address <input style="width:100%;" type="text"/>
	City State ZIP Code <input style="width:100%;" type="text"/>
	Telephone Number () () <input style="width:100%;" type="text"/>
	Fax () () <input style="width:100%;" type="text"/>
	Submitted by Date Submitted (Month/Day/Year) <input style="width:100%;" type="text"/>

REPORT TO

**Santa Clara County
Public Health Department
645 S. Bascom Ave., Room 163
San Jose, CA 95128**

**TEL: (408) 885-4214
FAX: (408) 885-3709**

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STD)	
Syphilis <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Late latent > 1 year <input type="checkbox"/> Secondary <input type="checkbox"/> Late (tertiary) <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Congenital <input type="checkbox"/> Latent (unknown duration)	Syphilis Test Results <input type="checkbox"/> RPR Titer: _____ <input type="checkbox"/> VDRL Titer: _____ <input type="checkbox"/> FTA/MHA: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> CSF-VDRL: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Other: _____
<input checked="" type="checkbox"/> Neurosyphilis	
Gonorrhea <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____	Chlamydia <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____
STD TREATMENT INFORMATION <input type="checkbox"/> Treated (Drugs, Dosage, Route): _____ Date Treatment Initiated Month Day Year <input style="width:100%;" type="text"/>	<input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____

VIRAL HEPATITIS					
<input type="checkbox"/> Hep A	anti-HAV IgM	Pos	Neg	Pend	Not Done
<input type="checkbox"/> Hep B	HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acute	anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic	anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hep C	anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acute	PCR-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic					
<input type="checkbox"/> Hep D (Delta)	anti-Delta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other:					
Suspected Exposure Type					
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Other needle exposure	<input type="checkbox"/> Sexual contact	<input type="checkbox"/> Household contact		
<input type="checkbox"/> Child care	<input type="checkbox"/> Other: _____				

TUBERCULOSIS (TB)
Status <input type="checkbox"/> Active Disease <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Infected, No Disease <input type="checkbox"/> Converter <input type="checkbox"/> Reactor
Site(s) <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both

Mantoux TB Skin Test Month Day Year <input style="width:100%;" type="text"/>
Date Performed Month Day Year <input style="width:100%;" type="text"/>
Results: _____ mm <input type="checkbox"/> Pending <input type="checkbox"/> Not Done
Chest X-Ray Month Day Year <input style="width:100%;" type="text"/>
Date Performed Month Day Year <input style="width:100%;" type="text"/>
<input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Cavitory <input type="checkbox"/> Abnormal/Noncavitory

Bacteriology Month Day Year <input style="width:100%;" type="text"/>
Date Specimen Collected Month Day Year <input style="width:100%;" type="text"/>
Source Smear: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Culture: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done
Other test(s) _____

TB TREATMENT INFORMATION
<input type="checkbox"/> Current Treatment <input type="checkbox"/> INH <input type="checkbox"/> RIF <input type="checkbox"/> PZA <input type="checkbox"/> EMB <input type="checkbox"/> Other: _____
Date Treatment Initiated Month Day Year <input style="width:100%;" type="text"/>
<input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____

REMARKS

**Title 17, California Code of Regulations (CCR) §2500, §2593, §2641-2643, and §2800-2812
Reportable Diseases and Conditions***

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

☎ = Report immediately by telephone (designated by a ♦ in regulations).

† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)

FAX (☎) = Report by FAX, telephone, or mail within one working day of identification (designated by a + in regulations).

= All other diseases/conditions should be reported by FAX, telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(i)(1), §2641-2643

<p>FAX (☎) (☎) Acquired Immune Deficiency Syndrome (AIDS) (HIV infection only: see "Human Immunodeficiency Virus")</p> <p>FAX (☎) (☎) Amebiasis</p> <p>☎ Anthrax</p> <p>☎ Avian Influenza (human)</p> <p>FAX (☎) (☎) Babesiosis</p> <p>☎ Botulism (Infant, Foodborne, Wound)</p> <p>☎ Brucellosis</p> <p>FAX (☎) (☎) Campylobacteriosis</p> <p>Chancroid</p> <p>FAX (☎) (☎) Chickenpox (only hospitalizations and deaths)</p> <p>Chlamydial Infections, including Lymphogranulom Venereum (LGV)</p> <p>☎ Cholera</p> <p>☎ Ciguatera Fish Poisoning</p> <p>☎ Coccidioidomycosis</p> <p>FAX (☎) (☎) Colorado Tick Fever</p> <p>FAX (☎) (☎) Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology</p> <p>FAX (☎) (☎) Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)</p> <p>FAX (☎) (☎) Cryptosporidiosis</p> <p>Cysticercosis or Taeniasis</p> <p>☎ Dengue</p> <p>☎ Diarrhea of the Newborn, Outbreak</p> <p>☎ Diphtheria</p> <p>☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)</p> <p>☎ Ehrlichiosis</p> <p>FAX (☎) (☎) Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>☎ <i>Escherichia coli</i>: shiga toxin producing (STEC) including <i>E. coli</i> O157</p> <p>FAX (☎) (☎) Foodborne Disease</p> <p>Giardiasis</p> <p>Gonococcal Infections</p> <p>FAX (☎) (☎) <i>Haemophilus influenzae</i> invasive disease (report an incident less than 15 years of age)</p> <p>☎ Hantavirus Infections</p> <p>☎ Hemolytic Uremic Syndrome</p> <p>Hepatitis, Viral</p> <p>FAX (☎) (☎) Hepatitis A</p> <p>Hepatitis B (specify acute case or chronic)</p> <p>Hepatitis C (specify acute case or chronic)</p> <p>Hepatitis D (Delta)</p> <p>Hepatitis, other, acute</p> <p>Human Immunodeficiency Virus (HIV) (§2641-2643)</p> <p>Influenza deaths (report an incident of less than 18 years of age)</p> <p>Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)</p> <p>Legionellosis</p> <p>Leprosy (Hansen Disease)</p> <p>Leptospirosis</p> <p>FAX (☎) (☎) Listeriosis</p> <p>Lyme Disease</p> <p>FAX (☎) (☎) Malaria</p> <p>FAX (☎) (☎) Measles (Rubeola)</p> <p>FAX (☎) (☎) Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>☎ Meningococcal Infections</p> <p>Mumps</p> <p>☎ Paralytic Shellfish Poisoning</p>	<p>Pelvic Inflammatory Disease (PID)</p> <p>FAX (☎) (☎) Pertussis (Whooping Cough)</p> <p>☎ Plague, Human or Animal</p> <p>FAX (☎) (☎) Poliomyelitis, Paralytic</p> <p>FAX (☎) (☎) Psittacosis</p> <p>FAX (☎) (☎) Q Fever</p> <p>☎ Rabies, Human or Animal</p> <p>FAX (☎) (☎) Relapsing Fever</p> <p>Rheumatic Fever, Acute</p> <p>Rocky Mountain Spotted Fever</p> <p>Rubella (German Measles)</p> <p>Rubella Syndrome, Congenital</p> <p>FAX (☎) (☎) Salmonellosis (Other than Typhoid Fever)</p> <p>☎ Scombroid Fish Poisoning</p> <p>☎ Severe Acute Respiratory Syndrome (SARS)</p> <p>☎ Shiga toxin (detected in feces)</p> <p>FAX (☎) (☎) Shigellosis</p> <p>☎ Smallpox (Variola)</p> <p>FAX (☎) (☎) Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)</p> <p>FAX (☎) (☎) Syphilis</p> <p>Tetanus</p> <p>Toxic Shock Syndrome</p> <p>Toxoplasmosis</p> <p>FAX (☎) (☎) Trichinosis</p> <p>FAX (☎) (☎) Tuberculosis</p> <p>☎ Tularemia</p> <p>FAX (☎) (☎) Typhoid Fever, Cases and Carriers</p> <p>Typhus Fever</p> <p>FAX (☎) (☎) <i>Vibrio</i> Infections</p> <p>☎ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)</p> <p>FAX (☎) (☎) Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash)</p> <p>FAX (☎) (☎) West Nile Virus (WNV) Infection</p> <p>☎ Yellow Fever</p> <p>FAX (☎) (☎) Yersiniosis</p> <p>☎ OCCURRENCE of ANY UNUSUAL DISEASE</p> <p>☎ OUTBREAKS of ANY DISEASE (Including diseases not listed in §2500). Specify if institutional and/or open community.</p>
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REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800-2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

Methicillin-Resistant *Staphylococcus Aureus* (MRSA)
Vancomycin-Resistant *Enterococcus* (VRE)

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health and Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty (§250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at www.ccrca.org

Appendix B

California Department of Public Health
Surveillance and Statistics Section
MS 7306, P.O. Box 997413
Sacramento, CA 95899-7413

DRAFT
February 28, 2008

**SEVERE STAPHYLOCOCCUS AUREUS INFECTION IN A PREVIOUSLY HEALTHY PERSON*
CASE REPORT**

*A **Previously Healthy Person** is defined as a person "who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or cutaneous medical device at the time of culture."

SECTION 1. INITIAL SCREENING FOR CASE DEFINITION						
Did the patient's infection result in: ICU admission <input type="checkbox"/> Yes <input type="checkbox"/> No Death <input type="checkbox"/> Yes <input type="checkbox"/> No						
If No to both of the above, patient does not meet the case definition. Please do not complete or submit this form.						
Does the patient have ANY of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
If yes, check all that apply						
<input type="checkbox"/> Hospitalized within the past year (including >48 hours prior to first <i>S. aureus</i> positive culture)						
<input type="checkbox"/> Surgery within past year			<input type="checkbox"/> Residence in long-term care within the past year			
<input type="checkbox"/> Dialysis (hemo or peritoneal) within past year			<input type="checkbox"/> Percutaneous device or indwelling catheter (e.g. BROVIAC®, foley, tracheostomy, gastrostomy)			
If ANY risk factor is checked, patient does not meet the case definition. Please do not complete or submit this form.						
SECTION 2. DEMOGRAPHIC INFORMATION						
Patient Name – Last		First	Middle Initial	Date of Birth ____/____/____	Age ____ years	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (number, street)		City	State	ZIP code	County	Telephone Number
Race (check all that apply) <input type="checkbox"/> African-American <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____				Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
If Asian/Pacific Islander, check all that apply: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____						
Occupation						
SECTION 3. CLINICAL INFORMATION						
Patient Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, Hospital Name		City		
Admit Date ____/____/____		Medical Record #				
Illness Onset Date ____/____/____		Physician Name – Last First		Telephone Number		
Chest X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal describe _____						
Was a clinically-relevant infection associated with the positive culture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
If Yes, type of infection (check all that apply)						
<input type="checkbox"/> Bacteremia		<input type="checkbox"/> Septic emboli		<input type="checkbox"/> Endocarditis		
<input type="checkbox"/> Bursitis		<input type="checkbox"/> Wound infection		<input type="checkbox"/> Skin or soft tissue infection (specify if known) _____		
<input type="checkbox"/> Pyomyositis		<input type="checkbox"/> Osteomyelitis		<input type="checkbox"/> Necrotizing fasciitis		
<input type="checkbox"/> Meningitis		<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Other infection (specify) _____		
<input type="checkbox"/> Septic arthritis		<input type="checkbox"/> Necrotizing <input type="checkbox"/> Hemorrhagic		<input type="checkbox"/> Toxic shock syndrome (see Instructions)		
Underlying condition(s) (check all that apply):						
<input type="checkbox"/> Alcohol abuse		<input type="checkbox"/> HIV/AIDS		<input type="checkbox"/> Malignancy – hematologic		
<input type="checkbox"/> Asthma		<input type="checkbox"/> IVDU		<input type="checkbox"/> Malignancy – solid organ		
<input type="checkbox"/> Eczema		<input type="checkbox"/> Diabetes mellitus		<input type="checkbox"/> Chronic renal insufficiency		
<input type="checkbox"/> Psoriasis		<input type="checkbox"/> Emphysema/COPD		<input type="checkbox"/> Current smoker		
<input type="checkbox"/> Folliculitis		<input type="checkbox"/> Heart failure/CHF		<input type="checkbox"/> Other (specify) _____		
<input type="checkbox"/> Other chronic dermatologic condition (specify) _____		<input type="checkbox"/> Immunosuppressive therapy		<input type="checkbox"/> None		
<input type="checkbox"/> Liver disease						
Past Medical History <input type="checkbox"/> Staphylococcal disease <input type="checkbox"/> MRSA infection or colonization						
Patient Outcome <input type="checkbox"/> Survived (as of ____/____/____) <input type="checkbox"/> Died (Date ____/____/____) <input type="checkbox"/> Unknown						

California Department of Public Health

SECTION 4. LABORATORY INFORMATION				
Is the isolate: <input type="checkbox"/> MRSA <input type="checkbox"/> MSSA		Culture date: ____/____/____		Hospital/clinic where culture obtained:
Site from which <i>S. aureus</i> was isolated (check all that apply)				
<input type="checkbox"/> Blood	<input type="checkbox"/> Joint	<input type="checkbox"/> Skin (swab/aspirate)	<input type="checkbox"/> Urine	<input type="checkbox"/> Cerebrospinal fluid
<input type="checkbox"/> Bone	<input type="checkbox"/> Sputum/trach	<input type="checkbox"/> Ear (drainage/aspirate)	<input type="checkbox"/> Pleural fluid	<input type="checkbox"/> Surgical specimen
<input type="checkbox"/> Nares	<input type="checkbox"/> Eye	<input type="checkbox"/> Peritoneal fluid	<input type="checkbox"/> Wound	specify _____
<input type="checkbox"/> Other (specify) _____				
Susceptibility Results (or attach laboratory report of antibiotic susceptibilities)	Susceptible	Intermediate	Resistant	Not tested or unknown
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clindamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin (or other macrolide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gentamicin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxacillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Linezolid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Synercid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trimethoprim-sulfamethoxazole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telithromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vancomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory-confirmed influenza? <input type="checkbox"/> A <input type="checkbox"/> B Type of test _____ Date ____/____/____				
SECTION 5. 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.)				
<input type="checkbox"/> Correctional facility <input type="checkbox"/> Residential care facility <input type="checkbox"/> Indian reservation <input type="checkbox"/> Pre-school/child care <input type="checkbox"/> Team sports				
SECTION 6. ASSOCIATION WITH OTHER CASES				
Was this patient's illness associated with other cases of <i>S. aureus</i> illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
If Yes, specify nature of other illness _____				
Specify nature of association with other case(s) <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Other _____				
ADDITIONAL INFORMATION				
Comments/Remarks:				
Attachments/Reports: Please attach laboratory report of antibiotic susceptibilities unless Susceptibility Results have been provided above.				
REPORTING AGENCY				
Investigator Name	Local Health Jurisdiction	Telephone Number	Date	
STATE USE ONLY				
Case Counted <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason for case classification		