Vancomycin-Intermediate and Vancomycin-Resistant *Staphylococcus aureus* (VISA/VRSA) Case Report Form

Patient Information

1. Date of Birth____/____/_____(MM/DD/YYYY) Age_____
2. Sex ☐M ☐F
3. Race ☐White ☐Black ☐American Indian/Alaskan Native ☐Asian ☐ Native Hawaiian/Pacific Islander ☐Other
4. Ethnicity ☐Non-Hispanic ☐Hispanic ☐Unknown
5. Parish of Residence_____

Infection Hospitalization

6. Was patient hospitalized ☐Y ☐N ☐UNK
7. Hospital_____
8. Physician Name_____
9. Physician Telephone#_____
10. Admit Date____/____/_____(MM/DD/YYYY)
11. Discharge Date____/____/_____(MM/DD/YYYY)
12. Clinical Diagnosis_____

Exposure History

13. In the <u>past year</u> did patient have
    - ☐Surgery
    - ☐Dialysis
    - ☐Invasive device or catheter in place at least 1 day before *S. aureus* culture collected
    - ☐Residence in a nursing home or other long-term care facility (if yes, specify below)
    - ☐Prior hospitalization (if yes, specify below)

Location	Dates of Stay

14. Does patient have prior history of MRSA? ☐Y ☐N ☐UNK
15. Date of most recent MRSA positive culture____/____/_____(MM/DD/YYYY)
16. Site_____

17. Does patient have prior history of VRE? ☐Y ☐N ☐UNK
18. Date of most recent VRE positive culture_____/_____/_____(MM/DD/YYYY)
19. Site_____

20. Has patient received vancomycin in the past year? ☐Y ☐N ☐UNK
21. Dates patient received vancomycin_____/_____/_____(MM/DD/YYYY) to _____/_____/_____(MM/DD/YYYY)

22. Is the patient a healthcare worker? ☐Y ☐N ☐UNK

Past Medical History

23. Please check all that apply

☐Congestive heart failure	☐Liver disease	☐HIV/AIDS
☐Renal disease	☐Diabetes mellitus	☐Emphysema/COPD
☐Current smoker	☐Cystic fibrosis	☐IVDU
☐Other Drug Use	☐EtOH Abuse	☐Immunosupprevise therapy
☐Neoplastic disease	☐Cerebrovascular disease	
☐Asthma	☐Neurologic or neuromuscular disease	

☐Other_____

Culture Results

24. Is the isolate ☐VISA ☐VRSA (Note: *VISA* MIC= 4-8µg/mL, *VRSA* MIC≥ 16µg/mL)

25. Vancomycin MIC_____ µg/mL

26. Date first positive VISA/VRSA_____/_____/_____(MM/DD/YYYY)

27. Hospital/Clinic where culture was obtained_____

28. Susceptibility method used
- ☐Automated susceptibility method (name of system)
- ☐Non-automated MIC
- ☐Kirby Bauer
- ☐E test
- ☐Vancomycin screening plate

29. Isolate submitted to State Lab for confirmation? ☐Y ☐N ☐UNK

30. Site from which *S. aureus* was isolated

☐Blood	☐CSF	☐Pleural Fluid	☐Peritoneal fluid
☐Joint	☐Bone	☐Surgical Specimen	☐Post-op wound
☐Skin (swab/aspirate)		☐Sputum/Trach/BAL	☐Nares
☐Ear(drainage/aspirate)		☐Eye	☐Urine

☐Other (specify)_____

31. Was culture result polymicrobial? ☐Y ☐N

a. If Yes, list other organisms_____

Treatment

32. Were antibiotics prescribed? ☐Y ☐N ☐UNK
    b. List antibiotics prescribed **before** VISA/VRSA culture results known_____
    _____
    _____
    _____
    c. List antibiotics prescribed **after** VISA/VRSA culture results known_____
    _____
    _____
    _____

33. Were other treatment modalities used (e.g. surgical intervention)? ☐Y ☐N ☐UNK
    a. If yes, specify_____

Patient Outcome

34. Patient outcome ☐Survived ☐Died
35. If the patient died, Date of Death____/____/_____(MM/DD/YYYY)
36. If patient died, cause of death_____
    a. Was VISA/VRSA causal or contributory to death? Y N UNK