

Invasive Pneumococcal Disease (Streptococcus pneumoniae)

Demographic Data

Patient name: _____
 Last First MI
 Address: _____
 Number & Street

 City County Zip
 Phone(s): () _____ () _____
 Home Work

Sex: Female Male Date of Birth: ____/____/____ Age: _____
 Race: American Indian Asian/Pacific Islander Black
 White Unknown _____
 Hispanic: Yes No Unknown

Sources of Report

Laboratory Public Health Laboratory
 Physician Infection Control Practitioner
 Other _____
 (e.g. school, camp, etc...)
 Facility name: _____
 Address, City: _____
 Submitted by: _____
 Phone: () _____ Date: ____/____/____
 First Report
 Primary physician: _____
 Phone: () _____

Clinical Data

Outcome:
 Survived
 Died Date: ____/____/____
 Unknown

Hospitalized:
 Yes No Unknown
 If Yes, Name of Hospital: _____

 Med. Record # _____
 Admission Date: ____/____/____
 Discharge Date: ____/____/____

Transferred to/from another hospital:
 Yes No Unknown
 If Yes, Transfer Hospital name: _____

 Transfer date: ____/____/____

Vaccination status:
 If ≥ 65 years old,
 Yes No Unknown
 If < 5 years old,
 No. of doses received _____
 Unknown

Laboratory Data

Date specimen collected: ____/____/____
 Specimen type (**NORMALLY STERILE SITES ONLY**):
 Amniotic Fluid Blood
 CSF Joint/synovial Fluid
 Pericardial Fluid Peritoneal Fluid
 Pleural Fluid Other _____

Antibiotic susceptibilities performed? Yes No Unknown
 If YES, specify antibiotic susceptibility results and what method(s) were used for each antibiotic.
YOU MAY ATTACH A COPY OF ANTIBIOTIC SUSCEPTIBILITY RESULTS or YOU MAY TRANSCRIBE THE RESULTS TO THE FORM.

Use the following codes to specify method used: KB for disk diffusion (Kirby-Bauer), MIC for dilution diffusion (minimum inhibitory concentration), or specify other method used.

For results, specify S=susceptible, I=intermediate resistance, or R=high resistance.

| Antibiotic Name | Result | Method(s) Used | Antibiotic Name | Result | Method(s) Used | Antibiotic Name | Result | Method(s) Used |
|-----------------|-----------|----------------|-----------------|-----------|----------------|---------------------------------|-----------|----------------|
| Azithromycin | S / I / R | _____ | Ciprofloxacin | S / I / R | _____ | Ofloxacin | S / I / R | _____ |
| Cefepime | S / I / R | _____ | Clarithromycin | S / I / R | _____ | Penicillin | S / I / R | _____ |
| Cefotaxime | S / I / R | _____ | Clindamycin | S / I / R | _____ | Rifampin | S / I / R | _____ |
| Ceftriaxone | S / I / R | _____ | Erythromycin | S / I / R | _____ | Tetracycline | S / I / R | _____ |
| Cefuroxime | S / I / R | _____ | Imipenem | S / I / R | _____ | TMP-SMX | S / I / R | _____ |
| Chloramphenicol | S / I / R | _____ | Levofloxacin | S / I / R | _____ | (Trimethoprim-sulfamethoxazole) | | |
| | | | | | | Vancomycin | S / I / R | _____ |

If not listed above, please specify antibiotic result and method used:

**PLEASE RETURN COMPLETED FORM TO FAX (888) 397-3778
 FOR QUESTIONS AND ADDITIONAL FORMS, PLEASE CALL (213) 240-7941 OR VISIT:**

<http://lapublichealth.org/acd/pneumo.htm>