Arizona Department of Health Services

Methicillin-Resistant *Staphylococcus aureus* (MRSA) Surveillance Supplemental Form (12/6/2004)

Complete this form if Methicillin-Resistant *Staphylococcus aureus* has been isolated from a normally sterile site.

Case's Name (Last Name, First Name):_____
Date of Birth___/___/_____ Race:_____ Ethnicity:_____
Address:_____City:_____State:_____Zip Code:_____

Residence/Location At Time of Onset:
☐Home ☐Long Term Care Facility ☐Acute Care Hospital ☐Retirement Home
☐Shelter ☐Homeless ☐Other, Specify_____ ☐Unknown

Date of Admission:___/___/_____ Outcome:___(1=Lived, 2=Died, 3=Transferred)

Healthcare Acquired ☐Yes ☐No (Community Acquired) ☐Unk

Disease(s) Caused By Methicillin-Resistant *Staphylococcus aureus*:
CHECK ALL THAT APPLY

☐Pneumonia ☐Skin Infection,specify:_____
☐Bacteremia ☐Meningitis ☐Septic Arthritis
☐Ottitis(Media/Externa) ☐Bursitis ☐Impetigo
☐Osteomyelitis ☐Abscess ☐Cellulitis
☐Folliculitis ☐Other, Please Specify:_____
☐Wound infection, Specify:_____

Date of Symptom Onset:___/___/_____ DNR? ☐Y ☐N ☐DK

Positive Methicillin-Resistant *Staphylococcus aureus* cultures:
Source_____Date__/___/_____
Source_____Date:___/___/_____

Categorization of Place of Onset/Population

☐Yes☐No☐Unk Previously known MRSA infection or colonization
☐Yes☐No☐Unk Hospitalized or in LTCF/Other Healthcare facility >2 Days before event
☐Hospital ☐LTC ☐Other, Specify:_____
☐Yes☐No☐Unk Chronic dialysis (hemo or PD) at time of event

☐Yes☐No☐Unk Surgery within past year
☐Yes☐No☐Unk Hospitalized or in healthcare facility within past year (but not prior two days)
☐Yes☐No☐Unk Central venous catheter or other percutaneous device or indwelling catheter currently in use
☐Yes ☐No ☐Unk Was the hospitalization intially due to MRSA infection?

Underlying Disease: ☐**Check Here If None**

CHECK ALL THAT APPLY
☐Emphysema/COPD ☐Heart Failure/CHF ☐Alcohol Abuse
☐Chronic Renal Insufficiency ☐Artherosclerotic Cardiovascualr Disease
☐Current Smoker ☐Liver Disease
☐Diabetes Mellitus ☐HIV/AIDS ☐Asthma ☐IVDU
☐Chronic Dermatologic Condition ☐Psoriasis ☐Folliculitis
☐Eczema
☐Other Immunosuppressive Therapy_____
☐ Malignancy-Solid Tumor Type:_____
☐Malignancy-Hematologic Type_____
Post Operative☐(Yes): Operative Procedure Associated With SourceDate___/___/_____

Procedure:_____(Code)_____
Flu Vaccine ☐Yes ☐No☐Unk Date__/___/_____ (**For Pneumonia Patients Only**)
Susceptibility Method: **1=Agar**: Agar Dilution Method; **2=Broth:** Bacterial Broth Dilution; **3=Disk:** Bacterial Disk Diffusion (Kirby Bauer); **4=Strip:** Antimicrobial Gradient Strip (E-Test) **8=** MIC Result of unknown method **9=Unknown**

MIC Result: Enter the numeric MIC result (i.e.,>=2)
S,I,R Results: S=Susceptible; **I**=Intermediate **R**=Resistant

Antimicrobial Agent	Susceptibility Method	MIC Results	S,I,RResults
Linozelid			
Oxacillin			
Synercid			
Vancomycin			

Form Completed By:_____Date;___/___/_____
Facility:_____Phone:_____

Mail Completed Form To: **Infectious Disease Epidemiology Section**
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