

Streptococcus pneumoniae Investigation Form

NBS Patient ID: _____

Confirmed Probable Not a Case

Patient's name: _____
Last First MI
Address: _____
City: _____ **County:** _____ **Zip:** _____
Phone 1: () _____ **Phone 2:** () _____
Date of birth: ___/___/___ **Age:** _____ **Sex:** Male Female Unknown
Race: White Black Asian Pacific Islander Native American/Alaskan
 Unknown Other: _____ **Hispanic:** Yes No Unknown
Occupation: _____
Long-term care resident: Yes, at: _____ No Unknown

Reported by: _____
Agency: _____
Phone: () _____ **Date reported:** ___/___/___
Investigated by: _____
Agency: _____
Phone: () _____
Email: _____
Investigation start date: ___/___/___

CLINICAL DATA

Physician's name: _____
Physician's phone: () _____
Date of symptom onset: ___/___/___ **Date illness ended:** ___/___/___
Did patient die? Yes, date of death: ___/___/___ No Unknown
Type of Infection (Check all that apply): Bacteremia / Sepsis Pneumonia
 Toxic Shock Syndrome Necrotizing Fasciitis Meningitis Sinusitis
 Otis Media Endocarditis Peritonitis Septic Arthritis
 Other: _____

UNDERLYING HEALTH CONDITIONS

Does the patient have any underlying health conditions?
 Yes (check all that apply) No Unknown
 Asplenia Asthma Chronic lung disease Cancer
 Cochlear implant Diabetes Heart disease
 Hemoglobinopathy HIV Kidney disease
 Organ transplant recipient Other: _____
Does the patient have high risk behaviors?
 Yes (check behaviors below) No Unknown
 Consumes raw (unpasteurized) milk/cheese
 Current smoker Intravenous drug user (IVDU)
 Alcohol abuse Other: _____

For Streptococcus pneumoniae investigations for cases under 5 years of age:

Isolate submitted to DSHS for serotyping: Yes, date ___/___/___
 No* Unknown* If no or unknown, date education provided ___/___/___

**If no or unknown, add a comment to NBS*

VACCINATION HISTORY Source of vaccine history: ImmTrac Parent Doctor School Other _____

Did the patient receive a pneumococcal vaccine? Yes No Unknown*

**Note: All possible sources of vaccination history above should be exhausted before deciding that vaccination status is "unknown". Mark boxes for all sources checked.*

1st Dose: ___/___/___ Type: _____ Manufacturer: _____ Lot #: _____
2nd Dose: ___/___/___ Type: _____ Manufacturer: _____ Lot #: _____
3rd Dose: ___/___/___ Type: _____ Manufacturer: _____ Lot #: _____
4th Dose: ___/___/___ Type: _____ Manufacturer: _____ Lot #: _____

HOSPITALIZATION INFORMATION

Was the patient seen in an emergency room? Yes, name of hospital: _____ No Unknown
Was the patient hospitalized? Yes, name of hospital: _____ No Unknown
If yes, date of admission: ___/___/___ Date of discharge: ___/___/___

LABORATORY DATA

See DSHS' [Investigation Guidance](#) for case criteria and "normally sterile site" determination

Lab Dates	Test type	Sterile specimen source	Non-sterile specimen source	Specimen collected during a surgical procedure?
Date Collected: ___/___/___ Date Final*: ___/___/___	<input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> Antigen <input type="checkbox"/> Antibody <input type="checkbox"/> Other: _____	<input type="checkbox"/> CSF <input type="checkbox"/> Blood <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Bone <input type="checkbox"/> Joint fluid (no abscess) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Wound <input type="checkbox"/> Urine <input type="checkbox"/> Skin <input type="checkbox"/> Throat <input type="checkbox"/> Joint fluid (abscess present) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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**Date Final = Lab Report Date in a NEDSS ELR; if a non-specific test collected, such as a blood or CSF culture, this is also the earliest date suspected in NEDSS*

COMMENTS