TEXAS Health and Human Services | Texas Department of State Health Services

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: ____

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*

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: ____________________

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 Resulted: ___/____/____	☐ Culture ☐ PCR ☐ Antigen ☐ Antibody ☐ Other: ________	☐ CSF ☐ Blood ☐ Pericardial fluid ☐ Bone ☐ Joint fluid (no abscess) ☐Other:____________	☐ Wound ☐ Urine ☐ Skin ☐ Throat ☐ Joint fluid (abscess present) ☐Other:______________	☐ Yes ☐ No ☐ Unknown
Date Collected: ___/____/____ Date Resulted: ___/____/____	☐ Culture ☐ PCR ☐ Antigen ☐ Antibody ☐ Other: ________	☐ CSF ☐ Blood ☐ Pericardial fluid ☐ Bone ☐ Joint fluid (no abscess) ☐Other:____________	☐ Wound ☐ Urine ☐ Skin ☐ Throat ☐ Joint fluid (abscess present) ☐Other:______________	☐ Yes ☐ No ☐ Unknown

COMMENTS