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_________________ Unk

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
- Bacteremia
- Skin Infection, specify:________________
- Meningitis
- Septic Arthritis
- Otitis (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 initially 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 Cardiovascular 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 Source Date ___/___/_____

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

<table>
<thead>
<tr>
<th>Antimicrobial Agent</th>
<th>Susceptibility Method</th>
<th>MIC Results</th>
<th>S,I,R Results</th>
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<tbody>
<tr>
<td>Linozelid</td>
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<td>Oxacillin</td>
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<td>Vancomycin</td>
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Form Completed By:______________________________________ Date: ___/___/_____
Facility:_____________________________________ Phone:___________

Mail Completed Form To:    Infectious Disease Epidemiology Section
150 North 18th Ave, Suite 140
Phoenix, AZ 85007
Fax   602-364-3199
Phone 602-364-3676