Methicillin-Resistant *Staphylococcus aureus* (MRSA) Surveillance Supplemental Form
Arizona Department of Health Services

PATIENT DEMOGRAPHICS

Name (last, first)_____ Birthdate___/___/____ or age_____ Sex: ☐M ☐F ☐UK

Street address_____ City_____ State_____ Zip_____

Occupation/school grade:_____ Employers/school/other:_____

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Race: ☐White ☐African American ☐Native Hawaiian/Pac Islander ☐Asian ☐American Indian/ AK Native ☐Other_____

Patient Chart Number:_____

Where was the patient located on the 4th calendar day prior to the date of initial culture?

☐ Private residence ☐ Homeless ☐Retirement home
☐ Long term care facility ☐ Incarcerated ☐Unknown
☐ Long term acute care facility ☐ Hospital Inpatient ☐Other (specify):_____

If resident of a facility, what was the name of facility?_____

Was patient transferred from another hospital?
☐Y ☐N ☐UK
If yes, hospital name:
_____

CLINICAL INFORMATION

Date of Onset of symptoms: ____/____/_____

Diagnosis Date: ____/____/_____

Disease caused by MRSA
(check all that apply)

☐ Abscess
☐ AV Fistula/Graft Infection
☐ Bacteremia
☐ Bursitis
☐ Catheter Site Infection
☐ Cellulitis
☐ Chronic Ulcer/Wound
☐ Decubitus/Pressure Ulcer
☐ Empyema
☐ Endocarditits
☐ Folliculitis
☐ Impetigo
☐ Meningitis
☐ Peritonitis
☐ Pneumonia
☐ Ottitis (Media/Externa)
☐ Osteomyelitis
☐ Septic Arthritis
☐ Septic Emboli
☐ Skin Abscess
☐ Surgical Site (specify)_____
☐ Traumatic wound
☐ Urinary Tract Infection
☐ Other (specify): _____

Categorization of Place of Onset/Population

	Y	N	UK
Previously known MRSA infection	☐	☐	☐
Chronic dialysis (hemo or PD) at time of event?	☐	☐	☐
Central venous catheter of other percutaneous device currently in use?	☐	☐	☐
Were cultures of the same or other sterile sites positive within 30 days after initial culture date?	☐	☐	☐
Was the hospitalization initially due to MRSA infection?	☐	☐	☐
Hospitalized or in healthcare facility within past year (but not prior days)	☐	☐	☐
Flu Vaccine (for pneumonia patients only)	☐	☐	☐

Did the patient have surgery within year before initial culture date?
☐Y ☐N ☐UK
If yes, date:____/____/____

At the time of 1st positive culture, patient was:
☐Pregnant ☐Post-partum
☐Neither ☐Unknown

Was culture collected >3 calendar days after hospital admission?
☐ Yes (HO-MRSA)
☐ No (CA-MRSA or HACO MRSA)

Hospitalization
(Was the patient hospitalized at the time of, or within 30 calendar days after, initial culture?)

Admit date:___/____/____ Discharge date: ___/____/____

Hospital Name:_____ Hospital Address:_____

Y= Yes **N=No** **U=Unknown**

Past Medical History and Underlying Conditions (check all that apply)

☐ Abscess/Boil (Recurrent)	☐ Current Smoker	☐ Other Drug Use
☐ Acute Varicella	☐ Dementia	☐ Paralysis
☐ AIDS	☐ Diabetes	☐ Peptic Ulcer Disease
☐ Alcohol Abuse	☐ Hematologic Malignancy	☐ Peripheral Vascular Disease
☐ Asthma	☐ Hemiplegia/Paraplegia	☐ Premature Birth
☐ Blunt Trauma	☐ HIV	☐ Renal failure w/dialysis
☐ Bone Marrow Transplant	☐ Influenza (within 10 days of initial culture)	☐ Seizure
☐ Chronic Heart Disease		☐ Sickle cell disease
☐ Chronic Kidney Disease	☐ IVDU	☐ Solid Tumor
☐ Chronic Pulmonary Disease	☐ Metastatic Solid Tumor	☐ Tobacco Use
☐ Chronic Skin Breakdown	☐ Myocardial Infaract	☐ Vasculitis/Lupus (SLE)
☐ Cirrhosis	☐ Obesity	☐ Other (specify)_____

Outcome of illness

☐ Survived ☐ Died Date of death:___/___/____ ☐ Transferred ☐ Unknown

If patient is deceased: Death Certificate Number:_____ Cause of death_____

LABORATORY INFORMATION

Culture Positive from sterile site:

Source_____	Date:____/____/_____	Lab name:_____
Source_____	Date:____/____/_____	Lab name:_____
Source_____	Date:____/____/_____	Lab name:_____
Source_____	Date:____/____/_____	Lab name:_____

SUSCEPTIBILITY METHOD

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

Susceptibility Method: 1=Agar Dilution Method 2=Bacterial Broth Dilution 3=Bacterial Disk Diffusion 4=Antimicrobial Gradient Strip 8=MIC Result of unknown method 9=Unknown

S,I,R Results: S=Susceptible I=Intermediate R=Resistant

ADDITIONAL NOTES AND INFORMATION

FORM COMPLETED BY:_____ **DATE:**____/_____/_____

FACILITY:_____ **PHONE:**_____

Office of Infectious Disease Services
150 North 18th Avenue,
Phoenix, AZ 85007
Phone: 602-364-3676 FAX: 602-364-3199

METHODS OF SUBMISSION
1. Attach form to MEDSIS case
OR
2. Fax it to (602)-364-3199

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