Toxic Shock Syndrome

Agency:

Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: First and middle name: Maiden name: Suffix: Address line: Zip: City: State: County: Phone: ( )- - Type: Long-term care resident: ☐ Yes ☐ No ☐ Unknown Facility name:

Date of Birth: / / Estimated? ☐ Age:

Gender: ☐ Female ☐ Male ☐ Other ____

Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed

Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Parent/Guardian name:

Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of Death / /

Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Outbreak name:

Exposure setting:

Epi-linked: ☐ Yes ☐ No ☐ Unknown

Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown

State: Country:

Healthcare provider information

Last name:

First name:

Provider title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP

Facility name:

Address line 1:

Address line 2:

Zip code: City:

State: County:

Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Test type:

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Type (e.g. serotype):

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Test type:

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Type (e.g. serotype):

Laboratory: _____ Accession #: _____ Collection date: / /

Date received: / / Specimen source: _____ Test type: _____

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Type (e.g. serotype):

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: Job title:

Worked date(s)
Symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name:
Date worked from: / / Address:
Date worked to: / / Zip code:
Removed from duties ☐ Yes ☐ No ☐ Unknown City: State: County:
Date removed: / / Phone: ( ) Type:
Handle food ☐ Yes ☐ No ☐ Unknown Work in a health care setting ☐ Yes ☐ No ☐ Unknown
Attend or provide child care ☐ Yes ☐ No ☐ Unknown Direct patient care duties in lab or health care setting ☐ Yes ☐ No ☐ Unknown
Attend school ☐ Yes ☐ No ☐ Unknown
Work in a lab setting ☐ Yes ☐ No ☐ Unknown Health care worker type:

Occupation type: Job title:

Worked date(s)
Symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name:
Date worked from: / / Address:
Date worked to: / / Zip code:
Removed from duties ☐ Yes ☐ No ☐ Unknown City: State: County:
Date removed: / / Phone: ( ) Type:
Handle food ☐ Yes ☐ No ☐ Unknown Work in a health care setting ☐ Yes ☐ No ☐ Unknown
Attend or provide child care ☐ Yes ☐ No ☐ Unknown Direct patient care duties in lab or health care setting ☐ Yes ☐ No ☐ Unknown
Attend school ☐ Yes ☐ No ☐ Unknown
Work in a lab setting ☐ Yes ☐ No ☐ Unknown Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / Discharge date: / / Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Fever: ☐ Yes ☐ No ☐ Unk Onset date: / / Highest known fever: C/F

Rash: ☐ Yes ☐ No ☐ Unk Rash characteristics:

- ☐ Burning
- ☐ Confluent lesions
- ☐ Could be felt (papule)
- ☐ Could not be felt (macule)
- ☐ Discrete lesions
- ☐ Distinct sharp borders
- ☐ Marked itching
- ☐ Dusky brown
- ☐ Numbness
- ☐ Painful
- ☐ Peeling skin
- ☐ Pustule
- ☐ Reddish
- ☐ Scaling/crusting

Soft tissue necrosis: ☐ Yes ☐ No ☐ Unk

Necrotizing fascitis present: ☐ Yes ☐ No ☐ Unk **DIC:** ☐ Yes ☐ No ☐ Unk **Lowest systolic blood pressure:** _____

Other symptoms present:

- ☐ Abdominal pain
- ☐ Confusion
- ☐ Conjuntival hyperemia
- ☐ Diarrhea
- ☐ Injected tongue
- ☐ Muscle pain
- ☐ Oropharyngeal hyperemia
- ☐ Seizures
- ☐ Sore throat
- ☐ Vaginal discharge
- ☐ Vaginal hyperemia
- ☐ Vaginal ulceration
- ☐ Vomiting

OTHER LAB FINDINGS

CBC performed: ☐ Yes ☐No ☐ Unk

WBC count (in mm3): _____

Neutrophils (in %): _____

Metamyelocytes (in %): _____

Myelocytes (in %): _____

Bands (in %): _____

Platelet count (in mm3): _____

Highest platelet value (in mm3): _____

Bilirubin (in mg/dl): _____

Creatine (in mg/dl): _____

Creatine phosphokinase (in IU/l): _____

Hypoalbuminemia: ☐ Yes ☐No ☐ Unk

Pyuria: ☐ Yes ☐No ☐ Unk

ALT performed: ☐ Yes ☐No ☐ Unk

Result (in IU/l): _____

Expected minimum (in IU/l): _____

Expected maximum (in IU/l): _____

AST performed: ☐ Yes ☐No ☐ Unk

Result (in IU/l): _____

Expected minimum (in IU/l): _____

Expected maximum (in IU/l): _____

Urinalysis performed: ☐ Yes ☐No ☐ Unk

WBC/HPF(in cells/mcl): _____

RBC/HPF (in cells/mcl): _____

Protein: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Chest x-ray done: ☐ Yes ☐No ☐ Unk Date: ___/___/___ Result: _____

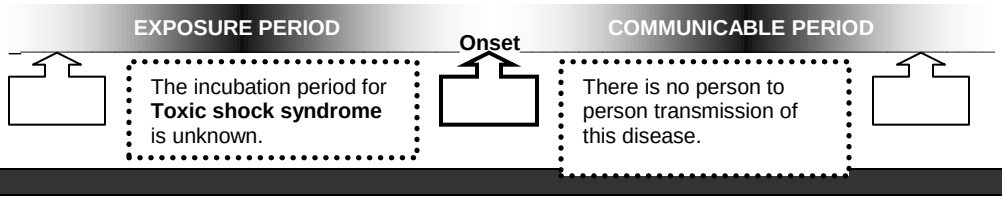
TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:	Antibiotic:	Antibiotic:
Date started: ___/___/___	Date started: ___/___/___	Date started: ___/___/___
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU # of days:	Unit: ☐ mg ☐ ml ☐ IU # of days:	Unit: ☐ mg ☐ ml ☐ IU # of days:
# of times a day: Route:	# of times a day: Route:	# of times a day: Route:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Similar illness in past: ☐ Yes ☐No ☐ Unk # of episodes: ☐ 1 ☐ 2 ☐ 3 ☐ >3

Tampon used: ☐ Yes ☐No ☐ Unk

Brand name: ☐ Assure ☐ Kotex ☐ OB ☐ Playtex ☐ Pursettes ☐ Rely ☐ Other _____ ☐ Store brand ☐ Tampax

Insertion type: ☐ Plastic inserter ☐ Stick inserter

Odor protection type: ☐ Deodorized ☐ Non-deodorized

Absorbency: ☐ Lite ☐ Regular ☐ Super ☐ Super plus

Napkin used: ☐ Yes ☐No ☐ Unk

Brand name: _____

Odor protection type: ☐ Deodorized ☐ Non-deodorized

Absorbency: ☐ Lite ☐ Regular ☐ Super ☐ Super plus

Sponge or diaphragm used: ☐ Yes ☐No ☐ Unk

Postpartum/ post abortion: ☐ Yes ☐No ☐ Unk

Mini-pad used: ☐ Yes ☐No ☐ Unk

Brand name: _____

Odor protection type: ☐ Deodorized ☐ Non-deodorized

Absorbency: ☐ Lite ☐ Regular ☐ Super ☐ Super plus

Surgical procedures: ☐ Yes ☐No ☐ Unk

Skin lesions (scratch or cut): ☐ Yes ☐No ☐ Unk

NOTES: