



GERMS-SA CASE REPORT FORM FOR ENHANCED SURVEILLANCE SITES

National Microbiology Surveillance Unit (NMSU)
TEL: 011 386 6234 OR 011 555 0353
FAX: 011 386 6077



Surveillance officer name:		Signature:		Date:	
Sources of data: Patient/Guardian <input type="checkbox"/>		Clinician <input type="checkbox"/>		Medical records <input type="checkbox"/>	
				No record found <input type="checkbox"/>	
Lab Specimen No: <input type="text"/>			Laboratory Name:		
Hospital Name:		Hospital Number:		Ward: Adult Ward <input type="checkbox"/>	
				Paed Ward <input type="checkbox"/>	
Gender: M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/>		Race: Asian <input type="checkbox"/> Black <input type="checkbox"/> Coloured <input type="checkbox"/> White <input type="checkbox"/> Unk <input type="checkbox"/>			
Date of Birth: <input type="text"/>		DOB Unk <input type="checkbox"/>		Age: <input type="text"/> Unit: Days <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Age Unk <input type="checkbox"/>	
Patient Surname:			Patient First Names:		
Address:			Town/City:		Province:
Tel no: (H) <input type="text"/>		(W) <input type="text"/>		(C) <input type="text"/>	
				(Neighbour) <input type="text"/>	
Has patient stayed in SA for the last month: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>		If no, which country has patient come from:			
ID No. <input type="text"/>		Unk <input type="checkbox"/>		ARV No. <input type="text"/>	
				Unk <input type="checkbox"/>	
Was patient referred from a hospital or chronic care facility: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> If yes, specify:					
Date of admission to acute hospital: <input type="text"/>		Unk <input type="checkbox"/>			
Was patient transferred to a step down hospital: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>		Date of transfer: <input type="text"/>			
If yes, name of step down hospital:					
Final outcome of patient: Discharged <input type="checkbox"/> Died <input type="checkbox"/> RHT/ Absconded <input type="checkbox"/> Unk <input type="checkbox"/>		Outcome date: <input type="text"/>			
If discharged, patient discharged to: Home <input type="checkbox"/> TB Hosp/Chronic care facility <input type="checkbox"/> Other <input type="checkbox"/>		Specify: <input type="text"/> Unk <input type="checkbox"/>			
<u>Discharge diagnosis:</u>					
Meningitis <input type="checkbox"/> LRTI <input type="checkbox"/> Dysentery <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Fungaemia/Bacteraemia without focus <input type="checkbox"/> Other <input type="checkbox"/> Specify:					
<u>Organism isolated:</u>		Cryptococcus sp. <input type="checkbox"/>		Date of specimen collection: <input type="text"/>	
Haemophilus sp. <input type="checkbox"/> N. meningitidis <input type="checkbox"/> Shigella sp. <input type="checkbox"/>		Site of specimen collection: CSF <input type="checkbox"/> Blood <input type="checkbox"/>			
S. pneumoniae <input type="checkbox"/> P. jirovecii <input type="checkbox"/> Salmonella sp. <input type="checkbox"/>		Joint Fluid <input type="checkbox"/> Other <input type="checkbox"/> Specify			
<u>Severity of illness (on the day the positive specimen was taken):</u>					
Temp: °C Unk <input type="checkbox"/>		BP: / Unk <input type="checkbox"/>		Mechanical Ventilation: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	
				Cardiac Arrest: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	
GCS: /15 Unk <input type="checkbox"/>		Mental Status: Alert <input type="checkbox"/> Disorientated <input type="checkbox"/> Stuporous <input type="checkbox"/> Comatosed <input type="checkbox"/> Unk <input type="checkbox"/>			
Previous admissions in the last 12 months: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>				Number of admissions: <input type="text"/>	
<u>Cotrimoxazole prophylaxis and TB treatment (from the last 3 months and current)</u>					
Cotrimoxazole prophylaxis: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>		Dosage:		Date initiated: <input type="text"/>	
				Compliant in last month: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	
TB Treatment: Drugs:		1. <input type="text"/>		Date initiated: <input type="text"/>	
		2. <input type="text"/>		Date stopped: <input type="text"/>	
Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>		3. <input type="text"/>			
		4. <input type="text"/>			



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Laboratory Specimen Number:		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Immunocompromising conditions:			
Alcohol dependency <input type="checkbox"/>	Chronic renal failure <input type="checkbox"/>	Heart failure <input type="checkbox"/>	Kwashiorkor/ Marasmus <input type="checkbox"/> Valvular heart disease <input type="checkbox"/> Unknown <input type="checkbox"/>
Asthma <input type="checkbox"/>	Current smoker <input type="checkbox"/>	History of head injury/head surgery <input type="checkbox"/>	Nephrotic syndrome <input type="checkbox"/> Malignancy <input type="checkbox"/> Specify: _____
Burns <input type="checkbox"/>	Coronary Artery Disease <input type="checkbox"/>	Hydrocephalus with VP shunt <input type="checkbox"/>	Sickle cell anaemia <input type="checkbox"/> Organ transplant <input type="checkbox"/> Specify: _____
CVA/Stroke <input type="checkbox"/>	Diabetes mellitus <input type="checkbox"/>	Immunoglobulin deficiency <input type="checkbox"/>	Splenectomy/ asplenia <input type="checkbox"/> Other <input type="checkbox"/> Specify: _____
Cirrhosis/ liver failure <input type="checkbox"/>	Emphysema/COPD <input type="checkbox"/>	Immunosuppressive rx (steroid,chemo) <input type="checkbox"/>	Systemic Lupus Erythematosus (SLE) <input type="checkbox"/> None <input type="checkbox"/>
HIV status prior to this admission:		Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk <input type="checkbox"/>	HIV related counseling offered by SO: Yes <input type="checkbox"/> No <input type="checkbox"/>
HIV status at this admission:		Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk <input type="checkbox"/>	HIV test performed by SO: Yes <input type="checkbox"/> No <input type="checkbox"/>
For children <18 months: HIV PCR Done:		Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	If HIV unknown, is there clinical suspicion of HIV: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>
If HIV unknown, why was patient not tested:		Patient died <input type="checkbox"/>	Patient not seen <input type="checkbox"/> No guardian <input type="checkbox"/> Unk <input type="checkbox"/>
		Refused consent <input type="checkbox"/>	Reason for refusal: _____
CD4 count closest to specimen collection date:		Absolute: Unk <input type="checkbox"/>	Date taken: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		Percentage: % Unk <input type="checkbox"/>	
Viral load closest to specimen collection date:		<400 <input type="checkbox"/> 400-10 000 <input type="checkbox"/> >10 000 <input type="checkbox"/> Unk <input type="checkbox"/>	Date taken: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clinical markers of HIV:		Diarrhoea >10days <input type="checkbox"/>	Oral candidiasis <input type="checkbox"/> Suspected PCP <input type="checkbox"/> None <input type="checkbox"/>
		Kaposi sarcoma <input type="checkbox"/>	Tuberculosis <input type="checkbox"/> HIV wasting <input type="checkbox"/> Unk <input type="checkbox"/>
Any antiretroviral use: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>		If yes: Current <input type="checkbox"/>	Previous <input type="checkbox"/> Perinatal <input type="checkbox"/> Unk <input type="checkbox"/>
Current antiretroviral use:		3TC <input type="checkbox"/> D4T <input type="checkbox"/> Efavirenz <input type="checkbox"/> Nevirapine <input type="checkbox"/> AZT <input type="checkbox"/> DDI <input type="checkbox"/> Kaletra <input type="checkbox"/> Unk <input type="checkbox"/>	
Date initiated: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Other ARVs: _____	
If HIV positive and no ARV use, has the patient been referred to an ARV clinic:		Yes <input type="checkbox"/> No <input type="checkbox"/> Died <input type="checkbox"/> Unk <input type="checkbox"/>	

PLEASE COMPLETE RELEVANT SECTIONS FOR SPECIFIED ORGANISMS

<i>Haemophilus spp., S. pneumoniae, N. meningitidis, Salmonella spp., Shigella spp. ONLY</i>			
Number of children, <18 years, living with patient:		None <input type="checkbox"/> Number <input type="text"/>	Place of safety <input type="checkbox"/> Unk <input type="checkbox"/>
Have any of these children been hospitalised in the last 3 months:		Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	
Antibiotic use prior to this admission:			
ABX in 24hr before specimen:		Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	Date initiated: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name of antibiotic:		1. _____	2. _____
		3. _____	4. _____
Other ABX in last 2 months:		Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	In last 30 days: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>
Name of antibiotic:		1. _____	2. _____
		In last 30 to 60 days: Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	
Antibiotic use in hospital during this admission (excluding TB therapy)			
Weight: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg Unk <input type="checkbox"/>		Antimicrobial therapy unknown: <input type="checkbox"/>	Antimicrobial therapy not prescribed: <input type="checkbox"/>
Name of antimicrobial	Dose	Route	Date initiated
		Total doses given/no. of days	
1.			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2.			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3.			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4.			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5.			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



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Laboratory Specimen Number:

Haemophilus spp. and S. pneumoniae ONLY

Vaccination status for *Haemophilus influenzae*:

If <15 years of age, did patient receive *Haemophilus influenzae* type b vaccine: Yes No Unk

Dose	Date given	Name of clinic	If patient received vaccine, was there documented proof of vaccine:
1	D D M M Y Y Y Y		Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>
2	D D M M Y Y Y Y		
3	D D M M Y Y Y Y		

Vaccination status for *Streptococcus pneumoniae*:

If <15 years of age, did patient receive pneumococcal conjugate vaccine: Yes No Unk

Has the patient (**all ages**) received 23-valent polysaccharide vaccine: Yes No Unk

Dose	Date given	Name of clinic	If yes, give date most recently given and vaccine name:
1	D D M M Y Y Y Y		i. Most recent date given:
2	D D M M Y Y Y Y		ii. Vaccine name: _____
3	D D M M Y Y Y Y		

Cryptococcus spp. ONLY

Antifungals prior to this admission: Weight . kg Unk

Fluconazole Yes No Unk If yes, date initiated Dose _____ Daily BD

Amphotericin B Yes No Unk If yes, date initiated Dose _____

Is this the first episode of cryptococcosis? Yes No Unk

Management during this admission:

Dose	Frequency	Date initiated	Total number of doses/ number of days
Fluconazole	Daily <input type="checkbox"/> BD <input type="checkbox"/>	D D M M Y Y Y Y	
Amphotericin B	Daily <input type="checkbox"/> BD <input type="checkbox"/>	D D M M Y Y Y Y	
Rifampicin	Daily <input type="checkbox"/>	D D M M Y Y Y Y	
Antifungal therapy unknown <input type="checkbox"/>	Antifungal therapy not prescribed <input type="checkbox"/>		

Was opening intracranial pressure documented at time of first LP? Yes No Unk

If yes, what was the recorded opening pressure: _____ cm H₂O Unk

On discharge, was patient given fluconazole: Yes No Unk Died Discharge dose _____ Daily BD

Pneumocystis jirovecii ONLY

Admission pulse oximeter reading off oxygen % Unk

PCP treatment during this admission: Weight . kg Unk

Dose	Route	Date initiated	Total number of doses/ number of days
Cotrimoxazole		D D M M Y Y Y Y	
Dapsone		D D M M Y Y Y Y	
Other		D D M M Y Y Y Y	
Prednisone		D D M M Y Y Y Y	
Hydrocortisone		D D M M Y Y Y Y	
PCP therapy unknown <input type="checkbox"/>	PCP therapy not prescribed <input type="checkbox"/>		

On discharge was patient given cotrimoxazole: Yes No Unk Died Discharge dose/ number of days: _____