Form Approved
OMB# 0929-1011
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Appendix 1: Case Investigation Form

Elizabethkingia Meningoseptica
Case Investigation Form

This form is intended to interview patients in Wisconsin with:

- Bloodstream isolates of *Elizabethkingia meningoseptica*.

  AND
- The blood specimen was collected after November 1, 2015

When initiating an interview, please use the script appropriate to a participant as a **case or control** in the **case-control** investigation.

Was consent given: ☐ Yes ☐ No (**DO NOT PROCEED**)

Contact Information

Patient contact information	Proxy contact information (if applicable):
(gather at least State and Zip Code, even if proxy was interviewed):	Name: _____
Name: _____	Relation to patient: ☐ Relative: _____
Address: _____	☐ Clinician ☐ Other: _____
City, State, Zip: _____	Address: ☐ Same as patient
Phone: ( ) _____	_____
	City, State, Zip: _____
	Phone: ( ) _____

Interview Information

Date reported to health department: ___/___/_____ (MM/DD/YYYY) ☐ Not applicable, why? _____

Date interview completed: ___/___/_____ (MM/DD/YYYY) ☐ Not applicable. Why? _____

Interviewer: Name: _____

Affiliation (state health dept. or CDC): _____

State Epi ID:_____ State Lab ID:

_____

For interviewer use only:

Information on this report was collected through (*check all that apply*): ☐ Patient/proxy interview ☐ Medical Record Review ☐ Review of health department notes ☐ Other: _____

Must be filled BEFORE faxing to DPH:

Does this patient have laboratory-confirmation of *Elizabethkingia meningoseptica* bloodstream infection? ☐ Yes ☐ No (**STOP** interview)

Patient Provider (*Patient interview or Medical Record Review*)

1. Primary care provider name: -

   _____

2. Location and phone number of Primary care provider:

   _____

Demographic Information (*Medical Record Review and Patient Interview*)

3. Date of birth: ____/____/_____ (MM/DD/YYYY)
4. What state do you live in? _____
5. What is your race: (*check all that apply*) ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander
6. What is your ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
7. What is your sex: ☐ Male ☐ Female

Facility at time of first positive culture *(Medical Record Review)*

8. Date of admission: ____/____/_____ (MM/DD/YYYY)
9. Name of current facility: _____
10. Facility type: _____
11. Unit patient located at time of culture collection:

Facility at time of Exposure *(Medical Record Review)*

12. Date of admission/outpatient visit: ____/____/_____ (MM/DD/YYYY)
13. Name of facility: _____
14. Facility type: _____

Incident *E. meningoseptica (Medical Record Review)*

15. Date of Culture: ____/____/_____ (MM/DD/YYYY)
16. Source of culture: _____
17. Susceptibility_____
18. List antibiotic exposure before positive culture during the inpatient admission _____
19. Indwelling devices at time of culture _____

Laboratory Information (*Medical Record Review*)

20. PFGE pattern (specify):

Risk factors (*Medical Record Review*)

21. Inpatient Antimicrobial history: List antibiotics used during past 3 months, indication and duration.

Antibiotics	Indication	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antibiotics

22. Outpatient Antimicrobial history: List of antibiotics used during the past 3 months, indication and duration.

Antibiotics	Indication	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antibiotics

Multidrug Resistant Organism (MDRO) *Medical Record Review*

23. During the past year have has the patient had infection with a multidrug resistant organism (MDRO) ☐ Yes
☐ No (Skip to Question 27)

Organism	Antibiotic Susceptibility Testing	Site of Infection	Facility (name and location) at time of Diagnosis	Incident Date (MM/DD/YYYY)

Medical History – Comorbidity Scale (*Patient Interview and Medical Record Review*)

24. ***Females only:*** Were you pregnant or ≤6 weeks postpartum when the illness began?
☐ Yes, pregnant (weeks pregnant at onset)_____ ☐Yes, postpartum (delivery date) ___/___/____ (MM/DD/YYYY) ☐ No ☐ Unknown

Do you have any of the following medical conditions? ***Please ask about each condition and specify <u>ALL</u> conditions that are present.***

25. Myocardial Infarction	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
26. Congestive Heart Failure	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
27. Peripheral Vascular Disease	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
28. Cerebrovascular Disease	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
29. Dementia	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
30. Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
31. Peptic Ulcer Disease	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
32. Diabetes Mellitus, uncomplicated	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
33. Diabetes Mellitus, complicated (end-organ damage)	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
34. Moderate to Severe Chronic Kidney Disease	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
35. Hemiplegia	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
36. Leukemia	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
37. Malignant Lymphoma	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
38. Solid Tumor	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
39. Liver Disease	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
40. AIDS	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown
41. History of decubitus ulcers	☐ Yes	(If YES, specify location) _____	☐ No	☐ Unknown
42. Height	_____			
43. Weight	_____			
44. Other (please specify)	☐ Yes	(If YES, specify) _____	☐ No	☐ Unknown

Dialysis (*Medical Record Review*)

45. List dialysis in the past year. If chronic, list dialysis days, and dialysis center (facility name, and phone number).

Type of dialysis (i.e. hemodialysis, peritoneal dialysis)	Indication	Type, and date of access (i.e. fistula, line) (MM/DD/YYYY)	Dialysis days (MM/DD/YYYY)	Location (for chronic dialysis name dialysis center)

Inpatient and Outpatient Surgical or Procedure History (*Medical Record Review)*

46. List surgical procedures in the past year.

Surgery/Procedure	Indication	Date of Surgery (MM/DD/YYYY)	Hospitalization Admission and Discharge (MM/DD/YYYY)	Total number of days receiving antibiotics

Immunosuppressant use (*Medical Record Review*)

47. Immunosuppressant history: List immunosuppressant used in past 6 months, indication and duration (prednisone 20 mg administered daily for ≥ 2 weeks would be considered an immunosuppressant), include chemotherapy and radiation therapy.

Immunosuppressant	Indication	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving drug

Activities (*Patient Interview*)

48. In the past year have you been to the dentist? ☐ Yes ☐ No (*Skip to Question 52*)

49. List types of procedures (cleaning, tooth extraction)? _____

50. What is your water supply? ☐ Well ☐ City or Municipal water ☐ Other, specify _____

51. Do you have a humidifier at home? ☐ Yes ☐ No

52. In the past year before you became ill, did you do any of the following activities either at home or while traveling:

Exposure	Yes	No	Location	Date(s) (MM/DD/YYYY)
Swimming				
Water aerobics				
Snorkeling				
Scuba diving				
Splash pad, water park				
Steam room, or wet sauna				
Hot tub or whirlpool/spa				

Healthcare Exposure (*Patient Interview*)

53. In the past year before you became ill, did you receive any intravenous infusions (infusions through the vein) for medicines, vitamins? ☐ Yes ☐ No (*Skip to Question 56*)

Medication/Vitamin or Substance	Facility or Location (Address/Phone number)	Date(s) (MM/DD/YYYY)

54. In the past three months before you became ill, were any central, peripheral lines or catheters inserted (for example, intravenous line, dialysis line)
☐ Yes ☐ No (*Skip to Question 57*)

Intravenous Line	Facility or Location (Address/Phone number)	Date of Insertion (MM/DD/YYYY)

55. In the past year have you been admitted to long term care facility, long term acute care hospital or an acute care hospital in Wisconsin, out of state or outside the country?

☐ Yes ☐ No (*Skip to Question 59*)

56. List facilities in Wisconsin and out of state or country that you have been admitted to with location and dates in the last year (including multiple stays or admissions).

Name and Type of Facility (LTCF, LTACHs, Acute Care Hospital)	Location (Address and phone number)	Indication	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days

57. Any travel outside of the U.S. in the last year? ☐ Yes ☐ No (*Skip to Question 61*)
58. If yes, please list countries visited in the last year. -
    _____
59. In the last year have you had any medical devices (i.e. peripheral intravenous catheter, pacemaker, PEG/J)? ☐ Yes ☐ No
60. In the last year have you received home health services? ☐ Yes ☐ No

61. Any additional comments or notes (e.g. travel details, additional visits to healthcare providers, other diagnostic testing, and information)?

This is the end of the interview. Thank you very much for your time.
If you have any questions please feel free to contact Wisconsin Division of Public Health at 608-267-9003.

Interviewer: Please fax completed forms to 608-261-4976