Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

# Undetermined source for *Salmonella* Infantis infections among detention center inmates — South Carolina, 2016

## *Chart abstraction form to be used by federal employees*

Public reporting burden of this collection of information is estimated to average 0 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

## MEDICAL RECORD ABSTRACTION FORM

**CDC ID:** ☐☐☐☐ **Date:** ☐☐/☐☐/☐☐ **Data collector initials:** _____

1. **Patient's Name:**
2. **Unit:**
3. **DOB:** ☐☐/☐☐/☐☐☐☐
4. **When was the first documented episode of diarrhea:** ☐☐/☐☐/☐☐☐☐
5. **Admission date:** ☐☐/☐☐/☐☐☐☐
6. **Discharge date:** ☐☐/☐☐/☐☐☐☐

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### Part 1. Demographic Information

**1. Gender:** ☐M ☐F ☐Unknown

**2. Race** *(check all that apply)*

☐American Indian or Alaska Native ☐Asian
☐Black or African American ☐White
☐Native Hawaiian/other Pacific Islander ☐Unknown
☐Other race

**3. Ethnicity**

☐Hispanic or Latino
☐Not Hispanic or Latino
☐Unknown

**4. Unit of residence:** ____________ ☐Unknown

**5. Underlying conditions** *(check all that apply)* ☐None ☐Unknown

☐Asplenia
☐Autoimmune disease
☐Cancer, any (incl. leukemia/lymphoma)
☐Chronic kidney disease (with or without dialysis)
☐Chronic liver disease (incl. cirrhosis)
☐Chronic pulmonary disease (incl. COPD/emphysema, asthma)
☐Congestive heart failure
☐Connective tissue disease
☐Diabetes mellitus
☐Gastroesophageal reflux disease (GERD)
☐HIV/AIDS
☐Ischemic heart disease/Myocardial infarction/Peripheral vascular dz
☐IVDU in past year
☐Peptic ulcer disease
☐Pregnancy (current)
☐Prosthetic device or vascular graft
☐Recurrent cystitis or urinary tract infection
☐Sickle cell disease
☐Smoking in past year
☐Transplant (incl. solid organ, hematopoietic stem cell, bone marrow)
☐Other ________________________

**6. How long did the patient remain in the medical unit?**

__________ ☐Hours ☐Days ☐Did not go to medical unit ☐Unknown

**7. In the 30 days <u>prior</u> to illness onset, did the patient receive any form of antacid?:** *(check all that apply)*

| Y | N | Unk | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | a. Calcium carbonate (may be taken for heartburn/indigestion)? *[Common medication names include Tums, Maalox, Mylanta, Rolaids]* | Name(s): __________ |
| ☐ | ☐ | ☐ | b. H2 receptor blocker (may be taken for peptic ulcer disease)? [Common medication names include cimetidine (Tagamet), ranitidine (Zantac), famotidine (Pepcid), nizatidine (Axid)] | Name(s): __________ |
| ☐ | ☐ | ☐ | c. Proton pump inhibitor (may be taken for peptic ulcer disease or gastroesophageal reflux disease [GERD])? *[Common medication names include omeprazole (Prilosec), pantoprazole (Protonix), lansoprazole (Prevacid), esomeprazole (Nexium)]* | Name(s): __________ |
| | | | d.Other | Name(s): __________ |

**8. In the 30 days <u>prior</u> to illness onset, did the patient receive any of the following?:** *(check all that apply)*

| Y | N | Unk | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | a. Any form of radiation therapy? | |
| ☐ | ☐ | ☐ | b. Abdominal surgery (e.g. removal of appendix, removal of gallbladder, any surgery of the stomach, small intestine or large intestine) | Notes: ____________ |
| ☐ | ☐ | ☐ | c. Any oral or intravenous (IV) steroid? *[Common steroids include prednisone, prednisolone, methylprednisolone, hydrocortisone, dexamethasone]* | Name(s): __________ |
| ☐ | ☐ | ☐ | d. Any other oral, intravenous (IV), or injectable immune-suppressing medication? *[Common medication names include azathioprine, cyclosporine, methotrexate, tacrolimus (FK 506), sirolimus, rituximab, infliximab, etanercept, or other chemotherapy]* | Name(s): __________ |
| ☐ | ☐ | ☐ | e. Probiotics | Name(s): __________ |

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**9. In the 30 days prior to illness onset, did the patient receive any antimicrobial medication(s)?**

☐ No antimicrobial medication was given

☐ Yes antimicrobial medication was given (please list them below)

| Drug no. | Drug name | Route | Start date *(mm/dd/yy)* | End date *(mm/dd/yy)* | Other Comments |
|---|---|---|---|---|---|
| 1 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 2 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 3 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 4 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 5 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 6 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 7 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |

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## Part 2. Medical unit Information

**10. When was the first documented episode of diarrhea?** ☐☐/☐☐/☐☐☐☐

**11. When was the patient first seen in the medical unit:** ☐☐/☐☐/☐☐☐☐

**12. What was the highest documented temperature at the time of medical unit visit?**
______°C _______°F ☐Unknown

**13. What were the documented clinical signs and symptoms?**

| Symptom | Yes/No/Don't Know | Onset Date | Resolution Date (only applicable for highlighted symptoms, V/D/F) | Notes |
|---|---|---|---|---|
| Nausea | ☐Yes ☐No ☐Unk | ___/____/_______ | | |
| Vomiting | ☐Yes ☐No ☐Unk | ___/____/_______ | ___/____/_______ | |
| Diarrhea | ☐Yes ☐No ☐Unk | ___/____/_______ | ___/____/_______ | |
| Bloody diarrhea | ☐Yes ☐No ☐Unk | ___/____/_______ | | |
| Abdominal pain/cramping | ☐Yes ☐No ☐Unk | ___/____/_______ | | |
| Fever | ☐Yes ☐No ☐Unk | ___/____/_______ | ___/____/_______ | |
| Chills | ☐Yes ☐No ☐Unk | ___/____/_______ | | |
| Headache | ☐Yes ☐No ☐Unk | ___/____/_______ | | |
| Body aches | ☐Yes ☐No ☐Unk | ___/____/_______ | | |
| Fatigue/Tiredness | ☐Yes ☐No ☐Unk | ___/____/_______ | | |
| Dizziness | ☐Yes ☐No ☐Unk | ___/____/_______ | | |
| Other:________________ | ☐Yes | ___/____/_______ | | |

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**14. Was any treatment given to the patient in the medical unit?** ☐Yes ☐No ☐Unknown

a. If yes, please select all that apply:

☐Probiotics (specify: ___________________________________)
☐Analgesic/antipyretic medication (specify: ____________________)
☐Antidiarrheal medication (specify: ____________________________)
☐Antiemetic medication (specify: ______________________________)
☐Antimicrobial medication (specify: ____________________________)
☐Oral fluids for rehydration (specify: ___________________________)
☐Intravenous fluids for rehydration (specify: ____________________)
☐Other: _____________________________________
☐Other: _____________________________________

**15. If any antimicrobial medication(s) were given to treat the gastrointestinal illness, please list them below. If none were given, please mark that none were given.**

☐ No antimicrobial medication was ever given

| Drug no. | Drug name | Route | First date *(mm/dd/yy)* | Last date *(mm/dd/yy)* | Other Comments |
|---|---|---|---|---|---|
| 1 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 2 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 3 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 4 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 5 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 6 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |
| 7 | | ☐IV ☐IM ☐PO ☐INH | ___/___/___ | ___/___/___ | |

**16. What diagnoses were given to the patient in the medical unit?**

| No. | Diagnoses |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |

***17.*** **Was this patient ever hospitalized?** ☐Yes ☐No ☐Unknown

*b. If yes, on what day was he/she admitted?* ☐☐/☐☐/☐☐☐☐

*c. When was he/she discharged?* ☐☐/☐☐/☐☐☐☐

*d. What were the discharge diagnoses?*

| No. | Discharge diagnoses |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |

**18. Were any specimens collected for laboratory testing at the medical unit?** ☐Yes ☐No ☐Unknown

e. *If yes, please proceed to Part 3 of this form.*

f. *If no, **end of survey.***

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## Part 3. Laboratory testing – Positive Culture Data

**19. Were cultures done?** ☐Yes ☐No ☐Unknown

*If "Yes," complete the table below.*

### Positive Cultures

| Culture No. | Specimen ID<br>--------------------<br>Alternate ID | Specimen | Collect date (mm/dd/yy) | Positive for any pathogen? | Pathogens identified | AST data recorded in AST Table? |
|---|---|---|---|---|---|---|
| 1 | | ☐Stool<br>☐Blood<br>☐Other ____________ | ____ / ___ / ___ | ☐Y ☐N ☐ Unk | Path1 ________<br>Path2 ________<br>Path3 ________ | Path1: ☐Y ☐N<br>Path2: ☐Y ☐N<br>Path3: ☐Y ☐N |
| 2 | | ☐Stool<br>☐Blood<br>☐Other ____________ | ____ / ___ / ___ | ☐Y ☐N ☐ Unk | Path1 ________<br>Path2 ________<br>Path3 ________ | Path1: ☐Y ☐N<br>Path2: ☐Y ☐N<br>Path3: ☐Y ☐N |
| 3 | | ☐Stool<br>☐Blood<br>☐Other ____________ | ____ / ___ / ___ | ☐Y ☐N ☐ Unk | Path1 ________<br>Path2 ________<br>Path3 ________ | Path1: ☐Y ☐N<br>Path2: ☐Y ☐N<br>Path3: ☐Y ☐N |
| 4 | | ☐Stool<br>☐Blood<br>☐Other ____________ | ____ / ___ / ___ | ☐Y ☐N ☐ Unk | Path1 ________<br>Path2 ________<br>Path3 ________ | Path1: ☐Y ☐N<br>Path2: ☐Y ☐N<br>Path3: ☐Y ☐N |
| 5 | | ☐Stool<br>☐Blood<br>☐Other ____________ | ____ / ___ / ___ | ☐Y ☐N ☐ Unk | Path1 ________<br>Path2 ________<br>Path3 ________ | Path1: ☐Y ☐N<br>Path2: ☐Y ☐N<br>Path3: ☐Y ☐N |
| 6 | | ☐Stool<br>☐Blood<br>☐Other ____________ | ____ / ___ / ___ | ☐Y ☐N ☐ Unk | Path1 ________<br>Path2 ________<br>Path3 ________ | Path1: ☐Y ☐N<br>Path2: ☐Y ☐N<br>Path3: ☐Y ☐N |
| 7 | | ☐Stool<br>☐Blood<br>☐Other ____________ | ____ / ___ / ___ | ☐Y ☐N ☐ Unk | Path1 ________<br>Path2 ________<br>Path3 ________ | Path1: ☐Y ☐N<br>Path2: ☐Y ☐N<br>Path3: ☐Y ☐N |
| 8 | | ☐Stool<br>☐Blood<br>☐Other ____________ | ____ / ___ / ___ | ☐Y ☐N ☐ Unk | Path1 ________<br>Path2 ________<br>Path3 ________ | Path1: ☐Y ☐N<br>Path2: ☐Y ☐N<br>Path3: ☐Y ☐N |

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## 20. Table 4: Antimicrobial Sensitivity

**Complete the AST table below by filling in the culture no. from the positive culture table, checking the appropriate pathogen, and circling the corresponding AST results.**

| Culture No. _______ Pathogen No. _______ | | Culture No. _______ Pathogen No. _______ | | Culture No. _______ Pathogen No. _______ | | Culture No. _______ Pathogen No. _______ | |
|---|---|---|---|---|---|---|---|
| Amoxicillin-clavulanic acid | S I R N | Amoxicillin-clavulanic acid | S I R N | Amoxicillin-clavulanic acid | S I R N | Amoxicillin-clavulanic acid | S I R N |
| Ampicillin | S I R N | Ampicillin | S I R N | Ampicillin | S I R N | Ampicillin | S I R N |
| Azithromycin | S I R N | Azithromycin | S I R N | Azithromycin | S I R N | Azithromycin | S I R N |
| Cefoxitin | S I R N | Cefoxitin | S I R N | Cefoxitin | S I R N | Cefoxitin | S I R N |
| Ceftiofur | S I R N | Ceftiofur | S I R N | Ceftiofur | S I R N | Ceftiofur | S I R N |
| Ceftriaxone | S I R N | Ceftriaxone | S I R N | Ceftriaxone | S I R N | Ceftriaxone | S I R N |
| Chloramphenicol | S I R N | Chloramphenicol | S I R N | Chloramphenicol | S I R N | Chloramphenicol | S I R N |
| Ciprofloxacin | S I R N | Ciprofloxacin | S I R N | Ciprofloxacin | S I R N | Ciprofloxacin | S I R N |
| Gentamicin | S I R N | Gentamicin | S I R N | Gentamicin | S I R N | Gentamicin | S I R N |
| Kanamycin | S I R N | Kanamycin | S I R N | Kanamycin | S I R N | Kanamycin | S I R N |
| Streptomycin | S I R N | Streptomycin | S I R N | Streptomycin | S I R N | Streptomycin | S I R N |
| Sulfamethoxazole | S I R N | Sulfamethoxazole | S I R N | Sulfamethoxazole | S I R N | Sulfamethoxazole | S I R N |
| Tetracycline | S I R N | Tetracycline | S I R N | Tetracycline | S I R N | Tetracycline | S I R N |
| | S I R N | | S I R N | | S I R N | | S I R N |
| | S I R N | | S I R N | | S I R N | | S I R N |
| | S I R N | | S I R N | | S I R N | | S I R N |

## 21. Culture-Independent Diagnostic Tests:

| Test | Results & Notes |
|---|---|
| | |
| | |
| | |
| | |

**END OF ABSTRACTION**