

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 (gather at least State and Zip Code, even if proxy was interviewed): Name: _____ Address: _____ City, State, Zip: _____ Phone: () _____	Proxy contact information (if applicable): Name: _____ Relation to patient: <input type="checkbox"/> Relative: _____ <input type="checkbox"/> Clinician <input type="checkbox"/> Other: _____ Address: <input type="checkbox"/> Same as patient _____ 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)

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 ALL conditions that are present.**

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

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				

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