

Patient's Name: (Last, First, MI.) Phone No.: ( ) Patient Chart No.: Address: (Number, Street, Apt. No.) Hospital: (City, State) (Zip Code)

- Patient identifier information is not transmitted to CDC -

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION ATLANTA, GA 30333

2016 SURVEILLANCE FOR NON-INVASIVE PNEUMOCOCCAL PNEUMONIA (SNiPP)



Expiration Date: 02/28/2019

CASE REPORT FORM

- SHADED AREAS FOR OFFICE USE ONLY -

OMB No. 0920-0978

1. STATE: (Residence of Patient) 2. STATE I.D.: 3a. DATE FIRST POSITIVE URINE ANTIGEN TEST COLLECTED (Date Specimen Collected) 3b. TYPE OF TEST 4. CRF Status:

5. COUNTY: (Residence of Patient) 6a. HOSPITAL/LAB I.D. WHERE UAT IDENTIFIED: 6b. HOSPITAL I.D. WHERE PATIENT TREATED:

7. DATE OF BIRTH: 8a. AGE: 9. SEX: 10a. ETHNIC ORIGIN: 10b. RACE: (Check all that apply)

11a. WHERE WAS THE PATIENT A RESIDENT AT THE TIME OF POSITIVE UAT?: 11b. If resident of a facility, what was the name of the facility?

12a. HOSPITAL ADMISSION DATE 12b. HOSPITAL DISCHARGE DATE (From second hospital, if transferred) 12c. Was this patient admitted to the ICU during hospitalization? 13a. WEIGHT: 13b. HEIGHT: 13c. BMI:

14. OUTCOME: 1 Survived 2 Died 9 Unknown

15. UNDERLYING CAUSES OR PRIOR ILLNESSES: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) 1 None 1 Unknown

16. DID THE PATIENT HAVE A CHEST CT OR CHEST X-RAY WITHIN 72 HOURS OF THEIR POSITIVE UAT?: 17a. Did patient receive pneumococcal vaccine during this hospitalization? 17b. If YES, please add date of vaccination:

18. WAS THE PATIENT DIAGNOSED WITH PNEUMONIA WITHIN 72 HOURS OF THE POSITIVE UAT?: 1 Yes 2 No 9 Unknown

19. COMMENTS 20. INITIALS OF S.O.