VRSA/VISA Case Report Form

Texas Department of State Health Services
Infectious Disease Control Unit
1100 W. 49th St., Austin, Texas 78756
ph: (512) 458-7676 fax: (512) 458-7616

PATIENT INFORMATION

Name:_____
Last **First** **MI**

Address:_____
Street **City** **County** **Zip**

(_____)_____ _____/_____/_____ _____ _____
Phone **Birth Date** **Sex** **Race***

*W = White; B = Black/African American; N = American Indian/Alaska Native; P = Native Hawaiian/Pacific Islander; A = Asian; O = Other; U = Unknown

MEDICAL INFORMATION

Hospitalized? ☐ **Yes** ☐ **No** **Hospital Name:** _____ _____/_____/_____ _____/_____/_____
Admit Date **Discharge Date**
Infection Preventionist Name: _____ **Phone (_____)** _____

Hospital laboratory phone (_____) _____ **ICU patient at time of specimen collection?** ☐ **Yes** ☐ **No** ☐ **Unknown**

Did patient have underlying conditions? (Check all that apply) ☐ **Diabetes Mellitus** ☐ **Renal disease** ☐ **Dialysis recipient** ☐ **HIV/AIDS**
☐ **Presence of intravenous catheter** ☐ **Organ Transplant** ☐ **Malignancy** ☐ **Other Disease (specify)** _____

History of MRSA? ☐ **Yes** ☐ **No** ☐ **Unknown** **If Yes, most recent test result date** ____/____/____ **History of VRE?** ☐ **Yes** ☐ **No** ☐ **Unknown**

History of vancomycin exposure? ☐ **Yes** ☐ **No** ☐ **Unknown** **If Yes, dates of most recent vancomycin usage:** ____/____/____ **to** ____/____/____

Health Care Worker? ☐ **Yes (Type HCW:** _____) ☐ **No** ☐ **Unknown**

Caretaker or household member of Dialysis patient? ☐ **Yes** ☐ **No** ☐ **Unknown** ☐ **Describe**_____

History of residence in Long Term Care Facility? ☐ **Yes** ☐ **No** ☐ **Unknown** **If Yes, Date of discharge/transfer from LTCF** ____/____/____

LABORATORY INFORMATION (attach lab report if available)

☐ **VRSA (Vancomycin Resistant *Staphylococcus aureus*) (MIC≥ 16 µg/ml)**

☐ **VISA (Vancomycin Intermediate Susceptible *Staphylococcus aureus*) (MIC 4-8 µg/ml)**
Both require immediate notification and submission of isolate to DSHS. Institute appropriate transmission precautions.

Date specimen collected ____/____/____ **Specimen source/site:** _____ **Test method:** _____**MIC result:** _____

If test repeated, by what method? _____ **Repeat MIC result?** _____ **Date isolate submitted to DSHS laboratory:** ___/___/___

COMMENTS

Reported by: _____ **Phone: (_____)** _____ **Date Reported:** ____/____/____

Investigated by: _____ **Investigation Start Date:** ____/____/____

Agency: _____ **Phone: (_____)** _____

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