

Patient's Name _____ Telephone No. _____ TOXIC - SHOCK SYNDROME

Address _____ (Detach top portion)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
ATLANTA, GEORGIA 30333

FORM APPROVED
OMB NO. 0920-0009

TOXIC - SHOCK SYNDROME CASE REPORT

The First Three Letters of Patient's Last Name (1-3)	CDC No. (4-8)	State No. (9-10)	State Case No. (11-15)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Age (16-17)	Date of Birth (Mo., Day, Yr.)	Sex (24)	Outcome (25)	Race/Ethnicity (26)
<input type="text"/>	<input type="text"/>	Male <input type="checkbox"/> 1 Female <input type="checkbox"/> 2	Lived <input type="checkbox"/> 1 Died <input type="checkbox"/> 2	<input type="checkbox"/> 1 White (not Hispanic) <input type="checkbox"/> 4 Asian/Pacific Islander <input type="checkbox"/> 2 Black (not Hispanic) <input type="checkbox"/> 5 American Indian/Alaskan Native <input type="checkbox"/> 3 Hispanic <input type="checkbox"/> 9 Not Specified

Date of Onset of Symptoms (Mo., Day, Yr.)	Date of Onset of Coincident Menstrual Period (If applicable) (Mo., Day, Yr.)	Admitted to Hospital (39)	Date of Hospital Admission (Mo., Day, Year)	CASE CLASSIFICATION (46)
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unk <input type="checkbox"/> 9	<input type="text"/>	Menstruation-associated <input type="checkbox"/> 1 Other <input type="checkbox"/> 4 Wound-associated <input type="checkbox"/> 2 (specify) Postpartum-associated <input type="checkbox"/> 3 No. days postpartum <input type="text"/> (47-48)

CLINICAL FINDINGS Major Criteria

Fever (highest-if not recorded, leave blank) F Hypotension (lowest) Systolic (53-55) Diastolic (56-57)

Syncope Yes 1 No 2 (58)
Orthostatic dizziness Yes 1 No 2 (59)

Rash (60) Yes 1 No 2 Unk. 9 (61) If yes, Generalized 1 Focal 2 Describe: _____

Desquamation (62) Yes 1 No 2 Unk. 9 If yes, describe: _____

SIGNS AND SYMPTOMS (First 4 Days of Illness)

	YES 1	NO 2	UNK 9		YES 1	NO 2	UNK 9		YES 1	NO 2	UNK 9
(63) Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(68) Conjunctival hyperemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(73) Vaginal ulceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(64) Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(69) Oropharyngeal hyperemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(74) Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(65) Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(70) Injected tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(75) Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(66) Myalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(71) Vaginal hyperemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(76) Cardiac Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(67) Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(72) Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, describe _____			

LABORATORY DATA (Most Abnormal Values in First 4 Days of Illness)

WBC Count (77-79) <input type="text"/> 000/mm ³	Not Obtained (80) <input type="checkbox"/>	Urinalysis	Not Obtained
(81-82) Neutrophils <input type="text"/> %	(83) <input type="checkbox"/>	(121-122) WBC/HPF <input type="text"/> ("Many" = 99)	(123) <input type="checkbox"/>
(84-85) Bands <input type="text"/> %	(86) <input type="checkbox"/>	(124-125) RBC/HPF <input type="text"/> ("Many" = 99)	(126) <input type="checkbox"/>
(87-88) Metamyelocytes <input type="text"/> %	(89) <input type="checkbox"/>	(127) Protein (0-4+) <input type="text"/>	(128) <input type="checkbox"/>
(90-91) Myelocytes <input type="text"/> %	(92) <input type="checkbox"/>		
(93-95) Platelets <input type="text"/> 000/mm ³	(96) <input type="checkbox"/>	(129-130) BUN <input type="text"/> mg/dl	(131) <input type="checkbox"/>
(97-99) Highest platelet value after 7 days of illness <input type="text"/> 000/mm ³	(98) <input type="checkbox"/>	(132-134) Creatinine <input type="text"/> mg/dl	(135) <input type="checkbox"/>
(100-102) SGOT <input type="text"/> IU/L	(103) <input type="checkbox"/>	(136-138) Calcium <input type="text"/> mg/dl	(139) <input type="checkbox"/>
(104-106) SGPT <input type="text"/> IU/L	(107) <input type="checkbox"/>	(140-141) Phosphorus <input type="text"/> mg/dl	(142) <input type="checkbox"/>
(108-110) Alkaline phosphatase <input type="text"/> IU/L	(111) <input type="checkbox"/>	(143-144) Albumin <input type="text"/> g/dl	(145) <input type="checkbox"/>
(112-114) Bilirubin <input type="text"/> mg/dl	(115) <input type="checkbox"/>	(146-149) Creatine phosphokinase (CPK) <input type="text"/> IU/L	(150) <input type="checkbox"/>
(116-119) Amylase <input type="text"/> Somogyi Units/dl	(120) <input type="checkbox"/>	(151) CPK-myo-cardial Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unk <input type="checkbox"/> 9	(152) <input type="checkbox"/>

Note: This form is for worksheet purposes only--do not send to ODH

Bureau of Disease Investigation and Surveillance 1-614-995-5599

HOME CASE REPORT

Physician's Name _____ Telephone No. _____

(before sending to CDC.)

Address _____

CULTURES

BLOOD (155) Positive 1 Negative 2 Not Done 3 Unk 9 If Positive, what organism(s): 1 _____ 2 _____
(156-157) (158-159)

URINE (160) Positive 1 Negative 2 Not Done 3 Unk 9 If Positive, what organism(s): 1 _____ 2 _____
(161-162) (163-164)

THROAT (171) Normal Flora 1 Abnormal 2 Not Done 3 Unk 9 If Abnormal, what organism(s): 1 _____ 2 _____
(172-173) (174-175)

NARES (176) Done 1 Not Done 3 Unk 9 If Done, what organism(s): 1 _____ 2 _____
(177-178) (179-180)

VAGINA (181) Done 1 Not Done 3 Unk 9 If Done, what organism(s): 1 _____ 2 _____
(182-183) (184-185)

Was *Staphylococcus aureus* present in the vagina? (186) Yes 1 No 2 Unk 9

If *S. aureus* present in vagina, is it resistant to penicillin and ampicillin only? (187) Yes 1 No 2 Unk 9

Other Site(s) _____ Organism(s) 1. _____ 2. _____
(188-189) (190-191) (192-193)

Was patient taking antibiotics when culture(s) performed? (194) Yes 1 No 2 Unk. 9 If yes, which sites? _____
(195-196)

TAMPON/NAPKIN/MINIPAD USE - IF APPLICABLE (During Period When Patient Became Ill)

PRODUCTS USED (197-198)
 Tampon only 1 Minipad only 3 Tampon and Minipad 5 Tampon, Napkin, and Minipad 7 Other _____ 10
(199-200)
 Napkin only 2 Tampon and Napkin 4 Napkin and Minipad 6 See Sponge 8 Unknown 9

(If Only One Brand Was Used Before Onset of Symptoms, List Only That Brand)

BRAND # 1 (Most frequently used, judged by time) NAME (201-202)		STYLE (ABSORBENCY) (203)		BRAND # 2 NAME (204-205)		STYLE (ABSORBENCY) (206)		Was Brand No. 1 the only tampon brand used during period when patient became ill? (207) Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unk. <input type="checkbox"/> 9
Assure <input type="checkbox"/> 1	Super-plus <input type="checkbox"/> 1	Assure <input type="checkbox"/> 1	Super-plus <input type="checkbox"/> 1	Assure <input type="checkbox"/> 1	Super-plus <input type="checkbox"/> 1	Assure <input type="checkbox"/> 1	Super-plus <input type="checkbox"/> 1	
Kotex <input type="checkbox"/> 2	Super <input type="checkbox"/> 2	Kotex <input type="checkbox"/> 2	Super <input type="checkbox"/> 2	Kotex <input type="checkbox"/> 2	Super <input type="checkbox"/> 2	Kotex <input type="checkbox"/> 2	Super <input type="checkbox"/> 2	
Plastic Inserter <input type="checkbox"/> 2	Regular <input type="checkbox"/> 3	Plastic inserter <input type="checkbox"/> 2	Regular <input type="checkbox"/> 3	Plastic inserter <input type="checkbox"/> 2	Regular <input type="checkbox"/> 3	Plastic inserter <input type="checkbox"/> 2	Regular <input type="checkbox"/> 3	
Stick Inserter <input type="checkbox"/> 3	Junior <input type="checkbox"/> 4	Stick inserter <input type="checkbox"/> 3	Junior <input type="checkbox"/> 4	Stick inserter <input type="checkbox"/> 3	Junior <input type="checkbox"/> 4	Stick inserter <input type="checkbox"/> 3	Junior <input type="checkbox"/> 4	
Inserter Unk <input type="checkbox"/> 4	Unknown <input type="checkbox"/> 9	Inserter unk <input type="checkbox"/> 4	Unknown <input type="checkbox"/> 9	Inserter unk <input type="checkbox"/> 4	Unknown <input type="checkbox"/> 9	Inserter unk <input type="checkbox"/> 4	Unknown <input type="checkbox"/> 9	
o.b. <input type="checkbox"/> 5		o.b. <input type="checkbox"/> 5		o.b. <input type="checkbox"/> 5		o.b. <input type="checkbox"/> 5		
Playtex <input type="checkbox"/> 6		Playtex <input type="checkbox"/> 6		Playtex <input type="checkbox"/> 6		Playtex <input type="checkbox"/> 6		
Deodorized <input type="checkbox"/> 6		Deodorized <input type="checkbox"/> 6		Deodorized <input type="checkbox"/> 6		Deodorized <input type="checkbox"/> 6		
Non-deodorized <input type="checkbox"/> 7		Non-deodorized <input type="checkbox"/> 7		Non-deodorized <input type="checkbox"/> 7		Non-deodorized <input type="checkbox"/> 7		
Deodorant unk <input type="checkbox"/> 8		Deodorant unk <input type="checkbox"/> 8		Deodorant unk <input type="checkbox"/> 8		Deodorant unk <input type="checkbox"/> 8		
Pursettes <input type="checkbox"/> 10		Pursettes <input type="checkbox"/> 10		Pursettes <input type="checkbox"/> 10		Pursettes <input type="checkbox"/> 10		
Rely <input type="checkbox"/> 11		Rely <input type="checkbox"/> 11		Rely <input type="checkbox"/> 11		Rely <input type="checkbox"/> 11		
Tampax <input type="checkbox"/> 12		Tampax <input type="checkbox"/> 12		Tampax <input type="checkbox"/> 12		Tampax <input type="checkbox"/> 12		
Other (specify) <input type="checkbox"/> 13		Other (specify) <input type="checkbox"/> 13		Other (specify) <input type="checkbox"/> 13		Other (specify) <input type="checkbox"/> 13		
Unknown <input type="checkbox"/> 9		Unknown <input type="checkbox"/> 9		Unknown <input type="checkbox"/> 9		Unknown <input type="checkbox"/> 9		

RECURRENCE INFORMATION FOR MENSTRUATION - ASSOCIATED CASES

Has patient had similar illness in past during menstrual period? (213) Yes 1 No 2 Unk. 9 If yes, how many episodes? (214) One 1 Two 2 Three 3 More than Three 4

OTHER INFORMATION

Please describe any other pertinent or unusual features of this case _____

How was case reported to Health Department? (215) By patient or relative <input type="checkbox"/> 1 By physician <input type="checkbox"/> 2 By hospital <input type="checkbox"/> 3 Other <input type="checkbox"/> 4	FOR CDC USE ONLY
Person Completing Form _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 (228)
Date Reported to Health Department (216-221) _____	<input type="checkbox"/> 3 <input type="checkbox"/> 4
Date Form Completed (222-227) _____	

It is also recommended by the Conference of State and Territorial Health Officers for the understanding and control of the disease.

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