

Update 2005: Isolate Record Form *S. pneumoniae*



To be filled out by laboratory

Instructions: Please send data on the **first blood and/or cerebrospinal fluid (CSF)** isolate of every patient with a *S. pneumoniae* infection, confirmed by an optochin test.
Please send data on resistant and on susceptible isolates; use 1 form per isolate.

Laboratory Data

Current date dd/mm/yyyy

Laboratory Code * CC000

Isolate Data

Isolate sample number (lab) max. 12 characters

Isolate source tick box

Blood CSF

Date of sample collection dd/mm/yyyy

Patient Data

Patient ID / Code max. 12 characters

Sex tick box

Male Female Unknown

Date of birth dd/mm/yyyy

Clinical diagnosis free text

Hospital Data

Name/code of hospital** 000X

Origin of patient tick box

Date of admission dd/mm/yyyy

Hospital Department tick box

Please specify _____

Admitted Outpatient Unknown

Surgery (Internal) Medicine Infectious diseases
 Ob/Gyn ICU Emergency
 Urology Haematology/oncology Pediatrics/neonatal
 Pediatric/neonatal ICU Other: _____

Antibiotic susceptibility testing

S/I/R, zone and/or MIC

Cefotaxime AND/OR

Ceftriaxone

Ciprofloxacin

Norfloxacin Disk load.....

Oxacillin Disk load.....

Penicillin

Erythromycin

Optional

Clindamycin

Levofloxacin

Moxifloxacin

Rifampin

Tetracycline

Vancomycin

Other:

Other:

S / I / R
(fill in S, I or R)

Zone diameter
(mm)

MIC
(in mg/l)

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Serotype (see annex 10 for serotype codes) : _____

* The national co-ordinators provide the laboratory code, consisting of a Country Code (CC) followed by 3 numbers.

** Consists of three numbers of the laboratory code, followed by a letter identifying the hospital.

Send this form to: EARSS, Health Protection Surveillance Centre (HPSC)

Address: 25-27 Middle Gardiner St, Dublin 1

Tel: 01-8765372.

Fax: 01-8765384

Update 2005: Isolate Record Form *S. aureus*



To be filled out by laboratory

Instructions: please send data of the first **blood**-isolate of every patient with a *S. aureus* infection, confirmed by a coagulase test. Please send data on resistant and on susceptible isolates; use 1 form per isolate.

Laboratory Data Current date dd/mm/yyyy ___ / ___ / ___ Laboratory Code * CC000 -----																											
Isolate Data Isolate sample number (lab) max. 12 characters ----- Date of sample collection dd/mm/yyyy ___ / ___ / ___																											
Patient Data Patient ID / Code max. 12 characters ----- Sex tick box <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown Date of birth dd/mm/yyyy ___ / ___ / ___ Clinical diagnosis free text																											
Hospital Data Name/code of hospital** 000X Origin of patient tick box <input type="checkbox"/> Admitted <input type="checkbox"/> Outpatient <input type="checkbox"/> Unknown Date of admission dd/mm/yyyy ___ / ___ / ___ Hospital Department tick box		Please specify _____ <input type="checkbox"/> Surgery <input type="checkbox"/> (Internal) Medicine <input type="checkbox"/> Infectious diseases <input type="checkbox"/> Ob/Gyn <input type="checkbox"/> ICU <input type="checkbox"/> Emergency <input type="checkbox"/> Urology <input type="checkbox"/> Haematology/oncology <input type="checkbox"/> Pediatrics/neonatal <input type="checkbox"/> Pediatric/neonatal ICU <input type="checkbox"/> Other: -----																									
Antibiotic susceptibility testing S/I/R, zone and/or MIC <input type="checkbox"/> Cefoxitin Disk load.....AND/OR <input type="checkbox"/> Oxacillin Linezolid Rifampin Vancomycin PCR mecA-gene PBP2a agglutination		<table border="0"> <thead> <tr> <th>S / I / R (fill in S, I or R)</th> <th>Zone diameter (mm)</th> <th>MIC (in mg/l)</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/> positive</td> <td><input type="checkbox"/> negative</td> <td><input type="checkbox"/> unknown (incl. not done)</td> </tr> <tr> <td><input type="checkbox"/> positive</td> <td><input type="checkbox"/> negative</td> <td><input type="checkbox"/> unknown (incl. not done)</td> </tr> </tbody> </table>		S / I / R (fill in S, I or R)	Zone diameter (mm)	MIC (in mg/l)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/> positive	<input type="checkbox"/> negative	<input type="checkbox"/> unknown (incl. not done)	<input type="checkbox"/> positive	<input type="checkbox"/> negative	<input type="checkbox"/> unknown (incl. not done)
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Optional Ciprofloxacin Erythromycin Fusidic acid Gentamicin Tetracycline Clindamycin Other: Other:		<table border="0"> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>-----</td> </tr> </tbody> </table>		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	-----
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MRSA isolates only: Please send a slope of the isolate + a copy of this form to:
 Dr Brian O'Connell, National MRSA Reference Laboratory, St James's Hospital, Dublin 8 **THANK YOU!**

Update 2005: Isolate Record Form *E. faecium/faecalis*



To be filled out by laboratory

Instructions: please send data of the first **blood**-isolate of every patient with invasive *E. faecium/faecalis* infection. It is essential to differentiate between *E. faecium* and *E. faecalis*. Send data on resistant and on susceptible isolates; use 1 form per isolate.

Laboratory Data				
Current date	dd/mm/yyyy		__ / __ / ____	
Laboratory Code *	CC000		-----	
Isolate Data				
Pathogen		<input type="checkbox"/> <i>E. faecium</i>	<input type="checkbox"/> <i>E. faecalis</i>	<input type="checkbox"/> <i>Enterococcus (not specified)</i>
Isolate sample number (lab)	max. 12 characters		-----	
Date of sample collection	dd/mm/yyyy		__ / __ / ____	
Patient Data				
Patient ID / Code	max. 12 characters		-----	
Sex	tick box	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Unknown
Date of birth	dd/mm/yyyy		__ / __ / ____	
Clinical diagnosis (optional)	free text		-----	
Hospital Data				
Name/code of hospital**	000X		Please specify _____	
Origin of patient	tick box	<input type="checkbox"/> Admitted	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Unknown
Date of admission	dd/mm/yyyy		__ / __ / ____	
Hospital Department	tick box	<input type="checkbox"/> Surgery	<input type="checkbox"/> (Internal) Medicine	<input type="checkbox"/> Infectious diseases
		<input type="checkbox"/> Ob/Gyn	<input type="checkbox"/> ICU	<input type="checkbox"/> Emergency
		<input type="checkbox"/> Urology	<input type="checkbox"/> Haematology/oncology	<input type="checkbox"/> Pediatrics/neonatal
		<input type="checkbox"/> Pediatric/neonatal ICU	<input type="checkbox"/> Other: _____	
Antibiotic susceptibility testing				
S/I/R, zone and/or MIC		S / I / R	Zone diameter	MIC
		(fill in S, I or R)	(mm)	(in mg/l)
<input type="checkbox"/> Amoxicillin	AND/OR	<input type="checkbox"/>	<input type="checkbox"/>	-----
<input type="checkbox"/> Ampicillin		<input type="checkbox"/>	<input type="checkbox"/>	-----
Gentamicin HIGH	Disk-load	<input type="checkbox"/>	<input type="checkbox"/>	-----
Vancomycin		<input type="checkbox"/>	<input type="checkbox"/>	-----
Optional				
Linezolid		<input type="checkbox"/>	<input type="checkbox"/>	-----
Teicoplanin		<input type="checkbox"/>	<input type="checkbox"/>	-----
Other:		<input type="checkbox"/>	<input type="checkbox"/>	-----
Other:		<input type="checkbox"/>	<input type="checkbox"/>	-----
Other:		<input type="checkbox"/>	<input type="checkbox"/>	-----
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Update 2005: Isolate Record Form *P. aeruginosa*



To be filled out by laboratory

Instructions: Please send data on the **first blood and/or cerebrospinal fluid (CSF)** isolate of every patient with a *P. aeruginosa* infection.

Please send data on resistant and on susceptible isolates; use 1 form per isolate.

Laboratory Data

Current date dd/mm/yyyy

Laboratory Code * CC000

Isolate Data

Isolate sample number (lab) max. 12 characters

Isolate source tick box

Blood CSF

Date of sample collection dd/mm/yyyy

Patient Data

Patient ID / Code max. 12 characters

Sex tick box

Male Female Unknown

Date of birth dd/mm/yyyy

Clinical diagnosis free text

Hospital Data

Name/code of hospital** 000X

Origin of patient tick box

Please specify _____
 Admitted Outpatient Unknown

Date of admission dd/mm/yyyy

Hospital Department tick box

Surgery (Internal) Medicine Infectious diseases
 Ob/Gyn ICU Emergency
 Urology Haematology/oncology Pediatrics/neonatal
 Pediatric/neonatal ICU Other: _____

Antibiotic susceptibility testing

S/I/R, zone and/or MIC

Piperacillin AND/OR

Piperacillin-tazobactam

Ceftazidime

Ciprofloxacin AND/OR

Levofloxacin

Imipenem AND/OR

Meropenem

Gentamicin AND/OR

Tobramycin AND/OR

Amikacin

Optional

Other:

Other:

Other:

Other:

S / I / R
(fill in S, I or R)

Zone diameter
(mm)

MIC
(in mg/l)

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