Patient's Name: _____ (Last, First, M.I.) Phone No.: _____ Hospital/Lab: _____

Address: _____ (Number, Street, Apt. No., City, State) _____ (Zip Code) Patient. Chart No.: _____

Patient identifier information is not transmitted to CDC

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333

Pneumococcal Conjugate Vaccine Failure Case Report

CDC SAFER·HEALTHIER·PEOPLE™

Use for children < 5 years old with a sterile site pneumococcal isolate and documented receipt of pneumococcal conjugate vaccine

Submitted by (name): Email _____ _____

(_____) _____ Phone (_____) _____ Fax

Physician's name: Email _____ _____

(_____) _____ Phone (_____) _____ Fax

– DEMOGRAPHIC SECTION –

1. Patient's Residence: State ☐☐ County _____

2. Date of Birth: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

3. Sex: 1 ☐ Male 2 ☐ Female

4. Race: 1 ☐ White 2 ☐ Black 3 ☐ American Indian/ Alaskan Native 4 ☐ Asian 5 ☐ Pacific Islander 9 ☐ Unk

5. Ethnic Origin: 1 ☐ Hispanic 2 ☐ Not Hispanic 9 ☐ Unk

– MEDICAL SECTION –

6. Pneumococcal illness onset date: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

7a. Was patient hospitalized? 1 ☐ Yes 0 ☐ No 9 ☐ Unk

7b. If yes, name of hospital: _____ City _____ State ☐☐

7c. Date of Admission: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

7d. Date of Discharge: ☐☐ ☐☐ ☐☐☐☐

8. Outcome: 1 ☐ Survived 2 ☐ Died 9 ☐ Unk

9. Type of infection (check all that apply)

- 1 ☐ Bacteremia (without focus)
- 1 ☐ Meningitis
- 1 ☐ Empyema
- 1 ☐ Hemolytic uremic syndrome (HUS)
- 1 ☐ Pneumonia
- 1 ☐ Otitis Media
- 1 ☐ Septic arthritis
- 1 ☐ Osteomyelitis
- 1 ☐ Pericarditis
- 1 ☐ Abscess
- 1 ☐ Peritonitis
- 1 ☐ Cellulitis
- 1 ☐ Other (specify) _____

10. Site of positive culture (check all that apply)

- 1 ☐ Blood
- 1 ☐ CSF
- 1 ☐ Pleural fluid
- 1 ☐ Pericardial fluid
- 1 ☐ Bone
- 1 ☐ Surgical specimen
- 1 ☐ Peritoneal fluid
- 1 ☐ Surgical aspirate
- 1 ☐ Joint
- 1 ☐ other (specify) _____

11. Culture date: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

12. Underlying illness or risk factors for pneumococcal infection (check all that apply)

- 1 ☐ Sickle cell disease
- 1 ☐ Solid organ or hematologic malignancy
- 1 ☐ Asplenia (congenital or acquired)
- 1 ☐ Congenital immunodeficiency
- 1 ☐ Hypogammaglobulinemia
- 1 ☐ HIV infection (if yes, last CD4 count: _____)
- 1 ☐ Invasive bacterial infection since birth (If yes, organism _____)
- 1 ☐ Solid organ transplant
- 1 ☐ Bone marrow transplant
- 1 ☐ Cerebrospinal fluid leak/shunt
- 1 ☐ Renal failure
- 1 ☐ Chronic lung disease
- 1 ☐ Diabetes mellitus
- 1 ☐ Prematurity (if yes, gestational age at birth: _____ weeks)
- 1 ☐ Nephrotic syndrome
- 1 ☐ Cardiac disease
- 1 ☐ Other (specify) _____

13a. Has patient been evaluated for an immune disorder? 1 ☐ Yes 0 ☐ No 9 ☐ Unk

13b. If yes:

Tests	Test Date (Mo. ☐☐ Day ☐☐ Year ☐☐☐☐)	Result		
Quantitative Immunoglobulin				
IgG		☐ Normal	☐ Abnormal	☐ Unknown
IgM		☐ Normal	☐ Abnormal	☐ Unknown
IgA		☐ Normal	☐ Abnormal	☐ Unknown
Complement Assays				
C3		☐ Normal	☐ Abnormal	☐ Unknown
C4		☐ Normal	☐ Abnormal	☐ Unknown
CH50		☐ Normal	☐ Abnormal	☐ Unknown
Specific Function (specify _____)		☐ Normal	☐ Abnormal	☐ Unknown
Other (specify _____)		☐ Normal	☐ Abnormal	☐ Unknown

– PNEUMOCOCCAL CONJUGATE VACCINE FAILURE CASE REPORT –

-- Patient identifier information is not transmitted to CDC --

– VACCINE HISTORY SECTION –

Vaccine*	Date	Manufacturer	Vaccine Name**	Lot #
14. Conjugate Pneumococcal #1				
#2				
#3				
#4				
15. Polysaccharide Pneumococcal #1				
#2				
16. Influenza #1				
#2				
#3				
#4				
17. Hib #1				
#2				
#3				
#4				
18. DTaP #1				
#2				
#3				
#4				
19. IPV #1				
#2				
#3				
#4				
20. MMR #1				
#2				
21. Hepatitis B #1				
#2				
#3				
22. Hepatitis A #1				
#2				
23. Varicella #1				
#2				
24. Other				
(specify _____)				
25. Other				
(specify _____)				

*For combination vaccines (e.g., Comvax, Tetramine, TriHIBit) enter information for each vaccine component

**Please give manufacturer's vaccine name: (e.g., Prevnar, Pneumovax , Pnu-Imune, HibTITER, ProHIBIT, ActHIB, etc.)

27. Name of laboratory where isolate is located:

_____

Phone: ( ) _____

Fax: ( ) _____

28. Date of Report: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

29a. Has this case been reported elsewhere?

1 ☐ Yes 0 ☐ No 9 ☐ Unk

29b. If yes, to whom?

1 ☐ Vaccine manufacturer 2 ☐ FDA (MedWatch) 3 ☐ VAERS 8 ☐ Other _____

Please return form with isolate to:

Centers for Disease Control and Prevention
NCID, DBMD, RDB, Streptococcus Laboratory
1600 Clifton Road N.E.; M/S C-02
Atlanta, GA 30333

tel: 404-639-2215
fax: 404-639-3970

(A report of the Laboratory Investigation will be returned if a return address and patient name are completed on CDC 3.203)

CDC use only

Case ID number _____

Serotype _____

Lab ID _____

Where serotyped:

☐ CDC ☐ AIP ☐ MDH

☐ Other: _____