





## BCCDC Invasive Pneumococcal Disease Enhanced Surveillance Case Report Form

### D. CASE IMMUNIZATION HISTORY

Did the case receive *conjugate* pneumococcal vaccine?  Yes  No  Unknown

If YES, please complete the following:

Vaccine name:	<input type="checkbox"/> Prevnar7 <sup>®</sup>	<input type="checkbox"/> Prevnar <sup>®</sup> 13	<input type="checkbox"/> Synflorix	<input type="checkbox"/> Unknown
Number of Doses:				

Did the case/ guardian recall that appropriate doses for the conjugate vaccine were given?  Yes  No  Unknown

Dose #1 Date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_      Dose #2 Date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose #3 Date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_      Dose #4 Date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

Did the case receive *polysaccharide* pneumococcal vaccine?  Yes  No  Unknown  Not Eligible

If YES, indicate when the last dose was received (approximately):  ≤ 1 year ago  2 to 5 years ago  ≥ 5 years ago

### E. RISK FACTORS AND EXPOSURES

Does the case have any underlying medical conditions or prior illnesses?  Yes  No  Unknown

If YES, check all that apply:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cardiovascular disease<br><input type="checkbox"/> Chronic CSF leak<br><input type="checkbox"/> Chronic liver disease (including cirrhosis, chronic hepatitis B, chronic hepatitis C)<br><br><input type="checkbox"/> Chronic renal disease<br><input type="checkbox"/> Cochlear implant recipient or candidate | <input type="checkbox"/> Congenital or acquired asplenia<br><input type="checkbox"/> Cystic fibrosis<br><input type="checkbox"/> Diabetes mellitus<br><br><input type="checkbox"/> Immunosuppression related to disease (e.g. multiple myeloma, HIV, lymphoma, Hodgkin's) or congenital conditions,<br><br><input type="checkbox"/> Immunosuppression related to therapy (e.g. high dose systemic steroids), | <input type="checkbox"/> Pulmonary disease<br><br><input type="checkbox"/> Receipt of hematopoietic stem cell transplant; solid organ transplant; or islet cell transplant<br><input type="checkbox"/> Sickle cell disease<br><input type="checkbox"/> Other ( <b>specify</b> ): _____ |
|--|--|--|
- specify:** \_\_\_\_\_

c) Did patient have contact with another confirmed IPD case?  Yes  No  Unknown

If YES, please describe: \_\_\_\_\_

If case is < 1 year old:

d) Low birth weight or premature (<2500 grams or born <36 weeks gestation)?  Yes  No  Unknown

e) Is patient being breastfed?  Yes  No  Unknown

### F. LABORATORY INFORMATION

Specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_      Serotype: \_\_\_\_\_

Source:  Blood  CSF  other sterile site, excluding the middle ear (specify): \_\_\_\_\_

### G. NOTES

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