

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



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
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- 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 3 ☐ American Indian/ 2 ☐ Black 4 ☐ Alaskan Native 5 ☐ Asian 9 ☐ Pacific Islander 9 ☐ Unk 2 ☐ Not Hispanic	5. Ethnic Origin: 1 ☐ Hispanic 9 ☐ Unk 2 ☐ Not Hispanic
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- MEDICAL SECTION -

6. Pneumococcal illness onset date: Mo. _____ Day _____ Year _____	7a. Was patient hospitalized? 1 ☐ Yes 9 ☐ Unk 0 ☐ No	7b. If yes, name of hospital: _____ _____ City State	7c. Date of Admission: Mo. _____ Day _____ Year _____ 7d. Date of Discharge: Mo. _____ Day _____ Year _____	8. Outcome: 1 ☐ Survived 2 ☐ Died 9 ☐ Unk
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9. Type of infection (check all that apply) 1 ☐ Bacteremia (without focus) 1 ☐ Pneumonia 1 ☐ Abscess 1 ☐ Meningitis 1 ☐ Otitis Media 1 ☐ Peritonitis 1 ☐ Empyema 1 ☐ Septic arthritis 1 ☐ Cellulitis 1 ☐ Hemolytic uremic syndrome (HUS) 1 ☐ Osteomyelitis 1 ☐ Other (specify) _____ 1 ☐ Pericarditis	10. Site of positive culture (check all that apply) 1 ☐ Blood 1 ☐ Surgical specimen 1 ☐ CSF 1 ☐ Peritoneal fluid 1 ☐ Pleural fluid 1 ☐ Surgical aspirate 1 ☐ Pericardial fluid 1 ☐ Joint 1 ☐ Bone 1 ☐ other (specify) _____
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11. Culture date:		
Mo. _____	Day _____	Year _____

12. Underlying illness or risk factors for pneumococcal infection (check all that apply) 1 ☐ Sickle cell disease 1 ☐ Invasive bacterial infection since birth 1 ☐ Solid organ or hematologic malignancy (If yes, organism _____) 1 ☐ Asplenia (congenital or acquired) 1 ☐ Solid organ transplant 1 ☐ Congenital immunodeficiency 1 ☐ Bone marrow transplant 1 ☐ Hypogammaglobulinemia 1 ☐ Cerebrospinal fluid leak/shunt 1 ☐ HIV infection (if yes, last CD4 count: _____) 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) _____
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13a. Has patient been evaluated for an immune disorder? 1 ☐ Yes 0 ☐ No 9 ☐ Unk																																											
13b. If yes:	Tests	Test Date	Result																																								
<table border="0" style="width:100%;"> <tr> <td style="width:40%;">Quantitative Immunoglobulin</td> <td style="width:15%; text-align: center;">Mo. _____ Day _____ Year _____</td> <td style="width:15%;"></td> <td style="width:30%;"></td> </tr> <tr> <td>IgG</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td> ☐ Normal ☐ Abnormal ☐ Unknown </td> </tr> <tr> <td>IgM</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td> ☐ Normal ☐ Abnormal ☐ Unknown </td> </tr> <tr> <td>IgA</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td> ☐ Normal ☐ Abnormal ☐ Unknown </td> </tr> <tr> <td>Complement Assays</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td></td> </tr> <tr> <td>C3</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td> ☐ Normal ☐ Abnormal ☐ Unknown </td> </tr> <tr> <td>C4</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td> ☐ Normal ☐ Abnormal ☐ Unknown </td> </tr> <tr> <td>CH50</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td> ☐ Normal ☐ Abnormal ☐ Unknown </td> </tr> <tr> <td>Specific Function (specify _____)</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td> ☐ Normal ☐ Abnormal ☐ Unknown </td> </tr> <tr> <td>Other (specify _____)</td> <td style="text-align: center;">Mo. _____ Day _____ Year _____</td> <td></td> <td> ☐ Normal ☐ Abnormal ☐ Unknown </td> </tr> </table>				Quantitative Immunoglobulin	Mo. _____ Day _____ Year _____			IgG	Mo. _____ Day _____ Year _____		☐ Normal ☐ Abnormal ☐ Unknown	IgM	Mo. _____ Day _____ Year _____		☐ Normal ☐ Abnormal ☐ Unknown	IgA	Mo. _____ Day _____ Year _____		☐ Normal ☐ Abnormal ☐ Unknown	Complement Assays	Mo. _____ Day _____ Year _____			C3	Mo. _____ Day _____ Year _____		☐ Normal ☐ Abnormal ☐ Unknown	C4	Mo. _____ Day _____ Year _____		☐ Normal ☐ Abnormal ☐ Unknown	CH50	Mo. _____ Day _____ Year _____		☐ Normal ☐ Abnormal ☐ Unknown	Specific Function (specify _____)	Mo. _____ Day _____ Year _____		☐ Normal ☐ Abnormal ☐ Unknown	Other (specify _____)	Mo. _____ Day _____ Year _____		☐ Normal ☐ Abnormal ☐ Unknown
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– 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	CDC use only Case ID number _____ Serotype _____ Lab ID _____ Where serotyped: ☐ CDC ☐ AIP ☐ MDH ☐ Other: _____	

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