**\*\*\*DÉFINITION NOSOLOGIQUE\*\*\***

**Isolement de *Staphylococcus aureus* résistant à la vancomycine dont la concentration minimale inhibitrice (CMI) est égale ou supérieure à 4 μg/ml.**

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| **A. Identification** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **B. Identification du cas** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nom :** | |  | | | | | | |  | **Prénom :** | |  | | | | | | | | | | |  | **N. A. M :** | | | |  | |  |
|  | **Naissance / usuel** | | | | | | | |  | | | | | | | | | | |  | | | | | | |  | | | |
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| **Date de naissance :** | | | | | | **/** **/** | | | | | **(A/M/J)** | | | |  | **Sexe :** | | M | | | | F | | |  | | | | | |
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| **Adresse :** | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| **Téléphone(s) :** | | | | | **(Domicile) :** | |  | | | | | | |  | | | **(Autre) :** | |  | | | | | | | | | |  | |
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| **ACQUIS HORS QUÉBEC ?** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Non | | | Oui Pays ou continent d’exposition : | | | | | | | | | |  | | | | | | | | | | | | |  | | | | |
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| **C. Informations sur le cas** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date d’admission du cas colonisé ou infecté par le SARV/SARIV :** | | | | | | | | | | | | | | | | | | | | | **/       /** | | | | | | | | | **(A/M/J)** | | | | | |  | | | | |
| **Unité :** |  | | | | |  | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | |
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| **Le patient était déjà sous précautions additionnelles au moment de la découverte du SARV/SARIV** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Non** | | **Oui** | | **Type :** | | | |  | | | | | | | | | | | **Depuis :** | | | | | | | **/       /** | | | | | | | | | **(A/M/J)** | | | | |  |
| **Date de la mise en place des mesures de contrôle :** | | | | | | | | | | | | | | | | | | | | | | | | | | **/       /** | | | | | | | | | **(A/M/J)** | | | | | |
| **Découverte de l’état porteur du cas** | | | | | | | | | | | | | | | **Date du prélèvement :** | | | | | | | | | | | **/       /** | | | | | | | | | **(A/M/J)** | | | | |  |
| **Dépistage** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | À l’admission/réadmission d’un patient connu porteur ou ayant des antécédents d’infection à SARM ou à SARV/SARIV. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | D’un patient en provenance d’un CH situé hors Canada (admis pour plus de 24 h, dans la dernière année). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | D’un patient en provenance d’un hôpital aux prises avec une éclosion de SARV/SARIV (admis pour plus de 24 h). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | D’un patient partageant la même chambre qu’un porteur de SARV/SARIV nouvellement détecté. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Site du dépistage :** | | | | | | | Narines | | | | | | | | Stomie | | | | | Plaie cutanée | | | | | | | | Autre : | | |  | | | | | | | |  | |
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| **OU** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Spécimen clinique** | | | | |  | | | Site : | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
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| **Statut du cas :** | | | | | | Colonisé | | | | | | |  | | | Infecté | | | | | | |  | | | | | | | | | | | | | | | | | |
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| **Concentration minimale inhibitrice (CMI) de la souche de Staphylocoque aureus :** | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | **μg/ml** | | | |  | | | |
| **Envoi de la souche au LSPQ :** | | | | | | | | | | | Non | | | Oui | | | | Date : | | | | **/       /** | | | | | | | | | | (A/M/J) | | | | | | | | |
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| **ACQUIS HORS QUÉBEC**?  Non  Oui  **Lieu probable d’acquisition selon l’étude du dossier (unité, hôpital, pays, etc.)** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Complications** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Évolution :** | | | Récupération | | | | | | Admission USI | | | | | | | | Décès | | | | | | | | Inconnu | | | |  | | | | |  | | | | | | |
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**Acheminer à la DSP ce formulaire dûment complété par courriel ou par télécopieur**

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