County of Los Angeles Public Health

INVASIVE GROUP A STREPTOCOCCAL (GAS) OR PNEUMOCOCCAL DISEASE REPORT FORM

Includes Streptococcal Toxic Shock Syndrome (STSS) & Necrotizing Fasciitis

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
213-240-7941 (phone) 213-482-4856 (facsimile)
www.ph.lacounty.gov/acd/

VCMR ID: _____

DISEASE: ☐ Group A Streptococcal Disease (*Streptococcus pyogenes*) OR ☐ Pneumococcal Disease (*S. pneumoniae*)

Patient Name-Last	First	Middle Initial	Date of birth	Age	Sex

Address- Number, Street, Apt #	City	State	ZIP Code

Telephone number Home Work	Occupation

Race (check one): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African Am. ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unk ☐ Other: _____	Ethnicity (check one): ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

DIAGNOSTIC TESTS

Date of 1ST positive culture: _____

Culture site: Sterile: ☐ Blood ☐ Joint/Synovial Fluid ☐ CSF ☐ Pleural Fluid
☐ Other: Specify. _____ ☐ Tissue: Specify. _____

Non-sterile (GAS only): ☐ Skin ☐ Wound ☐ Other: Specify. _____

Did this patient have a positive influenza test 10 days prior to or following any positive culture? ☐ Yes ☐ No ☐ Unknown

Where was the patient a resident at time of initial culture? ☐ Private residence ☐ Long term care facility ☐ Long term acute care fac
☐ Homeless ☐ Incarcerated ☐ College dormitory ☐ Non-medical ward ☐ Other *(specify)*_____ ☐ Unk

If checked, Facility name: _____

Antibiotic susceptibilities performed? ☐ Yes ☐ No ☐ Unknown

If Yes, Complete table below. For results, specify S=susceptible, I=intermediate, or R=high resistance.

Antibiotic	Result	If MIC, Value?	Antibiotic	Result	If MIC, Value?	Antibiotic	Result	If MIC, Value?
Azithromycin	S / I / R		Clarithromycin	S / I / R		Penicillin	S / I / R	
Cefepime	S / I / R		Clindamycin	S / I / R		Rifampin	S / I / R	
Cefotaxime	S / I / R		Erythromycin	S / I / R		Tetracycline	S / I / R	
Ceftriaxone	S / I / R		Imipenem	S / I / R		TMP-SMX	S / I / R	
Cefuroxime	S / I / R		Levofloxacin	S / I / R		Vancomycin	S / I / R	
Ciprofloxacin	S / I / R		Ofloxacin	S / I / R		Other: ____	S / I / R	

CLINICAL INFORMATION

Onset date	Facility/Hospital Name		Medical record no.

Hospitalized ☐ Yes ☐ No	Admit date	Discharge date	If hospitalized, was this patient admitted to the ICU? ☐ Yes ☐ No ☐ Unk

Was the onset of symptoms >48 hours after admission to a hospital or healthcare setting? ☐ Yes ☐ No ☐ Unknown

Was the onset of symptoms within 7 days after discharge from the hospital for surgery or delivery? ☐ Yes ☐ No ☐ Unknown

If Yes, Type of surgery/delivery: _____ When: _____

Facility name: _____ Address, City, ZIP: _____

At time of 1st positive culture, patient was: ☐ Pregnant ☐ Postpartum ☐ Neither ☐ Unknown

Weight: ____ ☐ lbs & oz / ☐ kg / ☐ Unk	Height: ____ ☐ ft & in/ ☐ cm/ ☐ Unk	BMI (body mass index): __ __. __

Type of infection: (Check all that apply.)

☐ Bacteremia (w/o focus) ☐ Wound Infection: Surgical ☐ Meningitis ☐ Septic Arthritis ☐ Necrotizing Fasciitis
☐ Pneumonia ☐ Wound Infection: Non-Surgical ☐ Peritonitis ☐ Neonatal Sepsis ☐ Toxic Shock Syndrome
☐ Cellulitis ☐ Myositis ☐ Osteomyelitis ☐ Postpartum Sepsis/Puerperal Fever
☐ Other: Specify. _____

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

CLINICAL INFORMATION (CONTINUED)

Significant past medical/social history: (Check all that apply……If none, check box: ☐)

☐ Alcohol Abuse (☐ Current, ☐ Past)
☐ Asthma
☐ Atherosclerotic Cardiovascular Disease (ASCVD)/CAD
☐ Bone Marrow Transplant (BMT)
☐ CVA/Stroke/TIA
☐ Chronic Kidney Disease
☐ Chronic Liver Disease/Cirrhosis
☐ Current Chronic Dialysis
☐ Cochlear Implant
☐ Complement Deficiency
☐ Connective Tissue Dis. (Lupus, etc.)
☐ COPD
☐ CSF Leak
☐ Diabetes mellitus
☐ Heart Failure/CHF
☐ HIV/AIDS
☐ Hodgkin's Disease/Lymphoma
☐ Immunoglobulin Deficiency
☐ Immunosuppressive Therapy (includes steroids)
☐ Intravenous Drug Use (☐ Current, ☐ Past)
☐ Leukemia
☐ Multiple Myeloma
☐ Myocardial Infarction
☐ Nephrotic Syndrome
☐ Obesity
☐ Organ transplant: Date transplant: _____ Organ(s): _____
☐ Other Drug Use (☐ Current, ☐ Past)
☐ Peripheral Vascular Disease
☐ Sickle Cell Disease
☐ Smoker (current)
☐ Solid Organ Malignancy Specify. _____
☐ Splenectomy/Asplenia
☐ Other: Specify. _____

Outcome? ☐ Survived ☐ Died: Date of Death _____ ☐ Unknown

If survived, Discharged to: ☐ Home ☐ Long term care facility/SNF ☐ Long term acute care ☐ Other: _____ ☐ Unk

Surgery (GAS only):

In the 14 days prior to 1st positive culture,

Did the patient have surgery or any skin incision? ☐ Yes ☐ No ☐ Unknown If Yes, Date of surgery or skin incision: _____

Did the patient deliver a baby (vaginal or C-section)? ☐ Yes ☐ No ☐ Unknown If Yes, Date of delivery: _____

Did patient have (Check all that apply): ☐ Varicella ☐ Penetrating trauma ☐ Blunt trauma ☐ Surgical wound (post-op) ☐ Burns

If Yes to any of the above, number of days prior to 1st positive culture *(if > 1, use most recent skin injury)*: ☐ 0-7 days ☐ 8-14 days ☐ Unk

Did the patient have surgery because of the GAS infection? ☐ Yes ☐ No

If Yes, Date of surgery: _____ Debridement/Myotomy? ☐ Yes ☐ No Amputation? ☐ Yes ☐ No What body part(s)? _____

Other (specify): _____

Streptococcal Toxic Shock Syndrome (GAS only):

Did the following clinical manifestations occur within a 48 hour time period? ☐ Yes ☐ No

Hypotension: ☐ Yes ☐ No (Systolic pressure ≤ 90mm Hg for adults)

Multi-organ involvement:

Renal Impairment (Creatinine ≥2 mg/dL for adults): Highest Creatinine _____

Coagulopathy (Platelets ≤100,000 or Disseminated Intravascular Coagulation [DIC]):

Platelets (Lowest) _____ INR/PTT (Highest) _____ Fibrin Split Products (FSP) _____ Other: Specify. _____

Liver Involvement: Highest SGOT (AST) _____ Highest SGPT (ALT) _____ Highest Bilirubin _____

Acute Respiratory Distress Syndrome (ARDS): ☐ Yes ☐ No

(Hypoxemia, diffuse pulmonary infiltrates, diffuse capillary leak, generalized edema, pleural/peritoneal effusions with hypoalbuminemia)

Soft-Tissue Necrosis: ☐ Yes ☐ No (Including necrotizing fasciitis, myositis or gangrene)

Rash: ☐ Yes ☐ No (Generalized, erythematous macular rash)

REMARKS (Attach a copy of the admission and discharge summary)

Submitter name (print)	Title	Telephone number	Date
Facility/Hospital name	Address, City	E-mail address	