

Invasive Group A *Streptococcus* Surveillance Supplemental Form Arizona Department of Health Services

PATIENT DEMOGRAPHICS

Name (last, first) _____	Birthdate ___/___/___ or age _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UK
Street address _____	City _____	State _____ Zip _____
Occupation/school grade: _____	Employers/school/other: _____	
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Race: <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pac Islander <input type="checkbox"/> American Indian/ AK Native	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Other _____
Patient Chart Number: _____		

Where was the patient a resident at the time of initial culture? <input type="checkbox"/> Private residence <input type="checkbox"/> Homeless <input type="checkbox"/> Non – medical ward <input type="checkbox"/> Long term care facility <input type="checkbox"/> Incarcerated <input type="checkbox"/> Unknown <input type="checkbox"/> Long term acute care facility <input type="checkbox"/> College dormitory <input type="checkbox"/> Other (specify): _____ If resident of a facility, what was the name of facility? _____	Was patient transferred from another hospital? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UK If yes, hospital name: _____
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CLINICAL INFORMATION

Date of Onset of symptoms: ___/___/___	Diagnosis Date: ___/___/___																																																																																																										
<p style="text-align: center;">Disease caused by group A Streptococcus (check all that apply)</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>Primary Sepsis (without focus)</td><td><input type="checkbox"/></td></tr> <tr><td>Secondary Bacteremia</td><td><input type="checkbox"/></td></tr> <tr><td>Pharyngitis</td><td><input type="checkbox"/></td></tr> <tr><td>Peritonitis</td><td><input type="checkbox"/></td></tr> <tr><td>Septic Arthritis</td><td><input type="checkbox"/></td></tr> <tr><td>Necrotizing fasciitis</td><td><input type="checkbox"/></td></tr> <tr><td>Streptococcal Toxic Shock Syndrome</td><td><input type="checkbox"/></td></tr> <tr><td>Pneumonia</td><td><input type="checkbox"/></td></tr> <tr><td>Meningitis</td><td><input type="checkbox"/></td></tr> <tr><td>Osteomyelitis</td><td><input type="checkbox"/></td></tr> <tr><td>Polyarthritits</td><td><input type="checkbox"/></td></tr> <tr><td>Endometritis/postpartum sepsis</td><td><input type="checkbox"/></td></tr> <tr><td>Surgical wound infection site: _____</td><td><input type="checkbox"/></td></tr> <tr><td>Gangrene</td><td><input type="checkbox"/></td></tr> <tr><td>Nonsurgical wound infection site: _____</td><td><input type="checkbox"/></td></tr> <tr><td>Cellulitis/abscess site: _____</td><td><input type="checkbox"/></td></tr> <tr><td>Other (specify): _____</td><td><input type="checkbox"/></td></tr> </table>	Primary Sepsis (without focus)	<input type="checkbox"/>	Secondary Bacteremia	<input type="checkbox"/>	Pharyngitis	<input type="checkbox"/>	Peritonitis	<input type="checkbox"/>	Septic Arthritis	<input type="checkbox"/>	Necrotizing fasciitis	<input type="checkbox"/>	Streptococcal Toxic Shock Syndrome	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Osteomyelitis	<input type="checkbox"/>	Polyarthritits	<input type="checkbox"/>	Endometritis/postpartum sepsis	<input type="checkbox"/>	Surgical wound infection site: _____	<input type="checkbox"/>	Gangrene	<input type="checkbox"/>	Nonsurgical wound infection site: _____	<input type="checkbox"/>	Cellulitis/abscess site: _____	<input type="checkbox"/>	Other (specify): _____	<input type="checkbox"/>	<p style="text-align: center;">Complications</p> <table style="width: 100%; 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Did the patient have surgery or any skin incision? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UK If yes, date: ___/___/___	Did the patient deliver a baby? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UK If yes, date: ___/___/___	Did patient have: <input type="checkbox"/> Varicella <input type="checkbox"/> Surgical wound <input type="checkbox"/> Blunt trauma <input type="checkbox"/> Burns <input type="checkbox"/> Penetrating trauma																																																																																																									
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Hospitalization

Admit date: ___/___/___

Discharge date: ___/___/___

Hospital Name: _____

Hospital Address: _____

Past Medical History and Underlying Conditions (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Splenectomy/asplenia |
| <input type="checkbox"/> Chronic heart disease | <input type="checkbox"/> Organ transplant | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Malignancy | <input type="checkbox"/> Injecting drug use |
| <input type="checkbox"/> Acute varicella | <input type="checkbox"/> Pregnancy/Peripartum | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Renal failure w/dialysis | <input type="checkbox"/> Nonsurgical wound | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Surgical wound | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Blunt trauma | <input type="checkbox"/> Vasculitis/Lupus (SLE) |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dementia | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Chronic Kidney disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Hodgkin's Disease/Lymphoma |
| <input type="checkbox"/> Acupuncture (type) _____ | <input type="checkbox"/> Due/Delivery date: ___/___/___ | <input type="checkbox"/> Other (specify) _____ |

LABORATORY INFORMATION

Culture Positive:

Source _____

Date: ___/___/___

Lab name: _____

DIAGNOSIS

- Invasive *Streptococcus* Group A
 Pharyngitis
 Other (specify): _____
 Unknown

- Associated with outbreak
(Specify location) _____
 Sporadic case
 Unknown

Outcome of illness

- Survived Died Date of death: ___/___/___ Transferred Unknown

If patient is deceased: Death Certificate Number: _____ Cause of death _____

ADDITIONAL NOTES AND INFORMATION

FORM COMPLETED BY: _____

DATE: ___/___/___

FACILITY: _____

PHONE: _____

150 North 18th Avenue, Suite 140
Phoenix AZ 85007
Phone: 602-364-3676 FAX: 602-364-319

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