



**CONFIDENTIAL INVASIVE GROUP A STREPTOCOCCUS (GAS)
CASE REPORT FORM**

(see reverse for instructions and routing procedures)

PART I: PATIENT INFORMATION

Social Security Number _____
 Driver's License Number(optional) _____
 Last Name _____ First Name _____ MI _____
 Address _____
 City _____ State _____ Zip _____
 County _____ Phone (____) _____
 Gender 1__ male 2__ female 9__ unknown
 Date of Birth ____/____/____ Age _____
 Race Ethnicity
 1__ Am. Indian/Alaskan 1__ Hispanic
 2__ Asian/Pacific Islander 2__ Non-hispanic
 3__ Black 9__ Unknown
 5__ White
 8__ Other
 9__ Unknown/not specified

Onset Date: ____/____/____

Outcome:
 1 __ lived
 2 __ died
 9 __ unknown

Hospital Admitting Diagnosis: _____

Residence/location at time of onset:
 1 __ home
 2 __ nursing home
 3 __ shelter
 4 __ acute care hospital
 5 __ unknown
 6 __ other

SECTION II: CLINICAL INFORMATION

Disease(s) Caused by Group A Streptococcus Infection: CHECK ALL THAT APPLY

<input type="checkbox"/> Primary Sepsis (w/out focus)	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Gangrene
<input type="checkbox"/> Secondary bacteremia	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Nonsurg. wound infxn site: _____
<input type="checkbox"/> Pharyngitis	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Cellulitis/abscess site: _____
<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Polyarthrits	<input type="checkbox"/> Other, please specify: _____
<input type="checkbox"/> Septic arthritis	<input type="checkbox"/> Necrotizing fasciitis	
<input type="checkbox"/> Endometritis/postpartum sepsis	<input type="checkbox"/> Streptococcal Toxic Shock Syndrome	
<input type="checkbox"/> Surgical wound infection site: _____		

Underlying illness or prodrome: CHECK HERE IF NONE OR CHECK ALL THAT APPLY

<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Chronic heart disease	<input type="checkbox"/> Diabetes mellitus
<input type="checkbox"/> Acute varicella (chicken pox)	<input type="checkbox"/> Renal failure w/dialysis	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Obesity	<input type="checkbox"/> Stroke	<input type="checkbox"/> Splenectomy/asplenia
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Injecting drug use	<input type="checkbox"/> Smoking (in last 6 mos)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/> Vasculitis/Lupus (SLE)
<input type="checkbox"/> Organ transplant type _____		
<input type="checkbox"/> Malignancy (non-skin) type _____		
<input type="checkbox"/> Pregnancy/Peripartum Due/delivery date: ____/____/____		
<input type="checkbox"/> Nonsurgical wound specify _____ Date: ____/____/____		
<input type="checkbox"/> Surgical wound specify _____ Date: ____/____/____		
<input type="checkbox"/> Blunt trauma specify _____ Date: ____/____/____		

SECTION III: LABORATORY INFORMATION

Positive GAS Cultures: _____ Has the isolate been sent to the state lab for further characterization?
 1 __ Blood Culture Date ____/____/____ ___ YES ___ NO
 2 __ CSF Date ____/____/____
 3 __ Other Date ____/____/____
 (Please specify) _____

Form Completed by (print name) _____

County Health Department _____

Date _____

Purpose:

Completion of this form will:

- 1) assist with the identification of GAS clusters,
- 2) provide information to assess the severity of disease at the local level,
- 3) provide data for trend analysis, such as changes in serotype distributions, and
- 4) provide important data for public dissemination.

Case Definition (June 2000):

Streptococcal Disease, Invasive, Group A

reporting code 03400

Clinical description:

Invasive group A streptococcal infections may manifest as any of several clinical syndromes, including pneumonia, bacteremia in association with cutaneous infection (e.g., cellulitis, erysipelas, or infection of a surgical or nonsurgical wound), deep soft tissue infection (e.g., myositis or necrotizing fasciitis), meningitis, peritonitis, osteomyelitis, septic arthritis, postpartum sepsis (i.e., puerperal fever), neonatal sepsis, and nonfocal bacteremia.

Laboratory criteria for diagnosis:

Isolation of group A *Streptococcus* (*Streptococcus pyogenes*) by culture from a normally sterile site (e.g., blood or cerebrospinal fluid, or, less commonly, joint, pleural, or pericardial fluid)

Case classification:

Confirmed: a clinically compatible case that is laboratory confirmed

Instructions:

This form is intended to be completed by county health department epidemiology staff. The form should be submitted to the Bureau of Epidemiology (HSDE) in Tallahassee. County epidemiology staff should complete this form if:

- 1) Group A streptococcus (GAS) has been isolated from a normally sterile site: OR
- 2) GAS isolated from a nonsterile site and patient has GAS systemic disease (e.g. necrotizing fasciitis)

Routing Procedures:

After completing this form, please fax or mail to the Surveillance Section, Bureau of Epidemiology. The confidential fax number and the Bureau's mailing address are as follows:

Florida Department of Health
Bureau of Epidemiology/Surveillance Section
4052 Bald Cypress Way, Bin #A-12
Tallahassee, FL 32399-1720
Confidential Fax #: (850) 414-6894 (SC 994-6894)

Forms Retention Schedule:

This form is subject to the retention period specified in DOH Schedule 1, Item 2. Once data is entered into the Florida morbidity reporting system database, backed-up, and verified as entered, the electronic copy becomes the permanent record and the hard copy of the disease reporting form becomes a duplicate.