

Group B Streptococcus

PATIENT DEMOGRAPHICS

Name (last, first): _____	Birth date: __/__/____ Age: _____
Address: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
City/State/Zip: _____	Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
Phone (home): _____ Phone (work) : _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. (Mark all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Other <input type="checkbox"/> Unk
Occupation/grade: _____ Employer/School: _____	
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____	

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigator : _____	WVEDSS ID: _____
Investigator phone: _____	Case Classification: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unk
Investigation Start Date: __/__/____	

REPORTING SOURCE

Date of report: __/__/____	Report Source: <input type="checkbox"/> Laboratory <input type="checkbox"/> Hospital <input type="checkbox"/> Physician <input type="checkbox"/> Public Health Agency <input type="checkbox"/> Other
Report Source Name: _____	Address: _____ Phone: _____
Earliest date reported to county: __/__/____	Earliest date reported to state: __/__/____
Reporter Name: _____	Address: _____ Phone: _____

CLINICAL

Physician Name: _____	Physician Facility : _____
Physician Address: _____	Phone: _____

Hospital Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hospitalized for this illness?	If yes: Hospital name: _____
	Admit date: __/__/____	Discharge date: __/__/____

Condition	Illness onset date: __/__/____	Diagnosis date: __/__/____	Illness end date: __/__/____
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Types of infection caused by organism:

<input type="checkbox"/> Abscess (not skin)	<input type="checkbox"/> Bacteremia without focus	<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Chorioamnionitis
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Empyema	<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Endometritis
<input type="checkbox"/> Epiglottitis	<input type="checkbox"/> Hemolytic uremic syndrome (HUS)	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Necrotizing fasciitis
<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Otitis media	<input type="checkbox"/> Pericarditis	<input type="checkbox"/> Peritonitis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Puerperal sepsis	<input type="checkbox"/> Septic abortion	<input type="checkbox"/> Septic arthritis
<input type="checkbox"/> Streptococcal toxic-shock syndrome (STSS)	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Unknown	

Date first positive culture obtained: __/__/____

Sterile sites from which organism was isolated: Blood Bone Cerebral Spinal Fluid Internal body site Joint Muscle
 Pericardial Fluid Peritoneal Fluid Pleural Fluid Other normally sterile site (specify) _____

Nonsterile sites from which organism isolated: Amniotic fluid Middle ear Placenta Sinus Wound Other (specify) _____

Did patient have any underlying medical conditions? Y N U If yes, specify:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Asthma
<input type="checkbox"/> Atherosclerotic Cardiovascular Disease	<input type="checkbox"/> Burns	<input type="checkbox"/> Cerebral vascular accident (CVA)/Stroke
<input type="checkbox"/> Cirrhosis/liver failure	<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Complement deficiency
<input type="checkbox"/> CSF leak (2 deg trauma/surgery)	<input type="checkbox"/> Current smoker	<input type="checkbox"/> Deaf/profound hearing loss
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Heart failure/CHF
<input type="checkbox"/> HIV	<input type="checkbox"/> Hodgkin's disease	<input type="checkbox"/> Immunoglobulin deficiency
<input type="checkbox"/> Immunosuppressive therapy (steroids, chemo)	<input type="checkbox"/> IVDU	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Multiple myeloma	<input type="checkbox"/> Nephrotic syndrome	<input type="checkbox"/> Obesity
<input type="checkbox"/> Renal failure/dialysis	<input type="checkbox"/> Sickle cell anemia	<input type="checkbox"/> Splenectomy/Asplenia
<input type="checkbox"/> Systemic lupus erythematosus (SLE)	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other prior illness (specify) _____
<input type="checkbox"/> Other malignancy (specify) _____	<input type="checkbox"/> Organ transplant (specify) _____	

Did patient die from this illness? Y N U If yes, date of death: __/__/____

EPIDEMIOLOGIC

- Y N U If <6 years of age, is the patient in daycare? If yes, name of day care facility: _____
- Y N U Was the patient a resident of a nursing home or other chronic care facility at time of first positive culture?
If yes, name of chronic care facility? _____
- Y N U Is this case part of an outbreak? If yes, name of outbreak? _____

Where was the disease acquired?

- Indigenous, within jurisdiction Out of country Out of jurisdiction, from another jurisdiction Out of state Unknown

Confirmation method:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Active surveillance | <input type="checkbox"/> Case/Outbreak management | <input type="checkbox"/> Clinical diagnosis (not lab confirmed) | <input type="checkbox"/> Epidemiologically linked |
| <input type="checkbox"/> Lab confirmed | <input type="checkbox"/> Lab report | <input type="checkbox"/> Local/State specified | <input type="checkbox"/> Medical record review |
| <input type="checkbox"/> No information given | <input type="checkbox"/> Occupational disease surveillance | <input type="checkbox"/> Provider certified | <input type="checkbox"/> Other (specify): _____ |

Was patient pregnant or post-partum at time of first culture? Y N U

- If yes, outcome of fetus: Survived, no apparent illness Survived, clinical infection Live birth, neonatal death
 Abortion or stillbirth Induced abortion Unknown

If patient < 1 month of age: Gestational age (in weeks) _____ Birth weight (in grams) _____

PUBLIC HEALTH ACTIONS/NOTES

- Lost to follow-up