West Virginia Bureau for Public Health
Your Health Your Safety Our Purpose
Department of Health & Human Resources

Streptococcal Toxic-Shock Syndrome (STSS)

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade:_____ Employer/School:_____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:*_____ *Phone:* _____

Birth date: __ / __ / ____ Age: _____
Gender: ☐Male ☐Female ☐Unk

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unk

REPORTING SOURCE

Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐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
☐ ☐ ☐ Hospitalized for this illness? If yes: Hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Condition Illness onset date: __ / __ / ____ Diagnosis date: __ / __ / ____ Illness end date: __ / __ / ____

Types of infection caused by organism:

☐ Abscess (not skin)	☐ Bacteremia without focus	☐ Cellulitis	☐ Chorioamnionitis
☐ Conjunctivitis	☐ Empyema	☐ Endocarditis	☐ Endometritis
☐ Epiglottitis	☐ Hemolytic uremic syndrome (HUS)	☐ Meningitis	☐ Necrotizing fasciitis
☐ Osteomyelitis	☐ Otitis media	☐ Pericarditis	☐ Peritonitis
☐ Pneumonia	☐ Puerperal sepsis	☐ Septic abortion	☐ Septic arthritis
☐ Streptococcal toxic-shock syndrome (STSS)		☐ Other (specify) _____	☐ 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:

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

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

Y=Yes N=No U=Unknown

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:

☐ Active surveillance	☐ Case/Outbreak management	☐ Clinical diagnosis (not lab confirmed)	☐ Epidemiologically linked
☐ Lab confirmed	☐ Lab report	☐ Local/State specified	☐ Medical record review
☐ No information given	☐ Occupational disease surveillance	☐ Provider certified	☐ Other (specify): _____

Did the patient have surgery? ☐ **Y** ☐ **N** ☐ **U** If yes, date of surgery: __/__/____

Did the patient deliver a baby? ☐ **Y** ☐ **N** ☐ **U** If yes, delivery method: ☐ Vaginal ☐ C-section ☐ Unknown

Date of delivery: __/__/____

Did the patient have: ☐ Varicella ☐ Penetrating trauma ☐ Blunt trauma ☐ Surgical wound (post-operative) ☐ None ☐ Unknown

PUBLIC HEALTH ACTIONS/NOTES

☐ Lost to follow-up