County of Los Angeles Public Health

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

INVASIVE GROUP A STREPTOCOCCAL DISEASE (IGAS) REPORT FORM

Includes Streptococcal Toxic Shock Syndrome (STSS) & GAS Necrotizing Fasciitis

VCMR ID: _____

Fax completed form to Acute Communicable Disease Control at (213) 482-4856

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)

☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other:_____

Ethnicity (check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

If Asian/Pacific Islander, please check one: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian ☐ Japanese ☐ Korean ☐ Laotian ☐ Samoan ☐ Vietnamese ☐ Other: _____

DIAGNOSTIC TESTS

Date of culture: _____ Culture site: **Sterile** **Non-sterile**

☐ Blood ☐ Synovial Fluid ☐ Throat ☐ Vagina

☐ CSF ☐ Pleural Fluid ☐ Skin

☐ Tissue (specify) _____ ☐ Wound

☐ Other (specify) _____ ☐ Other (specify) _____

PRESENT ILLNESS

Onset date	Attending or consulting physician		Telephone number	Fax number

Hospitalized ☐ Yes ☐ No	Admit date	Discharge date	Facility/Hospital Name	Medical record no.

Was the patient admitted from a nursing home? ☐ Yes ☐ No If Yes, Facility name: _____

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

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

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

Facility name: _____ Address, City, ZIP: _____

Outcome? ☐ Recovered ☐ Fatal Date of Death: _____ ☐ Unknown

Symptoms of illness: (Check all that apply.)

☐ Bacteremia (without focus) ☐ Surgical Wound Infection ☐ Meningitis ☐ Septic Arthritis ☐ Necrotizing Fasciitis

☐ Pneumonia ☐ Non-Surgical Wound Infection ☐ Peritonitis ☐ Neonatal Sepsis ☐ Toxic Shock Syndrome

☐ Cellulitis ☐ Myositis ☐ Osteomyelitis ☐ Postpartum Sepsis/ Puerperal Fever

☐ Other (specify): _____

Surgery: Did the patient have surgery as a consequence of the IGAS infection? ☐ Yes ☐ No

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

Other (specify): _____

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

☐ Alcohol Abuse ☐ Tobacco Use (all forms) ☐ Intravenous Drug Use ☐ Chronic Lung Disease ☐ Cirrhosis ☐ Renal Failure with Dialysis

☐ Chronic Heart Disease ☐ Stroke ☐ Sickle Cell Disease ☐ Diabetes Mellitus ☐ Varicella ☐ Vasculitis/Lupus (SLE)

☐ HIV/AIDS ☐ Immunosuppressive therapy (including steroids) ☐ Splenectomy/Asplenia

☐ History of blunt trauma Specify: _____

☐ Organ transplant Date of transplant:: _____ Organ(s) _____

☐ Malignancy (non-skin) Specify: _____

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

CLINICAL FINDINGS for Streptococcal Toxic Shock Syndrome[STSS]

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) _____ PT/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	