Arizona Department of Health Services
INVASIVE GROUP A STREPTOCOCCUS SURVEILLANCE
SUPPLEMENTAL FORM

Case's name: ___________________________ Date of Birth: __/__/__
Date of admission: __/__/__ Outcome: ____ (1=Lived, 2=Died, 3=Transferred)

Disease(s) caused by group A strep infection: CHECK ALL THAT APPLY

- Primary Sepsis (without focus)
- Pneumonia
- Gangrene
- Secondary Bacteremia
- Meningitis
- Nonsurg. Wound infxn site:
- Pharyngitis
- Osteomyelitis
- Cellulitis/abscess site:
- Peritonitis
- Polyarthritis
- Other, please specify:
- Septic arthritis
- Endometritis/postpartum sepsis
- Necrotizing fasciitis
- Surgical wound infection site:
- Streptococcal Toxic Shock Syndrome (STSS)

Clinical Signs of Severity

- Hypotension (Systolic Blood Pressure ≤ 90) □ Y □ N □ DK
- Renal impairment (Creatinine ≥ 2 mg/dl) □ Y □ N □ DK
- Coagulopathy (Platelets ≤ 100,000 OR DIC) □Y □ N □ DK

Liver abnormalities

- AST, ALT, bilirubin > twice upper limit of normal □ Y □ N □ DK

Adult Respiratory Distress Syndrome □ Y □ N □ DK

Necrotizing Fasciitis or Gangrene □ Y □ N □ DK

Erythematous Rash □ Y □ N □ DK

Complications:

- Intensive care unit (ICU) care □ Y □ N □ DK
  If yes, given pressors?
  mechanical ventilation?
- Dialysis □ Y □ N □ DK
- Debridement/myotomy/l and D □ Y □ N □ DK
- Amputation □ Y □ N □ DK
DNR? □ Y □ N □ DK

Positive GAS cultures:
Source __________________ Date __/__/__     Source __________________Date __/__/__
Source __________________ Date __/__/__     Source __________________Date __/__/__

Date of symptom onset: __/__/__ (mo/day/yr)

Underlying illness or Prodrome:  CHECK HERE IF NONE □

CHECK ALL THAT APPLY
☐ Chronic lung disease     ☐ Splenectomy/asplenia
☐ Chronic heart disease   ☐ Alcohol abuse
☐ Diabetes mellitus      ☐ Injecting drug use
☐ Acute varicella (chicken pox)  ☐ Tobacco Use
☐ Renal failure w/dialysis ☐ Asthma
☐ Cirrhosis              ☐ Sickle cell disease
☐ Obesity               ☐ Vasculitis/Lupus (SLE)
☐ Stroke                ☐ Acupuncture
☐ Organ transplant type___________________________
☐ Malignancy (non-skin) type___________________________
☐ Pregnancy/Peripartum Due/delivery date: __/__/____
☐ Nonsurgical wound specify _________ Date: __/__/____
☐ Surgical wound specify _________ Date: __/__/____
☐ Blunt trauma specify _________ Date: __/__/____

Form completed by: _____________________________ Date __/__/__
Facility: _____________________________ Phone: ____________

Mail completed form to: Infectious Disease Epidemiology Section
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