

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**STREPTOCOCCAL INFECTION, GROUP A, INVASIVE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 61**

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U
 If yes, symptom onset date (mm/dd/yyyy): ___/___/___
 CHECK ALL THAT APPLY:
 Injury/wound/break in skin Y N U
 If yes:
 Recent/acute
 Pre-existing
 Date: ___/___/___
 Anatomic site: _____
 Principal wound type:
 Burn
 Surgery
 Other
 Unknown
 Current chicken pox (varicella) infection Y N U
 Is the patient a post-partum mother (<6 weeks)? Y N U
 Was patient hospitalized for this illness >24 hours? Y N U
 Hospital name: _____
 City, State: _____
 Hospital contact name: _____
 Telephone: (____) _____ - _____
 Admit date (mm/dd/yyyy): ___/___/___
 Discharge date (mm/dd/yyyy): ___/___/___
 Discharge/Final diagnosis: _____

During the 7 days prior to onset of symptoms, did the patient have surgery (besides oral surgery), obstetrical or invasive procedure? Y N U
 Visit/admit date (mm/dd/yyyy): ___/___/___
 Type of procedure _____
 Provider name _____
 Facility name _____
 City _____
 State _____
 Country _____
 Was facility notified regarding ill patient? Y N U N/A
 Name of person notified _____
 Date notified (mm/dd/yyyy): ___/___/___

REASON FOR TESTING
 Why was the patient tested for this condition?
 Symptomatic of disease
 Screening of asymptomatic person with reported risk factor(s)
 Exposed to organism causing this disease (asymptomatic)
 Household / close contact to a person reported with this disease
 Other, specify _____
 Unknown

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U
 Specify: _____

CLINICAL FINDINGS

Meningitis Y N U
 Arthritis Y N U
 Extent
 One joint
 Multiple joints
 Specify location _____
 Type
 Septic
 Other _____
 Osteomyelitis Y N U
 Myositis Y N U
 Necrotizing fasciitis Y N U
 Gangrene Y N U
 Amputation Y N U
 Pneumonia Y N U
 Confirmed by x-ray or CT Y N U
 Pericarditis Y N U
 Bacteremia Y N U
 Date of positive blood culture: ___/___/___
 Septicemia / sepsis Y N U
 Other symptoms, signs, clinical findings, or complications consistent with this illness? Y N U
 If yes, specify: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

TREATMENT

Did patient take an antibiotic as treatment for this illness? Y N U

If yes, specify antibiotic name: _____

Notes:

CLINICAL OUTCOMES

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ____/____/____

TRAVEL/IMMIGRATION

The patient is:

Resident of NC

Resident of another state or US territory

None of the above

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U

Patient a child care worker or volunteer in child care? Y N U

Patient a parent or primary caregiver of a child in child care? Y N U

Is patient a student? Y N U

Is patient a school WORKER/VOLUNTEER in NC school setting? Y N U

Give details:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 7 days prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U

Name of facility: _____

Dates of contact: from ____/____/____ until ____/____/____

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U

If yes, specify:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U

Who was interviewed?

Were health care providers consulted? Y N U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? Y N U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC

City _____

County _____

Outside NC, but within US

City _____

State _____

County _____

Outside US

City _____

Country _____

Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

Streptococcus infection, group A, invasive (*Streptococcus pyogenes*)

1995 CDC Case Definition

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 case that is laboratory confirmed

Comment

See also Streptococcal Toxic-Shock Syndrome.