Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Investigation of GAS outbreak in LTCF, Illinois – 2015
Resident Record Extraction Form

Person Completing Form _____ **Date Completed:** ____/____/____

A. Resident Background

1. Sex: Male Female 2. Age: _____ 3. Date of Birth: ____/____/____

4. Room History since [DATE]:

Room Number	Unit	Dates	Type	Acuity
a.			Private Double	Short Term Long Term
b.			Private Double	Short Term Long Term
c.			Private Double	Short Term Long Term
d.			Private Double	Short Term Long Term
e.			Private Double	Short Term Long Term
f.			Private Double	Short Term Long Term
g.			Private Double	Short Term Long Term
g.			Private Double	Short Term Long Term

Investigation of GAS outbreak in LTCF, Illinois – 2015
Resident Record Extraction Form

5a. Does/did the patient have a roommate with GAS infection or colonization? □ Yes □ No □ Unknown *(If no or unknown,skip to 6)*

(I)nfected or (C)olonized Roommate	Date of positive culture result	Site of Culture	Dates of Shared Rooms	
			From	To
b.	____/____/____		____/____/____	____/____/____
c.	____/____/____		____/____/____	____/____/____
d.	____/____/____		____/____/____	____/____/____
e.	____/____/____		____/____/____	____/____/____

6. Total length of stay at time of chart review (*mark only one*): □ ≤ 1 week □ 1-3 weeks □ 4-8 weeks □ ≥ 8 weeks

7a. Is resident currently living? □ Yes □ No If deceased, date of death ____/____/____

7b. If resident died, death was: □ Related to GAS infection □ Possibly related to GAS infection □ Not related □ Not applicable

8a. Resident's primary physician? _____

8b. Was this patient admitted to this facility from home? . □ Yes □ No

8c. Was this patient discharged from this facility to home? . □ Yes □ No □ Still in facility at time of chart review

9. List admission and discharge information since [5/1/2015].

Facility	Admission Date	Discharge Date	Diagnosis
a.	_____ / _____ / _____	_____ / _____ / _____	
b.	_____ / _____ / _____	_____ / _____ / _____	
c	_____ / _____ / _____	_____ / _____ / _____	
d.	_____ / _____ / _____	_____ / _____ / _____	
e.	_____ / _____ / _____	_____ / _____ / _____	

Investigation of GAS outbreak in LTCF, Illinois – 2015
Resident Record Extraction Form

B. Medical History

10a. Original date of admission to this facility: _____ / _____ / _____

10b. Facility patient admitted from? _____

□ Patient admitted from home

10c. Primary diagnosis (reason for admission to facility):

_____

11. Which medical condition(s) does the resident have? (*mark ALL that apply)*:

 Diabetes CHF/history of MI Peripheral Vascular Disease Stroke Asthma/COPD

 Hypertension Chronic Leg Edema Recent Herpes Zoster Dialysis

 Renal insufficiency Dementia Cancer (specify type) _____

 Vent dependence None Other: _____ _____

12. Weight: _____ lbs or kg *(circle unit of measure)* 12b. Height: _____

13a. Has the patient had a surgical procedure since [5/1/2015]? Yes No

Procedure	Date	Incision Site
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	

14b. Surgical skin wounds present since [5/1/2015] (*mark ALL that apply)*:

 PICC line Tracheostomy PEG/PEJ site Colostomy site

 AV fistula or graft Suprapubic catheter Hemodialysis catheter None

 Surgical wound: _____

 Other: _____

15. Type of IV access present at time of positive GAS culture None Not applicable

18a. Access Type	18b. Date of Insertion	18c. Person Inserting (e.g. RN)

16a. Since [5/1/2015], did the resident have non-surgical skin breakdown? □ Yes □ No *(If no, skip to 17)*

16b. Non-surgical skin breakdown since [5/1/2015] (*mark ALL that apply)*:

□ Sacrum □ Ischium □ Trochanter □ Heel □ Shoulder □ Occipital □ Lat. Malleolus

□ Med. Malleolus □ Elbow □ Ear □ Coccyx □ Toe □ Other: _____

17. Products used for wound care (surgical and nonsurgical):

□ Versafoam □ Granufoam □ Prisma Wound □ Matrix □ Mepilex □ Accuzyme

□ Ethyzyme □ DuoDerm □ Biotane Foam □ None □ Other:

_____

18a. Was a clinical diagnosis of cellulitis made since [5/1/2015]? □ Yes □ No *(If no, skip to 19)*

Location	Surgical Site	Date of Onset	Treated with Antibiotics
b.	□ Yes □ No	_____ / _____ / _____	□ Yes □ No
c.	□ Yes □ No	_____ / _____ / _____	□ Yes □ No
d.	□ Yes □ No	_____ / _____ / _____	□ Yes □ No

19. **Since** [5/1/2015] new, nonsurgical breakdown (*mark ALL that apply)*: □ None □ Not applicable

□ Sacrum □ Ischium □ Trochanter □ Heel □ Shoulder □ Occipital

□ Lat. Malleolus □ Med. Malleolus □ Elbow □ Ear □ Coccyx

□ Toe □ Other: _____

20. Surgical procedures **since** [5/1/2015] (*mark ALL that apply)*: □ None □ Not applicable

□ PICC line insertion □ Tracheostomy site □ PEG/PEJ site

 Colostomy site Suprapubic catheter Hemodialysis catheter

 AV fistula or graft Surgical incision: _____

 Debridement Other: _____

21a. Was a new clinical diagnosis of cellulitis made **since** [5/1/2015]? Yes No Not applicable *(If no or not applicable, skip to 22)*

Location	Surgical Site	Date of Onset	Treated with Antibiotics
21b.	Yes No	_____ / _____ / _____	Yes No
21c.	Yes No	_____ / _____ / _____	Yes No
21d.	Yes No	_____ / _____ / _____	Yes No

22a. Does/Did the resident receive negative pressure wound therapy via a vacuum-assisted closure device?

 Yes No

23b. If yes, date of initiation: _____ / _____ / _____

24b. Stop date: _____ / _____ / _____ or

 still in place at time of discharge from facility or at time of chart review

23. Since [5/1/2015], did the resident have any of the following signs or symptoms? (*mark ALL that apply)*

		Date of onset (dd/mm/yy)	
24a.	Fever (≥100.5°F)	_____ / _____ / _____	Max temp recorded:
24b.	Sore throat	_____ / _____ / _____	
24c.	Cough	_____ / _____ / _____	Productive? Yes No
24d.	Purulent discharge from wound	_____ / _____ / _____	Site:

C. Resident Baseline Status *(Can get further information from nursing)*

24. Which appliances does the resident use (*mark ALL that apply)*:

 Tracheostomy Nasal Cannula Oxygen Mask Nebulizer treatment

 G or J tube Nasogastric tube Colostomy Suprapubic catheter

 Chronic Foley Temporary Foley Texas/Condom catheter

 Dialysis Catheter PICC Line Other _____

25. Describe the resident's ambulatory status: (*mark ALL that apply)*

 Walks independently Walks with support Wheelchair Geri chair Bed bound

26. Indicate if resident incontinent of: (mark ALL that apply)

 Stool Urine Not Incontinent Urinary catheter Colostomy Unknown

27. Does the resident require tube feeds or TPN? Yes No

28. Does the patient have an alcohol-based hand-gel dispenser in his/her room? Yes No

29. How often did the resident participate in the following activities (mark ALL that apply):

30a. PT/OT Times per 2 month period: _____

30b. Speech pathology Times per 2 month period: _____

30c. Podiatry Times per 2 month period: _____

30d. Other: _____ Times per 2 month period: _____

D. Medications

30. Which of the following medications did the resident receive since [5/1/2015]? (*mark ALL that apply)*:

30a. Steroids

30b. Chemotherapy

30c. Radiation therapy

30d. Immunosuppressive agents to treat autoimmune disorders (e.g. methotrexate, infliximab)
(name)_____

E. Laboratory Results

31a. Did resident have a rapid Strep test since [5/1/2015]? Yes No

31b. Date _____ / _____ / _____

31c. Result? Positive Negative

32a. Did resident have an OP Strep culture since [5/1/2015]?

 Yes No

32b. Date _____ / _____ / _____

32c. Result? GAS Positive GAS Negative

32d. □ Positive for other Strep species 32e. List type _____

33a. Did resident have other cultures positive for GAS since [5/1/2015] □ Yes □ No *(if No skip to 35)*

33b. Culture #1 33c. Date obtained _____ / _____ / _____

33d. Site: □ Skin/Wound: _____ □ Blood □ Lung □ Sputum □ Other _____

33e. Culture #2 33f. Date obtained _____ / _____ / _____

33g. Site: □ Skin/Wound: _____ □ Blood □ Lung □ Sputum □ Other _____