**Person completing form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed:** **\_\_\_\_/\_\_\_\_/\_\_\_\_**

**Resident** *(check one)***:**  Case Control

**If CONTROL, date of matched case’s GAS culture: \_\_\_\_/\_\_\_\_/\_\_\_\_**

1. **GAS TESTING RESULTS**
	1. Did resident have any **cultures/tests positive** for GAS?

 Yes No

|  |  |  |
| --- | --- | --- |
| # | Date obtained | Site cultured |
| a. | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |  Blood Pleural Skin/Wound: \_\_\_\_\_\_\_\_\_ Rapid strep  Sputum Joint Other \_\_\_\_\_\_\_\_\_\_ Throat  Central line/TPN Catheter  |
| b. | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |  Blood Pleural Skin/Wound: \_\_\_\_\_\_\_\_\_ Rapid strep  Sputum Joint Other \_\_\_\_\_\_\_\_\_\_ Throat  Central line/TPN Catheter  |
| c. | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |  Blood Pleural Skin/Wound: \_\_\_\_\_\_\_\_\_ Rapid strep  Sputum Joint Other \_\_\_\_\_\_\_\_\_\_ Throat  Central line/TPN Catheter  |
| d. | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |  Blood Pleural Skin/Wound: \_\_\_\_\_\_\_\_\_ Rapid strep  Sputum Joint Other \_\_\_\_\_\_\_\_\_\_ Throat  Central line/TPN Catheter  |
| e. | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |  Blood Pleural Skin/Wound: \_\_\_\_\_\_\_\_\_ Rapid strep  Sputum Joint Other \_\_\_\_\_\_\_\_\_\_ Throat  Central line/TPN Catheter  |
| f. | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |  Blood Pleural Skin/Wound: \_\_\_\_\_\_\_\_\_ Rapid strep  Sputum Joint Other \_\_\_\_\_\_\_\_\_\_ Throat  Central line/TPN Catheter  |

**B. RESIDENT BACKGROUND**

2. Sex: Male Female 3. Age: \_\_\_\_\_\_\_\_\_\_ 4. Date of birth: **\_\_\_\_/\_\_\_\_/\_\_\_\_**

5a. Room history for 1 month prior to GAS culture (for case) or time of time match (for control):

|  |  |  |  |
| --- | --- | --- | --- |
| Room # (floor/wing) | Dates in room | Type of room | Roommate (dates) |
| a. | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |  Private Double Triple | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |
| b. | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |  Private Double Triple | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |
| c. | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |  Private Double Triple | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |
| d. | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |  Private Double Triple | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |
| e. | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |  Private Double Triple | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |
| f. | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |  Private Double Triple | **\_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_** |

5b. Did the resident have a roommate with GAS infection or colonization?

 Yes No Unknown *If yes*: initials of GAS+ roommate\_\_ Dates room shared: \_\_\_\_\_\_\_\_\_\_\_

5c. Did the resident have frequent visitors during his stay in the facility? (if no, skip to 6)

 Yes No Unknown

*If yes*: how many days per week?\_\_\_\_\_\_ How many regular visitors/week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Total length of stay at facility (most recent stay only) at time of GAS culture (*mark only one*):

 ≤ 1 week 1-3 weeks 4-8 weeks ≥ 8 weeks

7a. Is the resident deceased? Yes No If yes, date of death: \_\_\_\_/\_\_\_\_/\_\_\_\_

b. If resident died, death was: Related to GAS infection Possibly related to GAS infection

 Not related Not applicable

8. Resident’s physicians?

|  |  |  |
| --- | --- | --- |
| Physician’s name | Name of practice | Specialty (e.g., wound care, etc.) |
| a. |  |  |
| b. |  |  |
| c. |  |  |
| d. |  |  |

 9. List last admission prior to GAS infection or time of match for controls (including home, facility, hospitals, and any other LTCF).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name & location | Admission date | Discharge date | Diagnosis (if applicable) | Admission from: |
| a. | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ |  |  |
| b. | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ |  |  |

**C. MEDICAL HISTORY**

10. 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  Chronic skin condition

 Cancer, specify type: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immunosuppressed/immunosuppression None

 Cirrhosis Recent IV Drug Use Prosthetic Other: \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_

(**Note**: immunosuppression includes: HIV/AIDS, chemo, radiation, immunosuppressive meds, including tacrolimus [Prograf], sirolimus [Rapamune], mycophenolate mofetil [Cellcept], high-dose or chronic steroids [prednisone, methylprednisone, hydrocortisone, dexamethasone] methotrexate.)

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

12. Did patient have any surgical wounds, pressure ulcers, or other wounds at the time of admission to the facility?

 Yes If yes, how many \_\_\_\_\_ No

13. Did patient have any surgical wounds, pressure ulcers, or other wounds at the time of first GAS isolation for case or at time-match for controls?

 No Yes *If yes, how many* \_\_\_\_\_

 *Indicate location(s):*



14. Did the patient receive wound care consultation services within 1 month prior to the GAS case or time-match for controls?

 Yes No

|  |  |
| --- | --- |
| Dates | Name(s) of doctors or nurses |
|  |  |
|  |  |
|  |  |
|  |  |

15. Did the patient receive wound care WITHOUT wound care consultation within 1 month prior to GAS case or time-match for controls?

 Yes No

16. Products used for wound care (surgical and nonsurgical) (*check all*):

 Versafoam Granufoam Prisma Wound Matrix Mepilex Accuzyme

 Ethyzyme DuoDerm Biotane Foam Hydrogel Wound vac

 Antimicrobial cleanser/cream None Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Has the patient had a surgical procedure within 1 month of GAS infection or time match for control?

 Yes No

|  |  |  |
| --- | --- | --- |
| Procedure | Date | Incision Site |
|  | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ |  |

18. Type of IV access present at time of positive GAS culture/referral from CC? None Not applicable

|  |  |  |
| --- | --- | --- |
| 15a. Access Type | 15b. Date of Insertion | 15c. Person Inserting (e.g. RN) |
|  |  |  |

19. At time of GAS culture (case) or time-match (for control), was the resident diagnosed with:

1. Cellulitis Yes No Date of onset \_\_\_/\_\_\_/\_\_\_\_
2. Wound infection Yes No Date of onset \_\_\_/\_\_\_/\_\_\_\_
3. Pharyngitis Yes No Date of onset \_\_\_/\_\_\_/\_\_\_\_
4. Bacteremia Yes No Date of onset \_\_\_/\_\_\_/\_\_\_\_
5. Pneumonia  Yes  No Date of onset \_\_\_/\_\_\_/\_\_\_\_
6. Joint Infection  Yes  No Date of onset \_\_\_/\_\_\_/\_\_\_\_

20. Within 1 month of GAS culture or time-match for control, did the resident have any of the following signs or symptoms? (*mark ALL that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Date of onset (dd/mm/yy) |  |
| a. |  Fever (≥100.5oF or 38oC) | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Max temp recorded: |
| b. |  Sore throat | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ |  |
| d. |  Purulent discharge from wound | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Site: |
| e. |  Wound – warm on touch | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Site: |
| f. |  Wound – redness | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Site: |
| g. |  Edema at the site | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Site: |
| h. |  Increased pain at the site | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Site: |
| i. |  Joint – warm on touch | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Site: |
| j. |  Joint – redness | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Site: |
| k. |  Joint – warm on touch | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | Site: |

**C. RESIDENT BASELINE STATUS** *(Can get further information from nursing)*

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

 Tracheostomy Nasal cannula Oxygen mask Chronic Foley

 G or J tube Nasogastric tube Colostomy/ileostomy Temporary Foley

 Dialysis catheter PICC line Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Describe the resident’s ambulatory status: (*mark ALL that apply)*

 Walks independently Walks with support Wheelchair Geri chair Bed bound

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

 Stool Urine Not Incontinent Urinary catheter Colostomy/Ileostomy Unknown

24. Is the resident being tube fed? Yes No

25. Did the resident participate in the following activities in the 1 month prior to diagnosis or time-match for controls (mark ALL that apply):

 a. PT/OT Times per 2 month period: \_\_\_\_\_\_

 b. Speech pathology Times per 2 month period: \_\_\_\_\_\_

 c. Podiatry Times per 2 month period: \_\_\_\_\_\_

 d. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Times per 2 month period: \_\_\_\_\_\_