

## Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016 Resident Record Extraction Form

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

Person completing form \_\_\_\_\_

Date Completed: \_\_\_/\_\_\_/\_\_\_

Resident (check one):  Case  Control

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

**A. GAS TESTING RESULTS**

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

 Yes  No

#	Date obtained	Site cultured
a.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
b.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
c.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
d.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
e.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
f.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> 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 ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
b.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
c.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
d.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
e.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___

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Public reporting burden of this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

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f.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
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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: \_\_\_\_\_

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(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.)

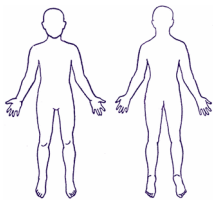
11. Weight: \_\_\_\_\_ lbs or kg (*circle unit of measure*)                      12b. Height: \_\_\_\_\_

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

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	____ / ____ / ____	
	____ / ____ / ____	

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:

- |                    |                              |                             |                              |
|--------------------|------------------------------|-----------------------------|------------------------------|
| a. Cellulitis      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____/____/____ |
| b. Wound infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____/____/____ |
| c. Pharyngitis     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____/____/____ |
| d. Bacteremia      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____/____/____ |
| e. Pneumonia       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____/____/____ |
| f. Joint Infection | <input type="checkbox"/> Yes | <input type="checkbox"/> 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.	<input type="checkbox"/> Fever ( $\geq 100.5^\circ\text{F}$ or $38^\circ\text{C}$ )	____ / ____ / ____	Max temp recorded:
b.	<input type="checkbox"/> Sore throat	____ / ____ / ____	
d.	<input type="checkbox"/> Purulent discharge from wound	____ / ____ / ____	Site:
e.	<input type="checkbox"/> Wound – warm on touch	____ / ____ / ____	Site:
f.	<input type="checkbox"/> Wound – redness	____ / ____ / ____	Site:
g.	<input type="checkbox"/> Edema at the site	____ / ____ / ____	Site:
h.	<input type="checkbox"/> Increased pain at the site	____ / ____ / ____	Site:
i.	<input type="checkbox"/> Joint – warm on touch	____ / ____ / ____	Site:
j.	<input type="checkbox"/> Joint – redness	____ / ____ / ____	Site:
k.	<input type="checkbox"/> 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*):

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Tracheostomy      | <input type="checkbox"/> Nasal cannula    | <input type="checkbox"/> Oxygen mask           | <input type="checkbox"/> Chronic Foley   |
| <input type="checkbox"/> G or J tube       | <input type="checkbox"/> Nasogastric tube | <input type="checkbox"/> Colostomy/ileostomy   | <input type="checkbox"/> Temporary Foley |
| <input type="checkbox"/> Dialysis catheter | <input type="checkbox"/> PICC line        | <input type="checkbox"/> Other, specify: _____ |  |

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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. | <input type="checkbox"/> PT/OT            | Times per 2 month period: _____ |
| b. | <input type="checkbox"/> Speech pathology | Times per 2 month period: _____ |
| c. | <input type="checkbox"/> Podiatry         | Times per 2 month period: _____ |
| d. | <input type="checkbox"/> Other: _____     | Times per 2 month period: _____ |