**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  |

Public reporting burden of this collection of information is estimated to average 30 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)

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. | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ |  |

**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 (≥100.5oF) | \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_