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

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)

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.	______ / _______ / _______	______ / _______ / _______	

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 _________________