Study ID #: _R□□□

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

Form Approved; OMB No. 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.	____/_____/_____	□ Blood □ Sputum □ Central line/TPN	□ Pleural □ Joint □ Catheter	□ Skin/Wound: _____ □ Other _____	□ Rapid strep □ Throat
b.	____/_____/_____	□ Blood □ Sputum □ Central line/TPN	□ Pleural □ Joint □ Catheter	□ Skin/Wound: _____ □ Other _____	□ Rapid strep □ Throat
c.	____/_____/_____	□ Blood □ Sputum □ Central line/TPN	□ Pleural □ Joint □ Catheter	□ Skin/Wound: _____ □ Other _____	□ Rapid strep □ Throat
d.	____/_____/_____	□ Blood □ Sputum □ Central line/TPN	□ Pleural □ Joint □ Catheter	□ Skin/Wound: _____ □ Other _____	□ Rapid strep □ Throat
e.	____/_____/_____	□ Blood □ Sputum □ Central line/TPN	□ Pleural □ Joint □ Catheter	□ Skin/Wound: _____ □ Other _____	□ Rapid strep □ Throat
f.	____/_____/_____	□ Blood □ Sputum □ Central line/TPN	□ Pleural □ Joint □ Catheter	□ Skin/Wound: _____ □ Other _____	□ Rapid strep □ Throat

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** ___/___/____

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** ___/___/____	□ 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: _____

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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: _____

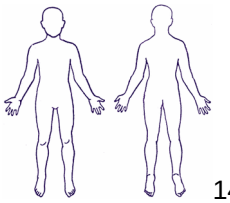
12. Did patient have any surgical wounds, pressure ulcers, or other wounds at the time of admission to the facility?

□ 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 □ Yes □ No Date of onset ___/___/____
b. Wound infection □ Yes □ No Date of onset ___/___/____
c. Pharyngitis □ Yes □ No Date of onset ___/___/____
d. Bacteremia □ Yes □ No Date of onset ___/___/____
e. Pneumonia □ Yes □ No Date of onset ___/___/____
f. 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: _____

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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. □ 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: _____

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