

# ABCs - Severe GAS Infection: Supplemental Form

State ID: \_\_\_\_\_

Symptom onset date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

Unknown symptom onset date (check if unknown)

**Please enter clinical finding and/or laboratory information requested below;  
record the HIGHEST or LOWEST value within 48 hours of culture or admission**

Form Approved  
0920-0978

REV. 2/2017

<p>1. Soft-tissue necrosis (necrotizing fasciitis, necrotizing myositis, or necrotizing gangrene)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>If yes, a. Location on body: _____</p> <p>b. Surgery? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>c. Amputation? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>d. Debridement <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p>		<p><b>OPTIONAL:</b> e. Is a pathology report available? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>f. Is a surgical report available? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>g. Is a CT or MRI report available? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p><i>(If yes to any of the questions above, please collect report)</i></p>																																																								
<p>2. Did the case have any of the following sequelae from the GAS infection? (Select all that apply)</p> <p>a. Dialysis? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK      If yes to 2c., please indicate rehab type:</p> <p>b. Impaired renal function? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK      <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Rehab facility</p> <p>c. Rehabilitation? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>d. Other <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK      <i>(If yes, specify)</i> _____</p>																																																										
<p>3. If the case died, and was not hospitalized, please indicate date of death: ___/___/___ (mm/dd/yyyy)</p>																																																										
<p>4. Hypotension? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK      Lowest systolic BP ___ mmHg or <input type="checkbox"/> not available</p> <p><i>(Systolic BP ≤ 90mmHg; for children &lt; 10yrs, see Instructions)</i>      <i>(Enter lowest systolic BP recorded during this illness)</i></p>																																																										
<p><b>***IF PATIENT DID NOT HAVE HYPOTENSION AT ANY TIME DURING THIS ILLNESS, PLEASE STOP HERE***</b></p>																																																										
<p>5. a. Renal impairment? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK      Highest creatinine ___ mg/dL or lab value unavailable</p> <p><i>(Creatinine ≥ 2.12 mg/dL; for children &lt; 15yrs, see Instructions)</i>      <i>(Enter highest creatinine recorded during this illness)</i></p> <p>b. Was chronic kidney disease specifically listed in the chart? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Baseline or lowest creatinine: ___ mg/dL or <input type="checkbox"/> lab value unavailable</p> <p><i>(Enter lowest creatinine recorded in the chart)</i></p> <p>Date of baseline value if obtained from current hospitalization: ___/___/___ (mm/dd/yyyy)</p>																																																										
<p>6 a. Coagulopathy? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK      Lowest platelets ___ (000)/mm<sup>3</sup> or <input type="checkbox"/> lab value unavailable</p> <p><i>(Platelets ≤ 100,000/mm<sup>3</sup>)</i>      <i>(Enter lowest platelet count recorded during this illness)</i></p> <p>b. Disseminated intravascular coagulation (DIC)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p>																																																										
<p>7a. Liver involvement? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p><b>Reference Table (2x upper limit)</b></p> <table border="1" style="width: 100%; border-collapse: collapse; font-size: small;"> <thead> <tr> <th colspan="2">Age</th> <th colspan="2">ALT (SGPT) ≥ or AST (SGOT) ≥</th> </tr> </thead> <tbody> <tr> <td rowspan="2">0 – 7 days:</td> <td>M</td> <td>80 U/L</td> <td>200 U/L</td> </tr> <tr> <td>F</td> <td>80 U/L</td> <td>190 U/L</td> </tr> <tr> <td rowspan="2">8 – 30 days:</td> <td>M</td> <td>80 U/L</td> <td>142 U/L</td> </tr> <tr> <td>F</td> <td>64 U/L</td> <td>142 U/L</td> </tr> <tr> <td>1 – 12 months</td> <td></td> <td>90 U/L</td> <td>126 U/L</td> </tr> <tr> <td>1 – 3 years</td> <td></td> <td>90 U/L</td> <td>120 U/L</td> </tr> <tr> <td>4 – 9 years</td> <td></td> <td>90 U/L</td> <td>100 U/L</td> </tr> <tr> <td>10 – 15 years</td> <td></td> <td>90 U/L</td> <td>80 U/L</td> </tr> <tr> <td rowspan="2">16 – 19 years:</td> <td>M</td> <td>90 U/L</td> <td>90 U/L</td> </tr> <tr> <td>F</td> <td>90 U/L</td> <td>60 U/L</td> </tr> <tr> <td>20+ years</td> <td></td> <td>80 U/L</td> <td>76 U/L</td> </tr> </tbody> </table> <p><b>Or Total bilirubin ≥ 2 mg/dL</b></p>	Age		ALT (SGPT) ≥ or AST (SGOT) ≥		0 – 7 days:	M	80 U/L	200 U/L	F	80 U/L	190 U/L	8 – 30 days:	M	80 U/L	142 U/L	F	64 U/L	142 U/L	1 – 12 months		90 U/L	126 U/L	1 – 3 years		90 U/L	120 U/L	4 – 9 years		90 U/L	100 U/L	10 – 15 years		90 U/L	80 U/L	16 – 19 years:	M	90 U/L	90 U/L	F	90 U/L	60 U/L	20+ years		80 U/L	76 U/L	<p>b. Was chronic liver disease specifically listed in the chart? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Enter baseline (from old or current charts) or lowest value and highest values recorded during this illness episode below. Enter <u>dates</u> of baseline values if obtained from <u>current hospitalization</u>.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">Highest</th> <th style="text-align: center; border-bottom: 1px solid black;">Baseline or lowest</th> <th style="text-align: center; border-bottom: 1px solid black;">Date of baseline</th> </tr> </thead> <tbody> <tr> <td>AST (SGOT) ___ U/L or <input type="checkbox"/> lab value unavailable</td> <td>AST (SGOT) ___ U/L or <input type="checkbox"/> lab value unavailable</td> <td>___/___/___ (mm/dd/yyyy)</td> </tr> <tr> <td>ALT (SGPT) ___ U/L or <input type="checkbox"/> lab value unavailable</td> <td>ALT (SGPT) ___ U/L or <input type="checkbox"/> lab value unavailable</td> <td>___/___/___ (mm/dd/yyyy)</td> </tr> <tr> <td>Bilirubin ___ mg/dL or <input type="checkbox"/> lab value unavailable</td> <td>Bilirubin ___ mg/dL or <input type="checkbox"/> lab value unavailable</td> <td>___/___/___ (mm/dd/yyyy)</td> </tr> </tbody> </table>	Highest	Baseline or lowest	Date of baseline	AST (SGOT) ___ U/L or <input type="checkbox"/> lab value unavailable	AST (SGOT) ___ U/L or <input type="checkbox"/> lab value unavailable	___/___/___ (mm/dd/yyyy)	ALT (SGPT) ___ U/L or <input type="checkbox"/> lab value unavailable	ALT (SGPT) ___ U/L or <input type="checkbox"/> lab value unavailable	___/___/___ (mm/dd/yyyy)	Bilirubin ___ mg/dL or <input type="checkbox"/> lab value unavailable	Bilirubin ___ mg/dL or <input type="checkbox"/> lab value unavailable	___/___/___ (mm/dd/yyyy)
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<p>8. a. Adult respiratory distress syndrome (ARDS)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>b. Acute onset of generalized edema? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>c. Pleural or peritoneal effusions with hypoalbuminemia? (Serum albumin &lt;3 g/dL or &lt; 30 g/L) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p> <p>Lowest albumin ___ g/dL or <input type="checkbox"/> lab value unavailable</p> <p><i>(Enter lowest albumin recorded during this illness)</i></p>																																																										
<p>9. Generalized erythematous rash? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK</p>																																																										

Form completed by (initials): \_\_\_\_\_ Date form completed: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

Public reporting burden of this collection of information is estimated to average 20 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 information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30329, ATTN: PRA(0920-0978). **Do not send the completed form to this address.**