

CASE REPORT FORM

Invasive Group A Streptococcal Infection

EpiSurv No.

Reporting Authority

Name of Public Health Officer responsible for case **OfficerName**

Notifier Identification

Reporting source* **ReportSrc**
☐ General Practitioner ☐ Hospital-based Practitioner ☐ Laboratory
☐ Self-notification ☐ Outbreak Investigation ☐ Other

Name of reporting source **ReportName** **Organisation** **ReportOrganisation**

Date reported* **ReportDate** **Laboratory sample date** **SampleDate** **Contact phone** **ReportPhone**

Usual GP **UsualGP** **Practice** **GPPracticeName** **GP phone** **GPPhone**

GP/Practice address Number **GPAddress** Street **GPAddress** Suburb **GPAddress** Town/City **GPAddress** Post Code **GPAddress** ☐ GeoCode **GPAddress**

Case Identification

Name of case* Surname **Surname** Given Name(s) **GivenName**

NHI number* **NHINumber** **Email** **Email**

Current address* Number **CaseAddress** Street **CaseAddress** Suburb **CaseAddress** Town/City **CaseAddress** Post Code **CaseAddress** ☐ GeoCode **CaseAddress**

Phone (home) **PhoneHome** **Phone (work)** **PhoneWork** **Phone (other)** **PhoneOther**

Case Demography

Location **TA* TA** **DHB* DHB**

Date of birth* **DateOfBirth** **OR** **Age** **Age** ☐ Days ☐ Months ☐ Years **AgeUnits**

Sex* **Sex** ☐ Male ☐ Female ☐ Indeterminate ☐ Unknown

Occupation* **Occupation**

Occupation location **PlaceOfWork1Type** ☐ Place of Work ☐ School ☐ Pre-school

Name **PlaceOfWork1**

Address Number **PlaceOfWork1Address** Street **PlaceOfWork1Address** Suburb **PlaceOfWork1Address** Town/City **PlaceOfWork1Address** Post Code **PlaceOfWork1Address** ☐ GeoCode **PlaceOfWork1Address**

Alternative location **PlaceOfWork2Type** ☐ Place of Work ☐ School ☐ Pre-school

Name **PlaceOfWork2**

Address Number **PlaceOfWork2Address** Street **PlaceOfWork2Address** Suburb **PlaceOfWork2Address** Town/City **PlaceOfWork2Address** Post Code **PlaceOfWork2Address** ☐ GeoCode **PlaceOfWork2Address**

Ethnic group case belongs to* (tick all that apply)

- ☐ NZ European **EthNZEuroean** ☐ Maori **EthMaori** ☐ Samoan **EthSamoan** ☐ Cook Island Maori **EthCookIslandMaori**
☐ Niuean **EthNiuean** ☐ Chinese **EthChinese** ☐ Indian **EthIndian** ☐ Tongan **EthTongan**
☐ Other (such as Dutch, Japanese) **EthOther** *(specify) **EthSpecify1** **EthSpecify2**

Invasive group A streptococcal infection	EpiSurv No. EpiSurvNumber
Basis of Diagnosis	
CLINICAL CRITERIA	
Fits clinical description* FitClinDes	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Clinical features	
Sepsis/septic shock* Sepsis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Streptococcal toxic shock syndrome* STSS	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Cellulitis* Cellulitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Necrotising fasciitis* NecFasc	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Osteomyelitis* Osteomyelitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Septic arthritis* SepticArthritis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Pneumonia* Pneumonia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Empyema* Empyema	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Meningitis* Meningitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Peripartum infection* PeripartInf	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Neonatal sepsis* NeonInfSepsis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Other invasive illness* (specify) OthInvas	<input style="width: 100%;" type="text"/>
LABORATORY CRITERIA	
Isolation of group A <i>Streptococcus</i> (<i>Streptococcus pyogenes</i>) from a clinical specimen* Isolation <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results	
If yes, site	
Sterile site IsolSite	
<input type="radio"/> Blood <input type="radio"/> CSF <input type="radio"/> Joint fluid <input type="radio"/> Bone <input type="radio"/> Tissue (specify) IsolTissue <input style="width: 150px;" type="text"/> <input type="radio"/> Other sterile site (specify) IsolOthSterile <input style="width: 150px;" type="text"/>	<input type="radio"/> Pleural fluid <input type="radio"/> Peritoneal fluid <input type="radio"/> Pericardial fluid
Non-sterile site	
<input type="radio"/> Non sterile site (specify) IsolNonSterile <input style="width: 150px;" type="text"/>	
Detection of group A <i>Streptococcus</i> (<i>Streptococcus pyogenes</i>) nucleic acid* NAAT <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results	
If yes, site NAATSite	
<input type="radio"/> Throat <input type="radio"/> Sputum <input type="radio"/> Blood <input type="radio"/> Other (specify site) NAATOther <input style="width: 150px;" type="text"/>	
CLASSIFICATION* Status <input type="radio"/> Under investigation <input type="radio"/> Probable <input type="radio"/> Confirmed <input type="radio"/> Not a case	
ADDITIONAL LABORATORY DETAILS	
emm type:* emmType <input style="width: 100px;" type="text"/>	

Invasive group A streptococcal infection		EpiSurv No. <input style="width: 100px;" type="text" value="EpiSurvNumber"/>	
Clinical Course and Outcome			
Date of onset* OnsetDt <input style="width: 100px;" type="text"/>		<input type="checkbox"/> Approximate OnsetDtApprox <input type="checkbox"/> Unknown OnsetDtUnknown	
Hospitalised* Hosp		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Date hospitalised* HospDt <input style="width: 100px;" type="text"/>		<input type="checkbox"/> Unknown HospDtUnknown	
Hospital* HospName <input style="width: 150px;" type="text"/>			
Died* Died		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Date died* DiedDt <input style="width: 100px;" type="text"/>		<input type="checkbox"/> Unknown DiedDtUnknown	
Was this disease the primary cause of death?* DiedPrimary <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
If no, specify the primary cause of death* DiedOther <input style="width: 150px;" type="text"/>			
Additional Outcome Details			
Was the case in ICU?* ICU <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Outbreak Details			
Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*			
<input type="checkbox"/> Yes Outbrk If yes, specify Outbreak No.* OutbrkNo <input style="width: 100px;" type="text"/>			
Risk Factors			
In the 30 days before onset, did the case:			
Attend school, pre-school or childcare?* AttendSch		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Use injectable drugs?* IDUse		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Experience homelessness?* i Homeless		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Live or work in a residential institution?* ResidInst		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Have close contact with a confirmed or probable case of iGAS?* ContCase		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
EpiSurv number of case* ContID <input style="width: 150px;" type="text"/>			
Other risk factor for iGAS infection?* RiskOthSpecify <input style="width: 150px;" type="text"/>			
Management			
CONTACT MANAGEMENT			
Type of contact	Number identified	Number offered antibiotics	Number given antibiotics
Birthing parent	NoParent <input style="width: 50px;" type="text"/>	NoParentAbx <input style="width: 50px;" type="text"/>	NoParentGivAbx <input style="width: 50px;" type="text"/>
Neonate(s)	NoNeonate <input style="width: 50px;" type="text"/>	NoNeonateAbx <input style="width: 50px;" type="text"/>	NoNeonateGivAbx <input style="width: 50px;" type="text"/>
Other (eg household or institutional contacts) (specify) OtherContact <input style="width: 100px;" type="text"/>	NoOther <input style="width: 50px;" type="text"/>	NoOtherAbx <input style="width: 50px;" type="text"/>	NoOtherGivAbx <input style="width: 50px;" type="text"/>
Comments			
<div style="color: red; font-weight: bold; margin-bottom: 10px;">Comments</div>			