TEXAS Department of State Health Services

Fax or mail this form to your local/regional health department
Contact your health department at 1-800-705-8868 www.dshs.state.tx.us/idcu/investigation/conditions/contacts/

Invasive Streptococcal Investigation Form

NBS Patient ID:

Patient's name: _____
Last First MI
Address: _____
City: _____ **County:** _____ **Zip:** _____
Phone 1: ( ) _____ **Phone 2:** ( ) _____
Date of birth: ___/___/___ **Age:** _____ **Sex:** ☐Male ☐Female ☐Unknown
Race: ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American/Alaskan
☐Unknown ☐ Other: _____ **Hispanic:** ☐ Yes ☐ No ☐ Unknown
Occupation:_____
Long-term care resident: ☐Yes, at:_____ ☐No ☐Unknown

Reported by: _____
Agency: _____
Phone: ( )_____**Date reported:** ___/___/___

Investigated by: _____
Agency: _____
Phone: ( ) _____
Email:_____
Investigation start date: ____/____/____

CLINICAL DATA

Physician's name: _____
Physician's phone: ( ) _____

Date of symptom onset: ___/___/___ **Date illness ended**: ___/___/___
Did patient die? ☐ Yes, date of death: ___/___/___ ☐ No ☐ Unknown

Type of Infection (Check all that apply): ☐ Bacteremia / Sepsis ☐ Pneumonia
☐ Toxic Shock Syndrome ☐ Necrotizing Fasciitis ☐ Meningitis ☐ Sinusitis
☐ Otis Media ☐ Endocarditis ☐ Peritonitis ☐ Septic Arthritis
☐ Other: _____

For Group B Strep investigations:
Pregnant: ☐ Yes: # weeks gestation: _____ ☐ No ☐ Unknown
Postpartum: ☐ Yes: date of delivery: ___/___/___ ☐ No ☐ Unknown

UNDERLYING HEALTH CONDITIONS

Does the patient have any underlying health conditions?
☐ Yes (check all that apply) ☐ No ☐ Unknown
☐ Asthma ☐ Chronic lung disease ☐ Cancer
☐ Cochlear implant ☐ Diabetes ☐ Heart disease
☐ Hemoglobinopathy ☐ HIV ☐ Kidney disease
☐ Organ transplant recipient ☐ Other: _____

Does the patient have high risk behaviors?
☐ Yes (check behaviors below) ☐ No ☐ Unknown
☐ Consumes raw (unpasteurized) milk/cheese
☐ Current smoker ☐ Intravenous drug user (IVDU)
☐ Alcohol abuse ☐ Other: _____

VACCINATION HISTORY (For *S. pneumoniae* investigations) **Source of vaccine history**:☐ ImmTrac ☐ Parent ☐ Doctor ☐ School ☐ Other
Did the patient receive a pneumococcal vaccine? ☐ Yes ☐ No ☐ Unknown If yes, year vaccine was given:_____
If yes, which vaccine: ☐ Conjugate pneumococcal vaccine ☐ Polysaccharide pneumococcal vaccine ☐ Other:_____ ☐ Unknown

HOSPITALIZATION INFORMATION

Was the patient seen in an emergency room? ☐ Yes, name of hospital: _____ ☐ No ☐ Unknown
Was the patient hospitalized? ☐ Yes, name of hospital: _____ ☐ No ☐ Unknown
If yes, date of admission: ____/____/____ Date of discharge: ____/____/____

LABORATORY DATA

See DSHS' *Epi Case Criteria Guide* at www.idcu.org for case definitions and "normally sterile site" determination.

Date of collection	Test type	Sterile specimen source	Non-sterile specimen source	Was specimen collected during a surgical procedure?	Bacterial species identified*
____/____/____	☐ Culture ☐ Antigen ☐ PCR ☐ Antibody ☐ Other: _____	☐ CSF ☐ Blood ☐ Pericardial fluid ☐ Bone ☐ Joint fluid (no abscess) ☐Other:_____	☐ Wound ☐ Urine ☐ Skin ☐ Throat ☐ Joint fluid (abscess present) ☐Other:_____	☐ Yes ☐ No ☐ Unknown	☐ Group A Strep (*S. pyogenes*) ☐ Group B Strep (*S. agalactiae*) ☐ *Streptococcus pneumoniae* ☐ Other:_____
____/____/____	☐ Culture ☐ Antigen ☐ PCR ☐ Antibody ☐ Other: _____	☐ CSF ☐ Blood ☐ Pericardial fluid ☐ Bone ☐ Joint fluid (no abscess) ☐Other:_____	☐ Wound ☐ Urine ☐ Skin ☐ Throat ☐ Joint fluid (abscess present) ☐Other:_____	☐ Yes ☐ No ☐ Unknown	☐ Group A Strep (*S. pyogenes*) ☐ Group B Strep (*S. agalactiae*) ☐ *Streptococcus pneumoniae* ☐ Other:_____

COMMENTS