GROUP A STREPTOCOCCAL, INVASIVE REPORTING FORM
EMAILS WILL NOT BE ACCEPTED FAX: 613-345-5777

REPORTING SOURCE		iPHIS CASE NUMBER:	
Name:	Agency:		
Phone #:	Date (y/m/d):	Time:	

CLIENT INFORMATION		
Last Name:	First Name:	Gender:
Phone #:	DOB (y/m/d):	
Address:	City:	Postal Code:
Name of Parent/Guardian (if applicable):		Cell/Work #:

Birth Country (if born outside of Canada):	Date of Arrival to Canada (y/m/d):
Country emigrated from:	Occupation:
Residency/Attendance at a Facility or Institution:	

FAMILY PHYSICIAN:	Phone #:	Fax #:

LAB INFORMATION			
Specimen Site:	Sterile Site: Yes ☐ No ☐	Date (y/m/d):	Result:
Specimen Site:	Sterile Site: Yes ☐ No ☐	Date (y/m/d):	Result:

CASE DETAILS			
Doctor who made diagnosis:			Phone #:
Onset Date (y/m/d):	Date of Diagnosis (y/m/d):		
Symptoms:			
Possible source of infection:			
Hospitalized: Yes ☐ No ☐	Admitted (y/m/d):	Discharged (y/m/d):	
Name of Hospital:		Room #:	

Evidence of clinical severity:

☐ Streptococcal Toxic Shock Syndrome (STSS) which is characterized by hypotension (systolic B.P. < 90mm Hg in adults or < 5th percentile for age for children) and at least 2 of the following signs:

- ☐ Renal impairment (creatinine > 177 µmol/L for adults)
- ☐ Coagulopathy (platelet count ≤100,000 mm^3 or disseminated intravascular coagulation)
- ☐ Liver function abnormality (SGOT, SGPT or total bilirubin ≥2x upper limit of normal for age)
- ☐ Adult respiratory distress syndrome (ARDS)
- ☐ Generalized erythematous macular rash that may desquamate

☐ Soft tissue necrosis (including necrotizing fasciitis or myositis or gangrene)

☐ Meningitis ☐ Death ☐ A combination of any of these conditions

Complications:	Outcome:

Leeds, Grenville & Lanark District HEALTH UNIT

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RISK FACTORS	
☐ Varicella within past month	☐ Recent non-invasive strep infection
☐ Immunocompromised (specify):	
☐ Chronic illness/underling medical condition (specify):	
☐ Skin condition/presence of wounds	
☐ Close contact with case	☐ Ingestion of contaminated food
☐ Alcohol abuse	☐ Under housed/homeless
☐ Injection drug use	
Other (specify): Yes ☐ No ☐	

TREATMENT	DOSE	FREQUENCY	ROUTE	START DATE (y/m/d)

TIMELINE PROPHYLAXIS		
DAY -7 (y/m/d)	**ONSET DATE (y/m/d)**	**24 HRS POST TREATMENT DAY (y/m/d)**

☐ **Consider anyone who had contact within 7 days prior to the case-client becoming ill & up to 24 hours following the start of appropriate treatment.**

☐ **Contacts may be given chemoprophylaxis no later than 7 days after the break of contact with the index case.**

CLOSE CONTACTS:

All close contacts of invasive disease should be instructed about the s & s of GAS infection and advised to seek medical attention if they develop symptoms within 30 days after exposure to case. If evidence of severity exists for case, chemoprophylaxis is recommended to eradicate nasopharyngeal colonization of GAS and prevent disease (as per protocol.)

NAME	RELATIONSHIP/HCW	PHONE #

Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c. H.7.

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FOR HEALTH UNIT USE ONLY				
NOTES (Response/Assessment/Intervention/Plan)			**INVESTIGATOR:**	
			iPHIS Client #:	
DATE	**TIME**		**iPHIS Case/Incident #:**	
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
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