

Group B Strep

Streptococcus agalactiae

Confidential case report



Please fill in the blanks or check the answer for each field

Demographic information			
Last name:		First name:	MI:
Address:		City:	State:
County:	ZIP:	Date of birth: ____/____/____	Age:
Phone #1:		Phone #2:	Phone #3:
Birth sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U		Race: (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Pacific Islander	
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown			
What type of insurance does patient have?			
Parent/guardian name:		Relationship:	
Patient's occupation:			
Clinical information			
Onset date: ____/____/____		Date diagnosed: ____/____/____	Clinician name:
Was patient hospitalized? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		Hospital: Date of admission: ____/____/____ to ____/____/____ Medical record #: Was the patient in an ICU or CCU? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Was the patient intubated? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Discharge location: <input type="checkbox"/> Home <input type="checkbox"/> Left AMA <input type="checkbox"/> LTC/SNF <input type="checkbox"/> Long-term acute care <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	
Did patient die? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		Date of death: ____/____/____ GBS-caused death? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
Was the patient pregnant at time of onset? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U			

*Streptococcus agalactiae***Syndromes, underlying causes, and sequelae**

Clinical syndromes (select all that apply):

- None Unknown Abortion with sepsis Abscess (not skin) Bacteremia Cellulitis
 Chorioamnionitis Empyema Endocarditis Endometritis Epiglottitis
 Hemolytic uremic syndrome Meningitis Necrotizing fasciitis Osteomyelitis Otitis media
 Pericarditis Peritonitis Pneumonia Puerperal septicemia Septic (infective) arthritis
 Septic shock Septicemia, bacterial Staphylococcal toxic shock syndrome
 Other (specify): _____

Did the patient have any underlying causes or prior illnesses? Y N U

If yes, check all that apply:

- AIDS Alcohol abuse Asthma Blood cancer Bone marrow transplant Broken skin
 Cancer Cancer treatment Cerebrospinal fluid leak Cerebrovascular accident
 Chronic respiratory disease Chronic hepatitis C Cirrhosis/liver failure Cochlear prosthesis
 Complement deficiency disease Congestive heart failure Connective tissue disorder
 Coronary arteriosclerosis Corticosteroids Current chronic dialysis Deaf/profound hearing loss
 Dementia Diabetes mellitus Drug user, IV Drug user, other Emphysema/COPD
 Hodgkin's disease (clinical) HIV infection Immunoglobulin deficiency
 Immunosuppressive therapy Kidney disease Leukemia Multiple myeloma Multiple sclerosis
 Myocardial infarction Nephrotic syndrome Neuromuscular disorder Obesity Paralysis
 Parkinson's disease Peptic ulcer Peripheral neuropathy Peripheral vascular disease
 Premature birth Renal failure/dialysis Seizure disorder Sickle cell trait Smoker, current
 Smoker, former Solid organ malignancy Solid organ transplant Missing spleen (asplenia)
 Splenectomy/asplenia Systemic lupus erythematosus

Current smoking status:

- E-cigarette user Marijuana user Not a smoker Tobacco user Unknown

Current alcohol abuse? Y N UDoes patient have documented drug user disorder (DUD) or abuse? Y N U

If yes, what is patient's mode of substance delivery? _____

List any other substances currently abused: _____

Childbirth-related disease

At the time of first positive culture, was the patient pregnant or postpartum?

The postpartum period is defined as the 30 days following a delivery or miscarriage

- Not pregnant or postpartum Patient currently pregnant Postpartum Unknown

If pregnant or postpartum:

What was the outcome of the fetus? (Select one)

- Live birth—neonatal death Induced abortion Survived, clinical infection*
 Survived, no apparent illness Still pregnant Abortion/stillbirth Unknown

*If yes to "Survived, clinical infection," create a CMR for the baby as well

Is the patient <2 years of age? Y N U

If yes, answer the following questions. If no or unknown, go to the next section.

If patient <1 month of age, indicate birth weight _____ Units: g kg oz lb

If premature birth was an underlying condition for an infant <2 year of age, specify gestational age at birth in completed weeks: _____ weeks

Early/late onset GBS disease

The information in this section will come from records of the infant's illness:

Was the patient less than 90 days old at time of onset? Y N U

If yes to above question, please fill out all questions under "Early/late onset GBS disease"

Answer the following questions from the infant's medical record+

Specify infant's birth place:

Hospital (name/location of hospital): _____ En route to hospital Birthing center

Home birth Other, specify _____ Unknown

Infant's birth weight: _____ Birth units: g kg oz lb

Date/time of newborn discharge from hospital of birth: ____/____/____ : ____

Did the infant receive antibiotics during the first illness episode? Y N U

If yes, name of antibiotic(s) used:

- amoxicillin amoxicillin/potassium clavulanate ampicillin ampicillin/sulbactam azithromycin
 cefazolin cefotaxime cefoxitin ceftazidime ceftriaxone cefuroxime cefuroxime axetil
 cefuroxime sodium cephalothin ciprofloxacin clarithromycin clindamycin doxycycline
 erythromycin gentamicin levofloxacin penicillin trimethoprim/sulfamethoxazole
 tetracycline vancomycin

Route of antibiotic administration:

- Intramuscular (IM) Intravenous (IV) Oral (PO)

Did infant receive breast milk from mother (for late onset GBS cases only): Y N U

If yes, was breast milk received before onset of GBS infection? Y N U

How was the baby delivered? (choose one)

- vacuum forceps primary c-section repeat c-section
 vaginal after previous c-section vaginal unknown

Was the baby admitted to the NICU? Y N U

Gestational age (in weeks): _____

The information in this section will come from the mother's medical records:

Maternal admission to hospital for delivery: ____/____/____ : ____ am pm

Date and time of membrane rupture: ____/____/____ : ____ am pm

What type of rupture? artificial spontaneous

Date and time of delivery: ____/____/____ : ____ am pm

Was duration of membrane rupture \geq 18 hours? Y N U

Streptococcus agalactiae

If membranes ruptured <37 weeks, did membranes rupture before onset of labor? Y N U

Did Labor and Delivery know about the mother's screening test and results? Y N U

Did the mother have a recorded fever >38 °C (100.4 °F) during delivery? Y N U

If yes, indicate the date/time of fever onset of the mother: ____/____/____ ____:____ am pm

Mother's age at delivery: _____

Number of prior pregnancies: _____

Mother's blood type:

A AB B O

Did the mother have prior history of penicillin allergy? Y N U

Maternal history of anaphylaxis Y N U

Did the mother have any underlying causes or prior illnesses? Y N U

- Other, specify _____ AIDS Alcohol abuse Asthma Blood cancer
 Bone marrow transplant Broken skin Cancer Cancer treatment CSF leak
 Cerebrovascular accident Chronic respiratory disease Chronic hepatitis C
 Cirrhosis/liver failure Cochlear prosthesis Complement deficiency disease
 Congestive heart failure Connective tissue disorder Coronary arteriosclerosis
 Current chronic dialysis Deaf/profound hearing loss Dementia Diabetes mellitus
 Drug user, intravenous Drug user, other Emphysema/COPD Hodgkin's disease (clinical)
 HIV infection Immunoglobulin deficiency Immunosuppressive therapy Kidney disease
 Leukemia Multiple myeloma Multiple sclerosis Myocardial infarction Nephrotic syndrome
 Neuromuscular disorder Obesity Paralysis Parkinson's disease Peptic ulcer
 Peripheral neuropathy Peripheral vascular disease Premature birth Renal failure/dialysis
 Seizure disorder Sickle cell trait Smoker, current Smoker, former Solid organ malignancy
 Solid organ transplant Missing spleen (asplenia) Splenectomy/asplenia
 Systemic lupus erythematosus

Did the mother receive intrapartum antibiotics? Y N U

If yes, what was the reason for administration of intrapartum antibiotics?

- C-section prophylaxis GBS prophylaxis Mitral valve prolapse
 Suspected amnionitis or chorioamnionitis Prolonged latency Unknown
 Other, specify _____

Name of antibiotic used:

- Amoxicillin Amoxicillin/potassium clavulanate Ampicillin Ampicillin and sulbactam
 Azithromycin Cefazolin Cefotaxime Cefoxitin Ceftazidime Ceftriaxone
 Cefuroxime Cefuroxime axetil Cefuroxime sodium Cephalothin Ciprofloxacin
 Clarithromycin Doxycycline Erythromycin Gentamicin Levofloxacin
 Penicillin Trimethoprim/sulfamethoxazole Tetracycline Vancomycin
 Other, specify: _____

Route of antibiotic administration: Intramuscular (IM) Intravenous (IV) Oral (PO)

Number of doses of antibiotic given before delivery: _____

Stop date of antibiotic: ____/____/____

Streptococcus agalactiae

Date of mother's last menstrual period before delivery? _____/_____/_____

Was maternal GBS colonization screened for BEFORE admission (in prenatal care) or AFTER admission (before delivery)?

 AFTER admission (before delivery) BEFORE admission (in prenatal care)

If BEFORE admission:

Did screening occur at 36 through 37 weeks of gestation? Y N U

Which laboratory performed the screening test? _____

What was the screening result? Positive Negative Inconclusive Unknown

If AFTER admission:

Date and time specimen was collected: _____/_____/_____ :_____ am pmWhat was the screening result? Positive Negative Inconclusive UnknownDid the mother have bacteriuria caused by GBS at any time during pregnancy? Y N U**If yes, what order of magnitude was the colony count?** 0 <10,000 10k - <25,000 25k - <50,000 50k - <75,000 75k - <100,000 ≥ 100,000 UHas this mother previously delivered an infant with GBS disease? Y N UDid the mother have a previous pregnancy with GBS colonization? Y N UDid the mother receive any prenatal care prior to delivery? Y N U

If yes, list number of prenatal care visits: _____

Date of first and last prenatal visits: First visit _____/_____/_____ Last visit _____/_____/_____

Estimated gestational age at last documented prenatal care visit in weeks: _____

Laboratory informationWas culture done? Y N U

Name of laboratory: _____ Date collected: _____/_____/_____

Sample collected: Blood CSF Tissue/muscle/bone
 Fluid Placenta Other

Test results: (Check one)

 Positive—Confirmed Inconclusive Negative PendingWas PCR done? Y N U

Name of laboratory: _____ Date collected: _____/_____/_____

Sample collected: Blood CSF Tissue/muscle/bone
 Fluid Placenta Other

Test results: (Check one)

 Positive—Confirmed Inconclusive Negative Pending

Group B strep

Patient name: _____

UT-NEDSS ID: _____

Streptococcus agalactiae

Reporting

Reported by: (Check all that apply)

Hospital/ICP Clinic/doctor's office Lab General public Other _____

What is the date the lab reported to the clinician? ____/____/____

Reporter's name: _____ Phone number: _____

Reporter's agency: _____ Date reported to public health: ____/____/____

LHD investigator:

Phone:

Date submitted to DHHS: ____/____/____

LHD reviewer:

LHD case classification: (Check one)

Confirmed Probable Suspect Pending Out of state Not a case

DHHS case classification:

Confirmed Probable Suspect Pending Out of state Not a case