

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**Communicable Disease and Immunization Division**  
**GROUP A STREPTOCOCCUS (GAS) INVASIVE DISEASE**  
**INVESTIGATION FORM**

*(Do not report streptococcal pharyngitis/sore throat  
or Streptococcus pneumoniae on this form)*

**CASE IDENTIFYING INFORMATION**

Case Name: \_\_\_\_\_ Age or Birthdate: \_\_\_\_\_ Sex: \_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
(Street) (City) (County) Work phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_  
(If infant or student, list school or daycare)

Attending Physician: \_\_\_\_\_ Address & Phone \_\_\_\_\_

Patient Hospitalized: **Y or N** Hospital: \_\_\_\_\_

(Admission date) \_\_\_\_\_ (Discharge date) \_\_\_\_\_ (City) \_\_\_\_\_

Admit diagnosis: \_\_\_\_\_

Survived: **Yes or No** (circle one): **Inpatient or Outpatient**

**DATE OF SYMPTOM ONSET:** \_\_\_\_\_ **DATE RECOVERED:** \_\_\_\_\_

**SOURCE OF Group A Streptococcal ISOLATE:**  
(culture e.g., blood, sputum or other respiratory tract, wound, CSF, joint fluid, bone):

**Culture:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_  
**Culture:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**DISEASE(S) CAUSED BY GROUP A STREP INFECTION: (Circle all that apply)**

Sepsis                      Pneumonia                      Meningitis                      Peritonitis                      Toxic Shock Syndrome  
Septic arthritis              Osteomyelitis                      Myositis                      Gangrene/necrotizing fasciitis  
Cellulitis/Abscess Site: \_\_\_\_\_ Surg. wound infection Site: \_\_\_\_\_  
Nonsurg. wound infection Site: \_\_\_\_\_ Other, specify \_\_\_\_\_

**CLINICAL FINDINGS**

**Fever (highest):** \_\_\_ F/C                      **Hypotension (lowest):** systolic \_\_\_ diastolic \_\_\_

**Rash: Y or N or Unknown**                      **If yes (circle one):** GENERALIZED      FOCAL  
Describe: \_\_\_\_\_

<b>Desquamation</b>	YES	NO	Unknown				
<b>Syncope/Orthostatic sx.</b>	Y	N	U	<b>Myalgia</b>	Y	N	U
<b>Diarrhea</b>	Y	N	U	<b>Pharyngitis</b>	Y	N	U
<b>Vomiting</b>	Y	N	U	<b>Injected tongue</b>	Y	N	U

**Name of person interviewed and relationship to case:** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Person completing form** \_\_\_\_\_ **Health Dept.** \_\_\_\_\_