STSS Assessment Form

(Please refer to the Disease Investigation Guideline for additional guidance.)

Clinical Case Definition Criteria for STSS

❑ Yes ❑ No **Hypotension present** (Systolic ≤ 90 mmHg for adults or <5th percentile in children < 16 years)

Systolic Blood pressure (lowest measurement): _____

Diastolic blood pressure (lowest measurement): _____

❑ Yes ❑ No **2 or more of the following multi-organ manifestations present:**

- ❑ **Renal impairment** (As shown by one of the following below)
  - ❑ Creatinine ≥ 2 mg/dl (≥ 177 umol/L) for adults, or
  - ❑ Creatinine ≥2x the normal upper limit for age, or
  - ❑ Creatinine > 2x elevation over baseline in patients with renal disease

  Creatine level: _____ mg/dl
- ❑ **Coagulopathy** (As shown by one of the following below)
  - ❑ Disseminated intravascular coagulation, defined by the following:
    - ○ Prolonged clotting times ○ Low fibrinogen level ○ Presence of fibrin degradation products
  - ❑ Platelets < 100,000 / mm³ (100 x 106/L): _____ /mm³
- ❑ **Hepatic involvement** (As shown by one of the following below)
  - ❑ Alanine aminotransferase (ALT) ≥2x the normal upper limit, ALT level: _____ IU/L
  - ❑ Aspartate aminotransferase (AST) ≥2x the normal upper limit, AST level: _____ IU/L
  - ❑ Total Bilirubin ≥2x the normal upper limit, Total Bilirubin level: _____ mg/dl
- ❑ **Acute respiratory distress syndrome** (As shown by one of the following below)
  - ❑ Acute onset of diffuse pulmonary infiltrates and hypoxemia in absence of cardiac failure, or
  - ❑ Diffuse capillary leak manifested by acute onset of generalized edema, or
  - ❑ Pleural or peritoneal effusions with hypoalbuminemia
- ❑ **Generalized erythematous macular rash that may desquamate.**
- ❑ **Soft-tissue necrosis,** including necrotizing fasciitis or myositis, or gangrene

Laboratory Testing Criteria

- ❑ **Culture isolation of Group A *Streptococcus.***

Specimen source: _____

Examination of bacterial culture results:

1. Was patient on antibiotics when ***any*** culture specimens were collected: ❑ Yes ❑ No ❑ Unk
   Note specimens affected by antibiotic use.

Additional epidemiological data to collect for CONFIRMED and/or PROBABLE cases:

Date of Onset of Symptoms: ☐☐/☐☐/☐☐ Collection Date of 1st positive culture: ☐☐/☐☐/☐☐

Hospitalized, date of admission: ☐☐/☐☐/☐☐ Date of hospital discharge: ☐☐/☐☐/☐☐

Was patient transferred from another hospital? ❑ Yes ❑ No If yes, specify hospital:

Was patient admitted to ICU? ❑ Yes ❑ No

Did the patient survive the infection? ❑ Yes ❑ No If NO, date of death: ☐☐/☐☐/☐☐

STSS Rapid Assessment Form

Where was the patient a resident at the time of the initial culture? (If resident of a facility, provide facility name.)	❑ Private residence ❑ Homeless ❑ Group Living, specify: ❑ Other, specify:		
Types of infection caused by organism, besides of STSS? ❑ Other (specify):	❑ Abscess (not skin) ❑ Bacteremia (no focus) ❑ Cellulitis ❑ Chorioamnionitis ❑ Empyema	❑ Endocarditis ❑ Endometritis ❑ Meningitis ❑ Necrotizing fasciitis ❑ Osteomyelitis	❑ Pericarditis ❑ Peritonitis ❑ Puerperal sepsis ❑ Septic abortion ❑ Septic arthritis
Did the patient survive the infection?	❑ Yes ❑ No	If NO, date of death:	□□/□□/□□
Any underlying health causes or prior illness?	❑ Yes ❑ No	If YES, specify:	
Did the patient have surgery or any skin incision within 14 days of the first positive culture? ❑ Yes ❑ No If YES, date of surgery or incision: □□/□□/□□ Surgery provider:			
Did patient have any of the following:	❑ Burns ❑ Blunt trauma	❑ Penetrating trauma ❑ Varicella	
If yes to any of the above, record the number of days prior to the first positive culture:	❑ 0-7 days ❑ 8-14 days		

FOR FEMALE PATIENTS ONLY

At the time of the positive culture, was the patient:	❑ Pregnant ❑ Post-partum	❑ Neither pregnant or post-partum ❑ Unknown pregnancy status
If pregnant or post-partum, the outcome of fetus:	❑ Survived, no apparent illness ❑ Survived, clinical infection ❑ Live birth/neonatal death	❑ Abortion/stillbirth ❑ Induced abortion ❑ Still pregnant
If the patient delivered a baby:	ethod of delivery: ❑ Vaginal ❑ C-section If yes, date of delivery: □□/□□/□□	

Any additional information: