BACTERIAL DISEASES SURVEILLANCE FORM – *Streptococcus agalactiae* (Group B)

Please complete this form and fax to ICS Coordinator at (907) 729-3429.

1. Name: _____ **2. Sex**: ☐ Male ☐ Female
Last, First, MI

3. Birthdate: _____ **or Age**: _____ years or _____ months or days _____
DD/MM/YYYY

4. Ethnicity: ☐ First Nations ☐ Inuit ☐ Metis ☐ Non Aboriginal ☐ Unknown

5. Village: _____ **6. Region:** ☐ Labrador ☐ NWT ☐ Nunavut ☐ Yukon ☐ Quebec (Cree) ☐ Quebec (Nunavik)

7. Reference lab accession #: _____

8. Source of positive isolate(s) from sterile site(s): ☐ Blood ☐ Pleural fluid ☐ Pericardial fluid ☐ Bone ☐ CSF ☐ Peritoneal fluid ☐ Joint ☐ Other _____

9. Date first positive culture obtained (date specimen drawn): _____
DD/MM/YYYY

10. Hospitalized: ☐ Yes ☐ No **If yes, answer questions 11-16.** **11. Facility**: _____

12. Admitted: _____ **13. Transferred?** ☐ Yes ☐ No **14. Final discharge**: _____
DD/MM/YYYY DD/MM/YYYY

15. Date Transferred **16. Facility Name(s)**
_____ _____

17. Organism: ***Streptococcus agalactiae* (Group B)** **18. Death during this illness?** ☐ Yes ☐ No **19. Date of death**: _____
DD/MM/YYYY

20. Infection(s) caused by organism: *(Check ALL pertinent diagnoses)*

☐ Amnionitis ☐ Empyema ☐ Epiglottitis ☐ Osteomyelitis ☐ Pneumonia
☐ Bacteremia ☐ Endocarditis ☐ Hemolytic uremic syndrome ☐ Pericarditis ☐ Septic abortion
☐ Cellulitis ☐ Endometritis ☐ Meningitis ☐ Peritonitis ☐ Septic arthritis
☐ Other (please specify): _____

21. Other concurrent INFECTIOUS illnesses: ☐ None ☐ No info available Specify other: _____

22. Underlying conditions or illnesses: ☐ None ☐ No info available

☐ Alcohol abuse ☐ Chronic renal failure ☐ Homelessness ☐ Pregnancy/post partum ☐ Stroke/CVA
☐ Asthma/RAD ☐ Cirrhosis/liver failure ☐ IVDU ☐ Premature infant ☐ Trauma
☐ Asplenia ☐ Congestive heart failure ☐ Immunodeficiency disease ☐ Rheumatoid arthritis
☐ Cancer ☐ CSF leak ☐ Immunosuppressive therapy ☐ Smoker (within past year)
☐ Chronic lung disease ☐ Diabetes ☐ Nephrotic syndrome ☐ Surgery/surgical wound
☐ Other conditions/illnesses (please specify): _____

23. Reviewer: _____ **24. Reviewer phone:** _____ **25. Date complete**: _____

36. Comments:

AIP use only