Client name:

Surname | First Name | Notification ID:

Acute Post Streptococcal Glomerulonephritis Case Report Form

NOTIFICATION

Public Health Unit | Completed by | Telephone | Fax

Date PHU notified | Date initial response | Notifier

Telephone | Fax | Email

Treating Dr

Telephone | Fax | Email

CASE DETAILS

Last Name | First Name

Middle Name | Third Name

Fourth Name | Name Prefix | Name Suffix

Medicare | DOB (dd/mm/yyyy) | Age | Months | Days

Address Number and Street | Apartment/Unit Number

Suburb | State | Postal Code | Country of Residence

Date of Arrival (DD/MM/YYYY) | Country of Birth

Home Telephone | Mobile Phone | Work/School Telephone

E-mail Address | International Phone Number

Client name:

Surname | First Name | Notification ID:

CASE DETAILS (continued)

Work/School Location

Work/School Contact

Sex

☐ Female ☐ Male ☐ Other ☐ Unknown

Pregnant?

☐ Yes ☐ No ☐ Unknown

Estimated Delivery Date (dd/mm/yyyy)

Marital Status

☐ De facto ☐ Divorced ☐ Married ☐ Never Married ☐ Not stated/Unknown ☐ Separated ☐ Widowed

Medical Record Number

Patient's Parent/Guardian Name

Occupation Setting

Describe/Specify

Occupation

Describe/Specify

Occupation Location

Person Status

☐ Active ☐ Deceased ☐ Unknown

Date of Death (dd/mm/yyyy)

Primary Language

Australian South Sea Islander

☐ Yes ☐ No ☐ Unknown

Indigenous Status: ☐ Aboriginal but not Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Not Stated ☐ Torres Strait Islander but not Aboriginal

Ethnicity: ☐ Oceanian ☐ European ☐ North African and Middle Eastern ☐ People of the Americas ☐ Sub-Saharan Africa ☐ Asian ☐ Not Stated/Unknown

Additional Demographics

Discrete Indigenous Community

Other Community

Language Spoken at Home

Interpreter Required

☐ Yes ☐ No ☐ Unknown

Further details for the primary address captured against the case

Premises Name

Type of Premises

Other Details

Address Comments:

☐ No Fixed Address

Client name:

Surname | First Name | Notification ID:

Temporary Address Details for Case

Premises Name

Address Number and Street

Apartment/Unit Number

Suburb | State | Post Code | Phone Number

Mobile Phone Number

Email Address

LABORATORY CRITERIA

Laboratory

First collection date (dd/mm/yyyy)

Haematuria: Microscopy

C3(complement)

ASOT (antistreptolysin):

OR

ADB (anti-DNase B):

OR Swab: ☐ Yes ☐ No Specify: ☐ Skin ☐ Throat

☐ Culture ☐ PCR ☐ Rapid antigen test

☐ Group A +ve

☐ Group A -ve

Renal biopsy suggestive of APSGN: ☐ Yes ☐ No

Serum: Creatinine: µmol/L eGFR: mL/min

Emm Type:

CLINICAL TAB

☐ Check details of onset symptoms is unknown

Onset APSGN symptoms (dd/mm/yyyy)

Onset GAS Symptoms (dd/mm/yyyy)

Client name:

Surname | First Name | Notification ID:

Clinical Presentation

Facial oedema: ☐ Yes ☐ No ☐ Unknown

Hypertension: ☐ Yes ☐ No ☐ Unknown

Peripheral oedema: ☐ Yes ☐ No ☐ Unknown

Highest diastolic BP:

Haematuria: ☐ Yes ☐ No ☐ Unknown

Highest systolic BP:

Macroscopic: ☐ Yes ☐ No ☐ Unknown

Microscopic: ☐ Yes ☐ No ☐ Unknown

Impetigo/Skin lesions present: ☐ Yes ☐ No ☐ Unknown

Other, specify:

In the last 6 weeks: ☐ Yes ☐ No ☐ Unknown

Swab taken: ☐ Yes ☐ No ☐ Unknown

Swab 1 taken: (dd/mm/yyyy)

Swab 2 taken: (dd/mm/yyyy)

Sore Throat present: ☐ Yes ☐ No ☐ Unknown

In the last 6 weeks: ☐ Yes ☐ No ☐ Unknown

Swab taken: ☐ Yes ☐ No ☐ Unknown

Swab taken: (dd/mm/yyyy)

Scabies present: ☐ Yes ☐ No ☐ Unknown

In the last 6 weeks: ☐ Yes ☐ No ☐ Unknown

Hospitalised

The case was hospitalised due to this condition

☐ Yes ☐ No ☐ Unknown

Date of admission to a public or private hospital excluding Virtual Ward settings (dd/mm/yyyy)

Hospital - Details

Hospital

Other

UR Number

Hospitilisation Type

☐ Emergency Department ☐ ICU ☐ General Admission

Discharge date: (dd/mm/yyyy)

Outcome

The outcome following this illness: ☐ Survived - no complications ☐ Survived - complications ☐ Survived - complications unknown ☐ Died ☐ Unknown

Complications Details:

Death Details

Died of condition

☐ Yes ☐ No ☐ Contributing Factor ☐ Unknown

Other condition

Place of Death

☐ Residential Aged Care Facility ☐ Hospital ☐ Other Health Care Facility Setting ☐ Home

☐ Disability Services Facility ☐ First Nations rural, remote, or discrete community ☐ Other

Place of Death Details:

Client name:

Surname | First Name | Notification ID:

ENHANCED SURVEILLANCE TAB

Place acquired

Country

Australian State/Territory

Location/Suburb/Place

Post Code

Exposure Period to GROUP A STREPTOCOCCAI

From: (dd/mm/yyyy)

(Onset of Group A strep symptoms -10 days (impetigo)
(Onset of Group A strep symptoms -3 days (pharyngeal)

To: (dd/mm/yyyy)

(Onset of symptoms GAS -1 day)

Exposure to Known Cases

Are they a contact of a confirmed/suspected APSGN case? ☐ Yes ☐ No ☐ Unknown

Name/NID

Contact type

Number of other recent skin infection cases in household?

Exposure Travel History

Travelled During Exposure Period

☐ Yes ☐ No ☐ Unknown

Was the case travelling within Queensland in expsoure period?

☐ Yes ☐ No ☐ Unknown

Was the case interstate in exposure period?

☐ Yes ☐ No ☐ Unknown

Was the case overseas in the exposure period?

☐ Yes ☐ No ☐ Unknown

Which country did the case spend most time in during their exposure period?

Date of arrival in Australia (mm/dd/yyyy)

High Risk Places Attended During Exposure Period

Did the case attend any of the following during their exposure period? ☐ Yes ☐ No ☐ Unknown

Childcare Facility:	☐ Yes	☐ No	☐ Unknown	Specify:	Dates attended (dd/mm/yyyy)
Preschool/School:	☐ Yes	☐ No	☐ Unknown	Specify:	Dates attended (dd/mm/yyyy)
Educational Facility:	☐ Yes	☐ No	☐ Unknown	Specify:	Dates attended (dd/mm/yyyy)
Residential Facility:	☐ Yes	☐ No	☐ Unknown	Specify:	Dates attended (dd/mm/yyyy)
Hospital:	☐ Yes	☐ No	☐ Unknown	Specify:	Dates attended (dd/mm/yyyy)
Healthcare Facility:	☐ Yes	☐ No	☐ Unknown	Specify:	Dates attended (dd/mm/yyyy)
Other:	☐ Yes	☐ No	☐ Unknown	Specify:	Dates attended (dd/mm/yyyy)

Client name:

Surname | First Name | Notification ID:

Infectious period for GROUP A STREPTOCOCCI

Date: (dd/mm/yyyy) TO Date: (dd/mm/yyyy)

(Onset of GAS symptoms -7 days)

(Date of commencement of antibiotics +24 hrs)
(+10–21 days in untreated, uncomplicated skin infections, or months in some cases).

High risk Places Attended During Infectious Period

Did case attend any of the following during their infectious period: ☐ Yes ☐ No ☐ Unknown

Childcare Facility: ☐ Yes ☐ No ☐ Unknown Specify: Dates attended (dd/mm/yyyy)

Preschool/School: ☐ Yes ☐ No ☐ Unknown Specify: Dates attended (dd/mm/yyyy)

Educational Facility: ☐ Yes ☐ No ☐ Unknown Specify: Dates attended (dd/mm/yyyy)

Residential Facility: ☐ Yes ☐ No ☐ Unknown Specify: Dates attended (dd/mm/yyyy)

Hospital: ☐ Yes ☐ No ☐ Unknown Specify: Dates attended (dd/mm/yyyy)

Healthcare Facility: ☐ Yes ☐ No ☐ Unknown Specify: Dates attended (dd/mm/yyyy)

Other: ☐ Yes ☐ No ☐ Unknown Specify: Dates attended (dd/mm/yyyy)

CASE MANAGEMENT

Antibiotic treatment commenced: IM benzathine penicillin:

☐ Yes ☐ No ☐ Unknown Date:(dd/mm/yyyy)

Other: Date:(dd/mm/yyyy)

☐ Yes ☐ No ☐ Unknown Date:(dd/mm/yyyy)

Scabies treatment of case: ☐ Yes ☐ No ☐ Unknown Date:(dd/mm/yyyy)

Scabies treatment of household/s: ☐ Yes ☐ No ☐ Unknown Date:(dd/mm/yyyy)

Number

Details:

If stayed in additional household: Contact name:

Address:

Referral for environmental health assessment: ☐ Yes ☐ No ☐ Unknown

Client name:

Surname | First Name | Notification ID:

RISK FACTORS

Underlying Chronic disease:	☐ Yes	☐ No	☐ Unknown	Specifiy:
Diabetes:	☐ Yes	☐ No	☐ Unknown	Specifiy:
Immunocompromise:	☐ Yes	☐ No	☐ Unknown	Specifiy:
Hazardous alcohol use:	☐ Yes	☐ No	☐ Unknown	Specifiy:
Previous iGAS notification:	☐ Yes	☐ No	☐ Unknown	Specifiy:
Other risk factors:	☐ Yes	☐ No	☐ Unknown	Specifiy:

Public Health Intervention

Please enter Public Heatlh Intervention directly into Notifiable Conditions System (NoCS)

Case Notes

Please enter Public Heatlh Intervention directly into Notifiable Conditions System (NoCS)

Tasks

Please enter Public Heatlh Intervention directly into Notifiable Conditions System (NoCS)

CONTACT MANAGEMENT

Contact Summary

Contact Type	Group	Total Number of Contacts	Number recommended for further assessment
Household	Adults		
	Children (under 17 years)		

Statuses

Process Status

☐ Assigned ☐ Needs Assignment ☐ Acknowledged ☐ Under Investigation ☐ For Review ☐ Closed

Resolution Status

☐ Confirmed ☐ Not a Case ☐ Probable ☐ Possible ☐ Unsure

Client name:

Surname | First Name | Notification ID:

Community Outbreak Management

Part of an outbreak: ☐ Yes ☐ No ☐ Unknown

Outbreak ID ____ Outbreak # ____ Location ____

Case classification:

Outbreak M type ____ OR Other clone identification ____

Additional Details

Case found by

☐ Clinical presentation ☐ Contact tracing/Epidemiological investigation ☐ Screening (Excluding antenatal)

☐ Clincial and Epidemiology ☐ Antenatal screening ☐ Auditing ☐ Unknown

☐ Clinical notificaiton failure

Clinical Notification Failure Reason ____

End of form