Infectious Disease Epidemiology Section,
Office of Public Health, Louisiana Dept. of Health & Hospitals
800-256-2748 (24 hr. number), and (504) 568-8313
www.infectiousdisease.dhh.louisiana.gov

Group B Streptococcal Newborn Investigation Report

Newborn Demographic Information

1. Name:
Last:_____
First: _____MI_____
2. DOB:___/____/_____
3. Sex: ☐ Male ☐ Female
4.Address: _____
City: _____Zip_____

5. Ethnicity:
☐Hispanic/Latino
☐ Non-Hispanic/
Non-Latino
☐Unknown

6. Race
☐ American Indian/Alaskan Native
☐ Black/African American
☐ Asian
☐ White/Caucasian
☐ Hawaiian/Pacific Islander
☐ Other
☐ Unknown

Mother Demographic Information

1. Name:
Last:_____
First: _____MI_____
2. DOB:____/_____/_____ **Age**:_____
3.Address: _____
City: _____Zip_____
4. Phone:_____

5. Ethnicity:
☐Hispanic/Latino
☐ Non-Hispanic/
Non-Latino
☐Unknown

6. Race
☐ American Indian/Alaskan Native
☐ Black/African American
☐ Asian
☐ White/Caucasian
☐ Hawaiian/Pacific Islander
☐ Other
☐ Unknown

Newborn Clinical Information

7. Gestational Age: _____ Weeks
8. Birth Weight: _____
9. Age at Diagnosis:_____ ☐ Days ☐ Weeks ☐ Months
☐ Early On-set (<1 week) ☐ Late On-set (>1 week)

10. Diagnosis Date: _____

11. Source of culture: ☐Blood ☐ CSF ☐ Other (Specify)_____
Antibiotic Sensitivity: _____
Isolate Available?: ☐ Yes ☐ No ☐ Unknown
Polymicrobial: ☐ Yes ☐ No ☐ Unknown

12. Clinical Symptoms:_____
Underlying Condition(s): _____
Did the Patient die? ☐ Yes ☐ No ☐ Unknown

Mother Clinical Information

7. GBS Status: ☐ Positive ☐ Negative ☐ Unknown
Chorio-amnionitis: ☐ Yes ☐ No ☐ Unknown
8. GBS Test Date: _____ **or Gestational Weeks**_____

9. Delivery Type: ☐ Vaginal ☐ C-Section
Treatment received?: ☐ Yes ☐ No ☐ Unknown
Prenatal Care received? ☐ Yes ☐ No ☐ Unknown

10. Previous Pregnancies?: ☐ Yes ☐ No ☐ Unknown
If Yes, GBS Status of Previous Pregnancies:
☐ Positive ☐ Negative ☐ Unknown

11. Breast Fed? ☐ Yes ☐ No ☐ Unknown

Hospital Information

Hospital of Delivery: _____ ☐ **Home Delivery**
Primary Physician: _____ **Phone:**_____
Person Providing Referral: _____**Phone:**_____
Facility of Referral: _____

Investigation Information

Investigated by: _____ **Date Investigated**_____
Part of an Outbreak? ☐ Yes ☐ No ☐ Unknown
Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown

Notes:
_____
_____
_____
_____