

Patient's Name: (Last, First, MI) Phone No.: () Patient Chart No.: Address: (Number, Street, Apt. No.) Hospital: (City, State) (Zip Code)

- Patient identifier information is not transmitted to CDC -

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION ATLANTA, GA 30333

ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK



- SHADED AREAS FOR OFFICE USE ONLY -

1. STATE: (Residence of Patient) 2. COUNTY: (Residence of Patient) 3. STATE I.D.: 4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: 4b. HOSPITAL I.D. WHERE PATIENT TREATED:

5. WAS PATIENT HOSPITALIZED? If YES, date of admission: Mo. Day Year Date of discharge: Mo. Day Year 6. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 1 Yes 2 No 9 Unknown

7a. Where was the patient a resident at time of initial culture? 1 Private residence 4 Homeless 6 College dormitory 2 Long term care facility 5 Incarcerated 9 Unknown 3 Long term acute care facility 7b. If resident of a long term care facility, what was the name of the facility? 8a. Was patient transferred from another hospital? 1 Yes 2 No 9 Unknown 8b. If YES, hospital I.D.:

9. DATE OF BIRTH: Mo. Day Year 10a. AGE: 11. SEX: 1 Male 2 Female 12a. ETHNIC ORIGIN: 1 Hispanic or Latino 2 Not Hispanic or Latino 9 Unknown 12b. RACE: (Check all that apply) 1 White 1 Asian 1 Black 1 Native Hawaiian or Other Pacific Islander 1 American Indian or Alaska Native 1 Unknown 10b. Is age in day/mo/yr? 1 Days 2 Mos. 3 Yrs.

13a. WEIGHT: lbs oz OR kg OR Unknown 13b. HEIGHT: ft in OR cm OR Unknown 14. TYPE OF INSURANCE: (Check all that apply) 1 Medicare 1 Indian Health Service (IHS) 1 No health care coverage 1 Military/VA 1 Private/HMO/PPO/managed care plan 1 Unknown 1 Medicaid/state assistance program 1 Other (specify)

15. OUTCOME: 1 Survived 2 Died 9 Unknown 16. If patient died, was the culture obtained on autopsy? 1 Yes 2 No 9 Unknown

17a. At time of first positive culture, patient was: 1 Pregnant 3 Neither 2 Postpartum 9 Unknown 17b. If pregnant or postpartum, what was the outcome of fetus: 1 Survived, no apparent illness 4 Abortion/stillbirth 9 Unknown 2 Survived, clinical infection 5 Induced abortion 3 Live birth/neonatal death 6 Still pregnant 18. If patient <1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only. Gestational age: (wks) Birth weight: (gms)

19. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply) 1 Bacteremia without Focus 1 Meningitis 1 Otitis media 1 Pneumonia 1 Cellulitis 1 Epiglottitis 1 Hemolytic uremic syndrome (HUS) 1 Abscess (not skin) 1 Peritonitis 1 Pericarditis 1 Septic abortion 1 Chorioamnionitis 1 Septic arthritis 1 Osteomyelitis 1 Empyema 1 Endocarditis 1 Endometritis 1 STSS 1 Necrotizing fasciitis 1 Puerperal sepsis 1 Septic shock 1 Other (specify) 1 Unknown 20a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: 1 Neisseria meningitidis 4 Listeria monocytogenes 2 Haemophilus influenzae 5 Group A Streptococcus 3 Group B Streptococcus 6 Streptococcus pneumoniae 20b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: (specify)

21. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 1 Blood 1 CSF 1 Pleural fluid 1 Other normally sterile site (specify) 1 Peritoneal fluid 1 Pericardial fluid 1 Joint 1 Bone 1 Muscle 1 Internal body site (specify) 22. DATE FIRST POSITIVE CULTURE OBTAINED: (Date Specimen Collected) Mo. Day Year 23. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 1 Placenta 1 Amniotic fluid 1 Wound 1 Middle ear 1 Sinus

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0802). Do not send the completed form to this address.

24. UNDERLYING CAUSES OR PRIOR ILLNESSES: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) 1 None 1 Unknown

1 <input type="checkbox"/> Current Smoker	1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Alcohol Abuse	1 <input type="checkbox"/> Cochlear Implant
1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	1 <input type="checkbox"/> Deaf/Profound Hearing Loss
1 <input type="checkbox"/> Sickle Cell Anemia	1 <input type="checkbox"/> Systemic Lupus Erythematosus (SLE)	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Solid Organ Malignancy
1 <input type="checkbox"/> Splenectomy/Asplenia	1 <input type="checkbox"/> Diabetes Mellitus	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Solid Organ Transplant
1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> CSF Leak	1 <input type="checkbox"/> Premature Birth (specify gestational age at birth) <input type="text"/> (wks)
1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)	1 <input type="checkbox"/> Renal Failure/Dialysis	1 <input type="checkbox"/> IVDU	1 <input type="checkbox"/> Chronic Skin Breakdown
1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke	1 <input type="checkbox"/> Other Prior Illness (specify) _____
1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma	1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> Complement Deficiency	
1 <input type="checkbox"/> Bone Marrow Transplant (BMT)	1 <input type="checkbox"/> Cirrhosis/Liver Failure		

- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISMS:

HAEMOPHILUS INFLUENZAE DOSE: 1, 2, 3, 4 DATE GIVEN: Mo., Day, Year VACCINE NAME MANUFACTURER LOT NUMBER	25a. If <15 years of age and serotype 'b' or 'unknown' did patient receive Haemophilus influenzae b vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, please complete the list below.	25b. Were records obtained to verify vaccination history? (<5 years of age only) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If YES, what was the source of the information? (Check all that apply) 1 <input type="checkbox"/> Vaccine Registry 1 <input type="checkbox"/> Healthcare Provider 1 <input type="checkbox"/> Other (specify) _____

25c. What was the serotype?
 1 b 2 Not Typeable 3 a 4 c 5 d 6 e 7 f 8 Other (specify) _____ 9 Not Tested or Unknown

NEISSERIA MENINGITIDIS 26. What was the serogroup? 1 <input type="checkbox"/> A 3 <input type="checkbox"/> C 5 <input type="checkbox"/> W135 9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> B 4 <input type="checkbox"/> Y 6 <input type="checkbox"/> Not groupable 8 <input type="checkbox"/> Other (specify) _____	27. Is patient currently attending college? (15 - 24 years only) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
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28. Did patient receive meningococcal vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, please complete the following information: VACCINE NAME: 1 <input type="checkbox"/> Menomune®, Tetravalent Meningococcal Polysaccharide Vaccine (MPSV4) 1 <input type="checkbox"/> Menactra®, Tetravalent Meningococcal Conjugate Vaccine (MCV4) 1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Not Known DATE GIVEN: Mo., Day, Year LOT NUMBER	STREPTOCOCCUS PNEUMONIAE 29. If <15 years of age, did patient receive pneumococcal vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, please note which pneumococcal vaccine was received: (Check all that apply) 1 <input type="checkbox"/> Prevnar®, 7-valent Pneumococcal Conjugate Vaccine (PCV7) 1 <input type="checkbox"/> Prevnar-13®, 13-valent Pneumococcal Conjugate Vaccine (PCV13) 1 <input type="checkbox"/> Pneumovax®, 23-valent Pneumococcal Polysaccharide Vaccine (PPV23) If between 3 and 59 months of age and an isolate is available for serotyping, please complete the Invasive Pneumococcal Disease in Children expanded form.
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GROUP A STREPTOCOCCUS (#30-32 refer to the 7 days prior to first positive culture) 30. Did the patient have surgery? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, date of surgery: Mo., Day, Year	31. Did the patient deliver a baby (vaginal or C-section)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, date of delivery: Mo., Day, Year	32. Did patient have: 1 <input type="checkbox"/> Varicella 1 <input type="checkbox"/> Surgical wound (post operative) 1 <input type="checkbox"/> Penetrating trauma 1 <input type="checkbox"/> Burns 1 <input type="checkbox"/> Blunt trauma
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INFLUENZA 33. Did this patient have a positive flu test 10 days prior to or following any ABCs positive culture? 1 Yes 2 No 9 Unknown

34. COMMENTS: _____

- SURVEILLANCE OFFICE USE ONLY -

35. Was case first identified through audit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	36. CRF Status: 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Incomplete 3 <input type="checkbox"/> Edited & Correct 4 <input type="checkbox"/> Chart unavailable after 3 requests	37. Does this case have recurrent disease with the same pathogen? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, previous (1st) state I.D.: <input type="text"/>	38. Date reported to EIP site: Mo., Day, Year	39. Initials of S.O.: _____
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Submitted By: _____ Phone No. : () _____ Date: ____/____/____
 Physician's Name: _____ Phone No. : () _____