Patient's Name:_____ (Last, First, MI.) Phone No.: ( )_____

Address:_____ (Number, Street, Apt. No.) Patient Chart No.:_____

_____ (City, State) _____ (Zip Code) Hospital:_____

– *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* –

CDC SAFER·HEALTHIER·PEOPLE™

OMB No. 0920-0802

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? 1 ☐ Yes 2 ☐ No

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
2 ☐ Long term care facility
3 ☐ Long term acute care facility
4 ☐ Homeless
5 ☐ Incarcerated
6 ☐ College dormitory
9 ☐ Unknown

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: ☐☐☐

10b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

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 ☐ Black
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ Unknown

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 ☐ Military/VA
1 ☐ Medicaid/state assistance program
1 ☐ Indian Health Service (IHS)
1 ☐ Private/HMO/PPO/managed care plan
1 ☐ Other *(specify)* _____
1 ☐ No health care coverage
1 ☐ Unknown

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
2 ☐ Postpartum
3 ☐ Neither
9 ☐ Unknown

17b. If pregnant or postpartum, what was the outcome of fetus:
1 ☐ Survived, no apparent illness
2 ☐ Survived, clinical infection
3 ☐ Live birth/neonatal death
4 ☐ Abortion/stillbirth
5 ☐ Induced abortion
6 ☐ Still pregnant
9 ☐ Unknown

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*
2 ☐ *Haemophilus influenzae*
3 ☐ Group B *Streptococcus*
4 ☐ *Listeria monocytogenes*
5 ☐ Group A *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 ☐ Peritoneal fluid
1 ☐ Pericardial fluid
1 ☐ Joint
1 ☐ Bone
1 ☐ Muscle
1 ☐ Internal body site *(specify)*_____
1 ☐ Other normally sterile 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.**

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

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

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

– *IMPORTANT* – PLEASE COMPLETE FOR THE RELEVANT ORGANISMS:

HAEMOPHILUS INFLUENZAE

25a. If <15 years of age and serotype 'b' or 'unknown' did patient receive *Haemophilus influenzae* b vaccine? 1☐Yes 2☐No 9☐Unknown
If YES, please complete the list below.

DOSE	DATE GIVEN Mo.	Day	Year	VACCINE NAME	MANUFACTURER	LOT NUMBER
1						
2						
3						
4						

25b. Were records obtained to verify vaccination history? *(<5 years of age only)*
1☐Yes 2☐No

If YES, what was the source of the information? *(Check all that apply)*
1☐ Vaccine Registry
1☐ Healthcare Provider
1☐ 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☐A 3☐C 5☐W135 9☐Unknown
2☐B 4☐Y 6☐Not groupable 8☐Other *(specify)* _____

27. Is patient currently attending college? (15 – 24 years only)
1☐Yes 2☐No 9☐Unknown

28. Did patient receive meningococcal vaccine? 1☐Yes 2☐No 9☐Unknown

If YES, please complete the following information:

VACCINE NAME	DATE GIVEN List most recent date for each vaccine Mo.	Day	Year	LOT NUMBER
1☐ Menomune®, Tetravalent Meningococcal Polysaccharide Vaccine (MPSV4)				
1☐ Menactra®, Tetravalent Meningococcal Conjugate Vaccine (MCV4)				
1☐ Other *(specify)* _____				
1☐ Not Known				

STREPTOCOCCUS PNEUMONIAE

29. If <15 years of age, did patient receive pneumococcal vaccine?
1☐Yes 2☐No 9☐Unknown

If YES, please note which pneumococcal vaccine was received: *(Check all that apply)*
1☐ Prevnar®, 7-valent Pneumococcal Conjugate Vaccine (PCV7)
1☐ Prevnar-13®, 13-valent Pneumococcal Conjugate Vaccine (PCV13)
1☐ 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.

GROUP A STREPTOCOCCUS *(#30–32 refer to the 7 days prior to first positive culture)*

30. Did the patient have surgery? 1☐Yes 2☐No 9☐Unknown
If YES, date of surgery: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

31. Did the patient deliver a baby (vaginal or C-section)?
1☐Yes 2☐No 9☐Unknown
If YES, date of delivery: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

32. Did patient have:
1☐ Varicella
1☐ Penetrating trauma
1☐ Blunt trauma
1☐ Surgical wound (post operative)
1☐ Burns

INFLUENZA **33. Did this patient have a positive flu test 10 days prior to or following <u>any</u> ABCs positive culture?** 1☐Yes 2☐No 9☐Unknown

34. COMMENTS: _____

– SURVEILLANCE OFFICE USE ONLY –

35. Was case first identified through audit?
1☐Yes 2☐No 9☐Unknown

36. CRF Status:
1☐ Complete
2☐ Incomplete
3☐ Edited & Correct
4☐ Chart unavailable after 3 requests

37. Does this case have recurrent disease with the same pathogen?
1☐Yes 2☐No 9☐Unknown
If YES, previous (1st) state I.D.: ☐☐☐☐☐☐☐

38. Date reported to EIP site: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

39. Initials of S.O.: _____

Submitted By: _____ Phone No. : ( )_____ Date:____/____/____

Physician's Name: _____ Phone No. : ( )_____