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 –

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 ☐

6a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

6b. If YES, hospital I.D. ☐

7a. Was patient a resident of a nursing home or other chronic care facility at the time of first positive culture? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

7b. If YES, name ______

8. DATE OF BIRTH: Mo. ☐ Day ☐ Year ☐

9a. AGE: ☐

9b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

10. SEX: 1 ☐ Male 2 ☐ Female

11a. ETHNIC ORIGIN: 1 ☐ Hispanic or Latino 2 ☐ Not Hispanic or Latino 9 ☐ Unknown

11b. 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

12a. WEIGHT: ______lbs ______ oz **OR** ______ kg **OR** ☐ Unknown

12b. HEIGHT: ______ft ______ in **OR** ______ cm **OR** ☐ Unknown

13. 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

14. OUTCOME: 1 ☐ Survived 9 ☐ Unknown 2 ☐ Died

15a. At time of first positive culture, patient was: 1 ☐ Pregnant 2 ☐ Postpartum 3 ☐ Neither 9 ☐ Unknown

15b. If 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
9 ☐ Unknown

16. 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)

17. 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

18a. 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*

18b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: *(specify)* ______

19. 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)* ______

20. DATE FIRST POSITIVE CULTURE OBTAINED: (Date Specimen Collected) Mo. ☐ Day ☐ Year ☐

21. OTHER SITES FROM WHICH ORGANISM ISOLATED: *(Check all that apply)*
1 ☐ Placenta
1 ☐ Amniotic fluid
1 ☐ Wound
1 ☐ Other *(specify)* ______
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 –

22. IF PATIENT DIED, WAS THE CULTURE OBTAINED ON AUTOPSY? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23. UNDERLYING CAUSES OR PRIOR ILLNESSES: *(Check all that apply)* *(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

24a. 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						

24b. 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)* ____________

24c. 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

25. What was the serogroup?
1 ☐ A 3 ☐ C 5 ☐ W135 9 ☐ Unknown
2 ☐ B 4 ☐ Y 6 ☐ Not groupable 8 ☐ Other *(specify)* ____________

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

27. Did patient receive meningococcal vaccine?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If YES, please complete the following information:

VACCINE NAME/MANUFACTURER	DATE GIVEN (List most recent date for each vaccine) Mo.	Day	Year	LOT NUMBER
☐ Menomune, tetravalent meningococcal polysaccharide vaccine				
☐ Menactra, tetravalent meningococcal conjugate vaccine				
☐ Other *(specify)* ____________				
☐ Not Known				

STREPTOCOCCUS PNEUMONIAE

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

If YES and between 3 and 59 months of age, please complete the Invasive Pneumococcal Disease in Children expanded form.

GROUP A STREPTOCOCCUS

(#29–31 refer to the 7 days prior to first positive culture)

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

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

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

32. COMMENTS: ____________

– SURVEILLANCE OFFICE USE ONLY –

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

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

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

36. Date reported to EIP site
Mo. ☐ Day ☐ Year ☐

37. Initials of S.O. ____________

Submitted By: ____________ Phone No. : ( ) ____________ Date: ___/___/___

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