

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

- Patient identifier information is not transmitted to CDC -

DEPARTMENT OF HEALTH & 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



OMB No. 0920-0009

- 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: Date of discharge: 6a. Was patient transferred from another hospital? 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? 7b. If yes, name: 8. DATE OF BIRTH: 9a. AGE: 9b. Is age in day/mo/yr?:

10. SEX: 11a. ETHNIC ORIGIN: 11b. RACE: (Check all that apply) 12a. WEIGHT: 12b. HEIGHT:

13. TYPE OF INSURANCE: (check all that apply) 14. OUTCOME: 15. Was patient pregnant/post-partum at time of first positive culture? 16. If patient <1 month of age:

15. Was patient pregnant/post-partum at time of first positive culture? 16. If patient <1 month of age: Gestational age: Birthweight:

17. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply) 18a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: 18b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: (specify)

19. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 20. DATE FIRST POSITIVE CULTURE OBTAINED: 21. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)

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.

- IMPORTANT - PLEASE COMPLETE THE BACK OF THIS FORM -

22. UNDERLYING CAUSES OR PRIOR ILLNESS: (Check all that apply) (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"/> Cirrhosis/Liver Failure	1 <input type="checkbox"/> Cochlear Implant
1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Alcohol Abuse	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"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	1 <input type="checkbox"/> Other Malignancy (specify) _____
1 <input type="checkbox"/> Splenectomy/Asplenia	1 <input type="checkbox"/> Diabetes Mellitus	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Organ Transplant (specify) _____
1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Other Prior Illness (specify) _____
1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)	1 <input type="checkbox"/> Renal Failure/Dialysis	1 <input type="checkbox"/> CSF Leak	_____
1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> IVDU	_____
1 <input type="checkbox"/> Hodgkin's Disease	1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> Cerebral Vascular Accident (CVA) / Stroke	_____
		1 <input type="checkbox"/> Complement Deficiency	_____

- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISMS:

HAEMOPHILUS INFLUENZAE	23. If <15 years of age and serotype 'b' or 'unk' did patient receive Haemophilus influenzae b vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If YES, please complete the list below.	24. What was the serotype? 1 <input type="checkbox"/> b 9 <input type="checkbox"/> Not Tested or Unk 2 <input type="checkbox"/> Not Typeable 3 <input type="checkbox"/> a 4 <input type="checkbox"/> c 5 <input type="checkbox"/> d 6 <input type="checkbox"/> e 7 <input type="checkbox"/> f 8 <input type="checkbox"/> Other (specify) _____																																	
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NEISSERIA MENINGITIDIS 25. What was the serogroup? 1 <input type="checkbox"/> A 3 <input type="checkbox"/> C 5 <input type="checkbox"/> W135 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> B 4 <input type="checkbox"/> Y 6 <input type="checkbox"/> Not groupable 8 <input type="checkbox"/> Other (specify) _____	26. Is patient currently attending college? (15 – 24 years only) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
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27. Did patient receive meningococcal vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If YES, please complete the following information:	VACCINE NAME/MANUFACTURER <input type="checkbox"/> Menomune, tetravalent meningococcal polysaccharide vaccine <input type="checkbox"/> Menactra, tetravalent meningococcal conjugate vaccine <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Not Known	DATE GIVEN List most recent date for each vaccine <table border="0"> <thead> <tr> <th>Mo.</th> <th>Day</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> </tbody> </table>	Mo.	Day	Year	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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STREPTOCOCCUS PNEUMONIAE 28. If <15 years of age did patient receive pneumococcal conjugate vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If YES, please complete the following information:	<table border="0"> <thead> <tr> <th rowspan="2">DOSE</th> <th colspan="3">DATE GIVEN</th> <th rowspan="2">VACCINE NAME/MANUFACTURER</th> <th rowspan="2">LOT NUMBER</th> </tr> <tr> <th>Mo.</th> <th>Day</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td>1</td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>2</td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>3</td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>4</td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	DOSE	DATE GIVEN			VACCINE NAME/MANUFACTURER	LOT NUMBER	Mo.	Day	Year	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	_____	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	_____	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	_____	4	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	_____
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GROUP A STREPTOCOCCUS (#29–31 refer to the 7 days prior to first positive culture) 29. Did the patient have surgery? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If YES, date of surgery: Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	30. Did the patient deliver a baby (vaginal or C-section)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If YES, date of delivery: Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	31. 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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32. COMMENTS: _____

- SURVEILLANCE OFFICE USE ONLY -

33. Was case first identified through audit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	34. 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	35. Does this case have recurrent disease with the same pathogen? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If YES, previous (1st) state I.D. <input type="text"/>	36. Date reported to EIP site Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	37. Initials of S.O. _____
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Submitted By: _____ Phone No.: () _____ Date: ____/____/____

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