– ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT –

Patient's Name: _____ (Last, First, M.I.) 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 & 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

CDC SAFER·HEALTHIER·PEOPLE™

– SHADED AREAS FOR OFFICE USE ONLY –

OMB No. 0920-0009

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 ☐ Unk

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 ☐ Unk

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 ☐ Non-Hispanic or Latino
9 ☐ Unk

11b. RACE: (Check all that apply)
1 ☐ White
1 ☐ Black
1 ☐ American Indian/ Alaskan Native
1 ☐ Asian
1 ☐ Native Hawaiian/ Pacific Islander
1 ☐ Unk

12a. WEIGHT: _____ lbs _____ oz **OR** _____ kg ☐ Unk

12b. HEIGHT: _____ ft _____ in **OR** _____ cm ☐ Unk

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 ☐ Unk

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

15. Was patient pregnant/post-partum at time of first positive culture? 1 ☐ Yes 2 ☐ No 9 ☐ Unk

If YES, outcome of fetus:
1 ☐ Survived, no apparent illness
2 ☐ Survived, clinical infection
3 ☐ Live birth/neonatal death
4 ☐ Abortion/stillbirth
5 ☐ Induced abortion
9 ☐ Unk

16. If patient <1 month of age:
Gestational age: ☐☐ (wks) Birthweight: ☐☐☐☐ (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 ☐ Other *(specify)* _____

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 ☐ Internal body site *(specify)* _____
1 ☐ Other normally sterile site *(specify)* _____
1 ☐ Peritoneal fluid
1 ☐ Pericardial fluid
1 ☐ Joint
1 ☐ Bone
1 ☐ Muscle

20. DATE FIRST POSITIVE CULTURE OBTAINED:
(Date Specimen Drawn)
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

– *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 ☐ 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
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 ☐ Other Malignancy *(specify)* _____
1 ☐ Organ Transplant *(specify)* _____
1 ☐ Other Prior Illness *(specify)* _____

– *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 ☐ Yes 2 ☐ No 9 ☐ Unk
If YES, please complete the list below.

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

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

NEISSERIA MENINGITIDIS

25. What was the serogroup?
1 ☐ A 3 ☐ C 5 ☐ W135 9 ☐ Unk
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 ☐ Unk

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

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

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 ☐ Unk
If YES, date of surgery: Mo. / Day / Year

30. Did the patient deliver a baby (vaginal or C-section)?
1 ☐ Yes 2 ☐ No 9 ☐ Unk
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 ☐ Unk

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 ☐ Unk
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.: ( ) _____