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

– 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 ☐ Not Hispanic or Latino 9 ☐ Unk

11b. 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 ☐ 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 ☐ Indian Health Service (IHS) 1 ☐ No health care coverage
1 ☐ Military/VA 1 ☐ Private/HMO/PPO/managed care plan 1 ☐ Unk
1 ☐ Medicaid/state assistance program 1 ☐ Other *(specify)* ____________

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

15a. At time of first positive culture, patient was:
1 ☐ Pregnant 3 ☐ Neither
2 ☐ Post-partum 9 ☐ Unk

15b. If pregnant or post-partum, what was the outcome of fetus:
1 ☐ Survived, no apparent illness 3 ☐ Live birth/neonatal death 5 ☐ Induced abortion
2 ☐ Survived, clinical infection 4 ☐ Abortion/stillbirth 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 ☐ Peritonitis 1 ☐ Endometritis
1 ☐ Meningitis 1 ☐ Pericarditis 1 ☐ STSS
1 ☐ Otitis media 1 ☐ Septic abortion 1 ☐ Necrotizing fasciitis
1 ☐ Pneumonia 1 ☐ Chorioamnionitis 1 ☐ Puerperal sepsis
1 ☐ Cellulitis 1 ☐ Septic arthritis 1 ☐ Other *(specify)* ____________
1 ☐ Epiglottitis 1 ☐ Osteomyelitis
1 ☐ Hemolytic uremic syndrome (HUS) 1 ☐ Empyema
1 ☐ Abscess (not skin) 1 ☐ Endocarditis 1 ☐ Unk

18a. 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*

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

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 ☐ Middle ear
1 ☐ Amniotic fluid 1 ☐ Sinus
1 ☐ Wound
1 ☐ Other *(specify)* ____________

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 (0920-0009). **Do not send the completed form to this address.**

– *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 a. 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				

23b. 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)* ____________

24. 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 Unk

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.:( ) ____________