

NEONATAL GROUP B STREPTOCOCCAL DISEASE PREVENTION TRACKING FORM

Infant's Name: _____
(Last, First, M.I.)
 Mother's Name: _____
(Last, First, M.I.)
 Hospital Name: _____

Infant's Chart No.: _____
 Mother's Chart No.: _____
 Culture date: _____

*Patient identifier information is NOT transmitted to CDC *



ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)
 NEONATAL GROUP B STREPTOCOCCAL DISEASE PREVENTION TRACKING FORM



STATEID _____

HOSPITAL ID (of birth; if home birth leave blank) _____

Infant Information

Were labor & delivery records available? Yes (1) No (0)

1. Date of Birth: ____/____/____ <small>month / day / year (4 digits)</small> Time of birth: ____:____:____ <input type="checkbox"/> Unknown (1) <small>(times in military format)</small>		2. Did this birth occur outside of the hospital? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES , please check one: <input type="checkbox"/> Home Birth (1) <input type="checkbox"/> Birthing Center (2) <input type="checkbox"/> En route to hospital (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	
3. Gestational age in completed weeks: ____ (do not round up)		4. Birthweight: ____ lbs ____ oz OR _____ grams	
5. Date & time of newborn discharge after birth: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) <small>month / day / year (4 digits) time</small>			
6. Outcome: <input type="checkbox"/> Survived (1) <input type="checkbox"/> Died (2) <input type="checkbox"/> Unknown (9)			
7. Readmitted to the same hospital: <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) IF YES , date & time of readmission: ____/____/____ ____:____:____ <small>month / day / year (4 digits) time</small>			
8. Admitted from home to different hospital: <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) IF YES , hospital id: _____ AND date & time admission: ____/____/____ ____:____:____ <small>month / day / year (4 digits) time</small>			
9. Infant discharge diagnosis: ICD9-1 _____.____ ICD9-2 _____.____ ICD9-3 _____.____			
10. Did the baby receive breast milk from the mother? (for late-onset cases only) <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES , did the baby receive breast milk before onset of GBS infection (eg, date of first positive neonatal culture): <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)			

Maternal Information

11. Maternal admission date & time: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) <small>month / day / year (4 digits) time</small>	
Maternal age at delivery (years): ____ years	Maternal blood type: <input type="checkbox"/> A (1) <input type="checkbox"/> B (2) <input type="checkbox"/> AB (3) <input type="checkbox"/> O (4)
12. Did mother have a prior history of penicillin allergy? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) IF YES , was a previous maternal history of anaphylaxis noted? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	
13. Date & time membrane rupture: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) <small>month / day / year (4 digits) time</small>	
14. Was duration of membrane rupture \geq 18 hours? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)	
15. If membranes ruptured at <37 weeks, did membranes rupture before onset of labor? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)	
16. Type of rupture: <input type="checkbox"/> Spontaneous (1) <input type="checkbox"/> Artificial (2)	

Maternal Information (continued)

17. Type of delivery: (Check all that apply)
- Vaginal (1) Vaginal after previous C-section (1) Primary C-section (1) Repeat C-section (1)
- Forceps (1) Vacuum (1) Unknown (1)

If delivery was by C-section: Did labor or contractions begin before C-section? Yes (1) No (0) Unknown (9)

Did membrane rupture happen before C-section? Yes (1) No (0) Unknown (9)

18. Intrapartum fever (T ≥ 100.4 F or 38.0 C): Yes (1) No (0) Unknown (9)

IF YES, 1st recorded T ≥ 100.4 F or 38.0 C at: / / : :

month day year (4 digits) time

19. Did mother receive prenatal care? Yes (1) No (0) Unknown (9)

20. Was prenatal record (even partial information) in labor and delivery chart? Yes (1) No (0) Unknown (9)

IF YES: No. of visits: First visit: / / Last visit: / /

month day year (4 digits) month day year (4 digits)

21. Estimated gestational age (EGA) at last documented prenatal visit: . (weeks)

22. GBS bacteriuria during this pregnancy? Yes (1) No (0)

IF YES, what order of magnitude was the colony count?

- 0 (1) <10,000 (2) 10k-<25,000 (3) 25k-<50,000 (4) 50k-<75,000 (5) 75k-<100,000 (6)
- ≥100,000 (7) Unknown (9)

23. Previous infant with invasive GBS disease? Yes (1) No (0)

24. Previous pregnancy with GBS colonization? Yes (1) No (0)

- 25a. Was maternal group B strep colonization screened for BEFORE admission (in prenatal care)?

Yes (1) No (0) Unknown (9)

IF YES, list dates, test type, and test results below:

<u>Test date (list most recent first):</u>	<u>Test type:</u>	<u>Positive culture</u> (Do not include urine here!)
1. <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Culture (1) <input type="checkbox"/> Rapid pcr (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)
2. <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Culture (1) <input type="checkbox"/> Rapid pcr (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)

- 25b. If the *most recent* test was GBS positive, was antimicrobial susceptibility performed? Yes (1) No (0) Unknown (9)

IF YES, Was the isolate resistant to clindamycin? Yes (1) No (0) Unknown (9)

Was the isolate resistant to erythromycin? Yes (1) No (0) Unknown (9)

- 26a. Was maternal group B strep colonization screened for AFTER admission (before delivery)? Yes (1) No (0) Unknown (9)

IF YES, list date of most recent test, test type and test results below:

<u>Test date (list most recent first):</u>	<u>Test type:</u>	<u>Positive culture</u> (Do not include urine here!)
<u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Culture (1) <input type="checkbox"/> Rapid pcr (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)

