NEONATAL GROUP B STREPTOCOCCAL DISEASE PREVENTION TRACKING FORM

Infant's Name: _____ (Last, First, M.I.) Infant's Chart No.: _____

Mother's Name: _____ (Last, First, M.I.) Mother's Chart No.: _____

Hospital Name: _____ 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: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits))
   Time of birth: ___ ___ ___ ___ ☐ Unknown (1) (times in military format)

2. Did this birth occur outside of the hospital?
   ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
   IF YES, please check one: ☐ Home Birth (1) ☐ Birthing Center (2) ☐ En route to hospital (3) ☐ Other (4) ☐ 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: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

6. Outcome: ☐ Survived (1) ☐ Died (2) ☐ Unknown (9)

7. Readmitted to the same hospital: ☐ Yes (1) ☐ No (0)
   IF YES, date & time of readmission: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time)

8. Admitted from home to different hospital: ☐ Yes (1) ☐ No (0)
   IF YES, hospital id: ___ ___ ___ ___ ___ **AND date & time admission:** __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time)

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*) ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
    IF YES, did the baby receive breast milk before onset of GBS infection (eg, date of first positive neonatal culture): ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

Maternal Information

11. Maternal admission date & time: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

    Maternal age at delivery (years): __ __ years Maternal blood type: ☐ A (1) ☐ B (2) ☐ AB (3) ☐ O (4)

12. Did mother have a prior history of penicillin allergy? ☐ Yes (1) ☐ No (0)
    IF YES, was a previous maternal history of anaphylaxis noted? ☐ Yes (1) ☐ No (0)

13. Date & time membrane rupture: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

14. Was duration of membrane rupture ≥18 hours? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

15. If membranes ruptured at <37 weeks, did membranes rupture before onset of labor? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

16. Type of rupture: ☐ Spontaneous (1) ☐ 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: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) Last visit: __ __ /__ __ /__ __ __ __ (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)

☐ ≥100,0000 (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:

Test date (list most recent first):	Test type:	Positive culture (Do not include urine here!)
1. __ __ /__ __ /__ __ __ __	☐ Culture (1) ☐ Rapid pcr (2) ☐ Rapid antigen (3) ☐ Other (4) ☐ Unknown (9)	☐ Yes (1) ☐ No (0) ☐ Unknown (9)
2. __ __ /__ __ /__ __ __ __	☐ Culture (1) ☐ Rapid pcr (2) ☐ Rapid antigen (3) ☐ Other (4) ☐ Unknown (9)	☐ Yes (1) ☐ No (0) ☐ 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:

Test date (list most recent first):	Test type:	Positive culture (Do not include urine here!)
__ __ /__ __ /__ __ __ __	☐ Culture (1) ☐ Rapid pcr (2) ☐ Rapid antigen (3) ☐ Other (4) ☐ Unknown (9)	☐ Yes (1) ☐ No (0) ☐ Unknown (9)

Maternal Information *(continued)*

26b. 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)

27. Were GBS test results available to care givers at the time of delivery? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

Intrapartum Antibiotics

28. Were antibiotics given to the mother intrapartum? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

IF YES, answer a-b and Question 29-30

a) Date & time antibiotics 1st administered: (before delivery) __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time)

b) Antibiotic 1: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 2: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 3: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 4: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 5: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 6: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

29. Interval between receipt of 1st antibiotic and delivery: ___ ___ ___ (hours) ___ ___ (minutes)

30. What was the reason for administration of intrapartum antibiotics? (*Check all that apply*)

☐ GBS prophylaxis (1) ☐ C-section prophylaxis (1) ☐ Mitral valve prolapse prophylaxis (1)

☐ Suspected amnionitis (1) ☐ Other (1) ☐ Unknown (1)

Comments:_____

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