

Patient's Name: _____ (Last, First, MI.) 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 AND 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 -

1. STATE: (Residence of Patient) <input type="text"/> <input type="text"/>	2. COUNTY: (Residence of Patient) _____	3. STATE I.D.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	4b. HOSPITAL I.D. WHERE PATIENT TREATED: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5. WAS PATIENT HOSPITALIZED? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If YES, date of admission: Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			6a. Was patient transferred from another hospital? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	
7a. Was patient a resident of a nursing home or other chronic care facility at the time of first positive culture? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			8. DATE OF BIRTH: Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	9a. AGE: <input type="text"/> <input type="text"/> <input type="text"/>
7b. If YES, name _____			9b. Is age in day/mo/yr? 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.	
10. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	11a. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown	11b. RACE: (Check all that apply) 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Black 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Unknown		12a. WEIGHT: _____ lbs _____ oz OR _____ kg OR <input type="checkbox"/> Unknown
13. TYPE OF INSURANCE: (Check all that apply) 1 <input type="checkbox"/> Medicare 1 <input type="checkbox"/> Indian Health Service (IHS) 1 <input type="checkbox"/> No health care coverage 1 <input type="checkbox"/> Military/VA 1 <input type="checkbox"/> Private/HMO/PPO/managed care plan 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Medicaid/state assistance program 1 <input type="checkbox"/> Other (specify) _____				14. OUTCOME: 1 <input type="checkbox"/> Survived 9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Died
15a. At time of first positive culture, patient was: 1 <input type="checkbox"/> Pregnant 3 <input type="checkbox"/> Neither 2 <input type="checkbox"/> Postpartum 9 <input type="checkbox"/> Unknown	15b. If postpartum, what was the outcome of fetus: 1 <input type="checkbox"/> Survived, no apparent illness 4 <input type="checkbox"/> Abortion/stillbirth 2 <input type="checkbox"/> Survived, clinical infection 5 <input type="checkbox"/> Induced abortion 3 <input type="checkbox"/> Live birth/neonatal death 9 <input type="checkbox"/> Unknown		16. If patient <1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only. Gestational age: <input type="text"/> <input type="text"/> (wks) Birth weight: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (gms)	
17. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply) 1 <input type="checkbox"/> Bacteremia without Focus 1 <input type="checkbox"/> Peritonitis 1 <input type="checkbox"/> Endometritis 1 <input type="checkbox"/> Meningitis 1 <input type="checkbox"/> Pericarditis 1 <input type="checkbox"/> STSS 1 <input type="checkbox"/> Otitis media 1 <input type="checkbox"/> Septic abortion 1 <input type="checkbox"/> Necrotizing fasciitis 1 <input type="checkbox"/> Pneumonia 1 <input type="checkbox"/> Chorioamnionitis 1 <input type="checkbox"/> Puerperal sepsis 1 <input type="checkbox"/> Cellulitis 1 <input type="checkbox"/> Septic arthritis 1 <input type="checkbox"/> Septic shock 1 <input type="checkbox"/> Epiglottitis 1 <input type="checkbox"/> Osteomyelitis 1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Hemolytic uremic syndrome (HUS) 1 <input type="checkbox"/> Empyema 1 <input type="checkbox"/> Abscess (not skin) 1 <input type="checkbox"/> Endocarditis 1 <input type="checkbox"/> Unknown			18a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: 1 <input type="checkbox"/> <i>Neisseria meningitidis</i> 4 <input type="checkbox"/> <i>Listeria monocytogenes</i> 2 <input type="checkbox"/> <i>Haemophilus influenzae</i> 5 <input type="checkbox"/> Group A <i>Streptococcus</i> 3 <input type="checkbox"/> Group B <i>Streptococcus</i> 6 <input type="checkbox"/> <i>Streptococcus pneumoniae</i>	
19. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Muscle 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Joint 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> Other normally sterile site (specify) _____			18b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: (specify) _____ _____	
20. DATE FIRST POSITIVE CULTURE OBTAINED: (Date Specimen Collected) Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			21. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 1 <input type="checkbox"/> Placenta 1 <input type="checkbox"/> Middle ear 1 <input type="checkbox"/> Amniotic fluid 1 <input type="checkbox"/> Sinus 1 <input type="checkbox"/> Wound 1 <input type="checkbox"/> Other (specify) _____	

22. IF PATIENT DIED, WAS THE CULTURE OBTAINED ON AUTOPSY?

1 Yes 2 No 9 Unknown

23. UNDERLYING CAUSES OR PRIOR ILLNESSES: (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"/> Alcohol Abuse | 1 <input type="checkbox"/> Cochlear Implant |
| 1 <input type="checkbox"/> Multiple Myeloma | 1 <input type="checkbox"/> Emphysema/COPD | 1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD | 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"/> Heart Failure/CHF | 1 <input type="checkbox"/> Solid Organ Malignancy |
| 1 <input type="checkbox"/> Splenectomy/Asplenia | 1 <input type="checkbox"/> Diabetes Mellitus | 1 <input type="checkbox"/> Obesity | 1 <input type="checkbox"/> Solid Organ Transplant |
| 1 <input type="checkbox"/> Immunoglobulin Deficiency | 1 <input type="checkbox"/> Nephrotic Syndrome | 1 <input type="checkbox"/> CSF Leak | 1 <input type="checkbox"/> Premature Birth (specify gestational age at birth) <input type="text"/> (wks) |
| 1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation) | 1 <input type="checkbox"/> Renal Failure/Dialysis | 1 <input type="checkbox"/> IVDU | 1 <input type="checkbox"/> Chronic Skin Breakdown |
| 1 <input type="checkbox"/> Leukemia | 1 <input type="checkbox"/> HIV Infection | 1 <input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke | 1 <input type="checkbox"/> Other Prior Illness (specify) _____ |
| 1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma | 1 <input type="checkbox"/> AIDS or CD4 count <200 | 1 <input type="checkbox"/> Complement Deficiency | |
| 1 <input type="checkbox"/> Bone Marrow Transplant (BMT) | 1 <input type="checkbox"/> Cirrhosis/Liver Failure | | |

- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISMS:

HAEMOPHILUS INFLUENZAE

24a. If <15 years of age and serotype 'b' or 'unknown' did patient receive Haemophilus influenzae b vaccine? 1 Yes 2 No 9 Unknown
If YES, please complete the list below.

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"/>			

24b. 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) _____

24c. 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 Unknown

NEISSERIA MENINGITIDIS

25. What was the serogroup?

1 A 3 C 5 W135 9 Unknown
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 Unknown

27. Did patient receive meningococcal vaccine?

VACCINE NAME/MANUFACTURER

DATE GIVEN

LOT NUMBER

1 Yes 2 No 9 Unknown

If YES, please complete the following information:

Menomune, tetraivalent meningococcal polysaccharide vaccine

Menactra, tetraivalent meningococcal conjugate vaccine

Other (specify) _____

Not Known

List most recent date for each vaccine

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"/>	

STREPTOCOCCUS PNEUMONIAE

28. If <15 years of age, did patient receive pneumococcal conjugate vaccine? 1 Yes 2 No 9 Unknown

If YES and between 3 and 59 months of age, please complete the Invasive Pneumococcal Disease in Children expanded form.

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 Unknown

If YES, date of surgery: Mo. Day Year

30. Did the patient deliver a baby (vaginal or C-section)?

1 Yes 2 No 9 Unknown

If YES, date of delivery: Mo. Day Year

31. Did patient have:

1 Varicella 1 Surgical wound (post operative)

1 Penetrating trauma

1 Blunt trauma 1 Burns

32. COMMENTS: _____

- SURVEILLANCE OFFICE USE ONLY -

33. Was case first identified through audit?

1 Yes 2 No

9 Unknown

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 Unknown

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. : () _____