

Patient's Name _____

Patient's Date of Birth ___/___/___

**ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)
INVASIVE PNEUMOCOCCAL DISEASE IN CHILDREN**

Revised 10/24/2003

StateID: _____

Date of positive culture ___/___/___

Date form completed ___/___/___

- VACCINE HISTORY -

Child has never received vaccines

Vaccination history unknown

VACCINES	Dose #	Dates of immunizations	Manufacturer	Vaccine name	Lot #
Pneumococcal conjugate vaccine (Prennar®)	1				
	2				
	3				
	4				
Pneumococcal polysaccharide vaccine	1				
	2				
Diphtheria/Tetanus/Pertussis (DTP or DtaP)	1				
	2				
	3				
	4				
	5				
Haemophilus influenzae type B (Hib)	1				
	2				
	3				
	4				
Influenza vaccine	1				
	2				
	3				

*For combination vaccines (e.g. Trihibit, Tetramune, ActHIB/DTwP) enter information for each vaccine component

- IMMUNE SYSTEM EVALUATION -

Does this patient have an immune disorder other than HIV or AIDS? Yes No Unknown

If yes, diagnosis _____

If yes, indicate below results for any tests performed to evaluate immune function:

Tests	Test Date	Result			
IgGtotal.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
IgG1.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
IgG2.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
IgG3.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
IgG4.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
IgM.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
IgA.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
C3.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
C4.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
CH50.....	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
Other (specify _____)	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done
Other (specify _____)	___/___/___	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Not done

Person completing the form (please print): Phone: () _____
Name _____ Title _____ Fax: () _____

Please return _____ Phone: () _____
form to: _____ Fax: () _____
