

NEONATAL INFECTION EXPANDED 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 INFECTION EXPANDED 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 of infant at birth in completed weeks: ____ (do not round up)	4. Birth weight: ____ lbs ____ oz OR _____ grams
5. Date & time of newborn discharge from hospital of 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. Was the infant discharged to home and readmitted to the birth hospital? (for GBS cases only): <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. Was the infant admitted to a different hospital from home? (for GBS cases only): <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 (for GBS cases only): ICD9-1 _____ ICD9-2 _____ ICD9-3 _____	
10. Did the baby receive breast milk from the mother? (for late-onset GBS 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 (e.g., 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>	
12. Maternal age at delivery (years): ____ years	13. Maternal blood type: <input type="checkbox"/> A (1) <input type="checkbox"/> B (2) <input type="checkbox"/> AB (3) <input type="checkbox"/> O (4)
14. 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)	
15. Date & time membrane rupture: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>	
16. Was duration of membrane rupture \geq 18 hours? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)	
17. 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)	

18. Type of rupture: Spontaneous (1) Artificial (2)

19. 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)

20. 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

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

IF YES, answer a-b and Questions 22-23

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): ___ / ___ / ___

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

23. 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)

*****Questions 24–32 should only be completed for early- and late-onset GBS cases*****

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

25. 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: ___/___/___

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

27. 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)

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

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

30a. 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. ___/___/___	<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. ___/___/___	<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)

30b. If the *most recent* test was GBS positive was antimicrobial susceptibility performed BEFORE admission (in prenatal care)?
 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)

31a. 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!)
___/___/___	<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)

31b. If the *most recent* test was GBS positive, was antimicrobial susceptibility performed AFTER admission?
 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)

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

COMMENTS: _____

