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) ☐☐

2. COUNTY: (Residence of Patient) ____________

3. STATE I.D.: ☐☐☐☐☐☐☐

4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: ☐☐☐☐☐

4b. HOSPITAL I.D. WHERE PATIENT TREATED: ☐☐☐☐☐

5. WAS PATIENT HOSPITALIZED? 1 ☐ Yes 2 ☐ No

If YES, date of admission: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

Date of discharge: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

6a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

6b. If YES, hospital I.D. ☐☐☐☐☐

7a. Was patient a resident of a nursing home or other chronic care facility at the time of first positive culture? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

7b. If YES, name ____________

8. DATE OF BIRTH: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

9a. AGE: ☐☐☐

9b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

10. SEX: 1 ☐ Male 2 ☐ Female

11a. ETHNIC ORIGIN: 1 ☐ Hispanic or Latino 2 ☐ Not Hispanic or Latino 9 ☐ Unknown

11b. RACE: *(Check all that apply)* 1 ☐ White 1 ☐ Black 1 ☐ American Indian or Alaska Native 1 ☐ Asian 1 ☐ Native Hawaiian or Other Pacific Islander 1 ☐ Unknown

12a. WEIGHT: ______lbs ________ oz **OR** ________ kg **OR** ☐ Unknown

12b. HEIGHT: ______ft ________ in **OR** _________ cm **OR** ☐ Unknown

13. TYPE OF INSURANCE: *(Check all that apply)*
1 ☐ Medicare
1 ☐ Military/VA
1 ☐ Medicaid/state assistance program
1 ☐ Indian Health Service (IHS)
1 ☐ Private/HMO/PPO/managed care plan
1 ☐ Other *(specify)* ____________
1 ☐ No health care coverage
1 ☐ Unknown

14. OUTCOME: 1 ☐ Survived 9 ☐ Unknown 2 ☐ Died

15a. At time of first positive culture, patient was: 1 ☐ Pregnant 3 ☐ Neither 2 ☐ Postpartum 9 ☐ Unknown

15b. If postpartum, what was the outcome of fetus:
1 ☐ Survived, no apparent illness
2 ☐ Survived, clinical infection
3 ☐ Live birth/neonatal death
4 ☐ Abortion/stillbirth
5 ☐ Induced abortion
9 ☐ Unknown

16. If patient <1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only.
Gestational age: ☐☐ (wks) Birth weight: ☐☐☐☐ (gms)

17. TYPES OF INFECTION CAUSED BY ORGANISM: *(Check all that apply)*
1 ☐ Bacteremia without Focus
1 ☐ Meningitis
1 ☐ Otitis media
1 ☐ Pneumonia
1 ☐ Cellulitis
1 ☐ Epiglottitis
1 ☐ Hemolytic uremic syndrome (HUS)
1 ☐ Abscess (not skin)
1 ☐ Peritonitis
1 ☐ Pericarditis
1 ☐ Septic abortion
1 ☐ Chorioamnionitis
1 ☐ Septic arthritis
1 ☐ Osteomyelitis
1 ☐ Empyema
1 ☐ Endocarditis
1 ☐ Endometritis
1 ☐ STSS
1 ☐ Necrotizing fasciitis
1 ☐ Puerperal sepsis
1 ☐ Septic shock
1 ☐ Other *(specify)* ____________
1 ☐ Unknown

18a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:
1 ☐ *Neisseria meningitidis*
2 ☐ *Haemophilus influenzae*
3 ☐ Group B *Streptococcus*
4 ☐ *Listeria monocytogenes*
5 ☐ Group A *Streptococcus*
6 ☐ *Streptococcus pneumoniae*

18b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: *(specify)*
____
____

19. STERILE SITES FROM WHICH ORGANISM ISOLATED: *(Check all that apply)*
1 ☐ Blood
1 ☐ CSF
1 ☐ Pleural fluid
1 ☐ Peritoneal fluid
1 ☐ Pericardial fluid
1 ☐ Joint
1 ☐ Bone
1 ☐ Muscle
1 ☐ Internal body site *(specify)* ____________
1 ☐ Other normally sterile site *(specify)* ____________

20. DATE FIRST POSITIVE CULTURE OBTAINED:
(Date Specimen Collected) Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

21. OTHER SITES FROM WHICH ORGANISM ISOLATED: *(Check all that apply)*
1 ☐ Placenta
1 ☐ Amniotic fluid
1 ☐ Wound
1 ☐ Other *(specify)* ____________
1 ☐ Middle ear
1 ☐ Sinus

– *IMPORTANT* – PLEASE COMPLETE THE BACK OF THIS FORM –

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 ☐ Current Smoker
- 1 ☐ Multiple Myeloma
- 1 ☐ Sickle Cell Anemia
- 1 ☐ Splenectomy/Asplenia
- 1 ☐ Immunoglobulin Deficiency
- 1 ☐ Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)
- 1 ☐ Leukemia
- 1 ☐ Hodgkin's Disease/Lymphoma
- 1 ☐ Bone Marrow Transplant (BMT)
- 1 ☐ Asthma
- 1 ☐ Emphysema/COPD
- 1 ☐ Systemic Lupus Erythematosus (SLE)
- 1 ☐ Diabetes Mellitus
- 1 ☐ Nephrotic Syndrome
- 1 ☐ Renal Failure/Dialysis
- 1 ☐ HIV Infection
- 1 ☐ AIDS or CD4 count <200
- 1 ☐ Cirrhosis/Liver Failure
- 1 ☐ Alcohol Abuse
- 1 ☐ Atherosclerotic Cardiovascular Disease (ASCVD)/CAD
- 1 ☐ Heart Failure/CHF
- 1 ☐ Obesity
- 1 ☐ CSF Leak
- 1 ☐ IVDU
- 1 ☐ Cerebral Vascular Accident (CVA)/Stroke
- 1 ☐ Complement Deficiency
- 1 ☐ Cochlear Implant
- 1 ☐ Deaf/Profound Hearing Loss
- 1 ☐ Solid Organ Malignancy
- 1 ☐ Solid Organ Transplant
- 1 ☐ Premature Birth (*specify gestational age at birth)* ☐☐ (wks)
- 1 ☐ Chronic Skin Breakdown
- 1 ☐ Other Prior Illness *(specify)* ____________

– *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 (Mo. / Day / Year)	VACCINE NAME	MANUFACTURER	LOT NUMBER
1	☐☐ ☐☐ ☐☐☐☐			
2	☐☐ ☐☐ ☐☐☐☐			
3	☐☐ ☐☐ ☐☐☐☐			
4	☐☐ ☐☐ ☐☐☐☐			

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?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, please complete the following information:

VACCINE NAME/MANUFACTURER	DATE GIVEN (List most recent date for each vaccine) Mo. / Day / Year	LOT NUMBER
☐ Menomune, tetravalent meningococcal polysaccharide vaccine	☐☐ ☐☐ ☐☐☐☐	
☐ Menactra, tetravalent meningococcal conjugate vaccine	☐☐ ☐☐ ☐☐☐☐	
☐ Other *(specify)* ____________	☐☐ ☐☐ ☐☐☐☐	
☐ Not Known	☐☐ ☐☐ ☐☐☐☐	

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 ☐ Penetrating trauma
- 1 ☐ Blunt trauma
- 1 ☐ Surgical wound (post operative)
- 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. : ( ) ____________