

Patient's Name: (Last, First, M.I.) Address: (Number, Street, Apt. No.) (City, State) (Zip Code) Hospital: Phone No.: Patient Chart No.:

- Patient identifier information is not transmitted to CDC -

DEPARTMENT OF HEALTH & 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



OMB No. 0920-0009

- 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? If YES, date of admission: Date of discharge: 6a. Was patient transferred from another hospital? 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? 7b. If yes, name: 8. DATE OF BIRTH: 9a. AGE: 9b. Is age in day/mo/yr?:

10. SEX: 11a. ETHNIC ORIGIN: 11b. RACE: (Check all that apply) 12a. WEIGHT: 12b. HEIGHT:

13. TYPE OF INSURANCE: (check all that apply) 14. OUTCOME: 15. Was patient pregnant/post-partum at time of first positive culture? If YES, outcome of fetus: 16. If patient <1 month of age: Gestational age: Birthweight:

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17. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply) 18a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: 18b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: (specify)

19. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 20. DATE FIRST POSITIVE CULTURE OBTAINED: (Date Specimen Drawn) 21. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address.

**22. UNDERLYING CAUSES OR PRIOR ILLNESS:** (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"/> Cirrhosis/Liver Failure	1 <input type="checkbox"/> Cochlear Implant
1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Alcohol Abuse	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"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	1 <input type="checkbox"/> Other Malignancy (specify) _____
1 <input type="checkbox"/> Splenectomy/Asplenia	1 <input type="checkbox"/> Diabetes Mellitus	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Organ Transplant (specify) _____
1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Other Prior Illness (specify) _____
1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)	1 <input type="checkbox"/> Renal Failure/Dialysis	1 <input type="checkbox"/> CSF Leak	_____
1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> IVDU	_____
1 <input type="checkbox"/> Hodgkin's Disease	1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> Cerebral Vascular Accident (CVA) / Stroke	_____
		1 <input type="checkbox"/> Complement Deficiency	_____

**- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISMS:**

**HAEMOPHILUS INFLUENZAE** 23. If <15 years of age and serotype 'b' or 'unk' did patient receive *Haemophilus influenzae* b vaccine? 1  Yes 2  No 9  Unk  
If YES, please complete the following information:

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"/>	_____	_____

24. What was the serotype?  
 1  b 9  Not Tested or Unk  
 2  Not Typeable  
 3  a  
 4  c  
 5  d  
 6  e  
 7  f  
 8  Other (specify) \_\_\_\_\_

**NEISSERIA MENINGITIDIS** 25. What was the serogroup?  
 1  A 3  C 5  W135 9  Unk  
 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  Unk

27. Did patient receive meningococcal vaccine? 1  Yes 2  No 9  Unk

If YES, please complete the following information:

VACCINE NAME/MANUFACTURER	DATE GIVEN			LOT NUMBER
	Mo.	Day	Year	
<input type="checkbox"/> Menomune, tetravalent meningococcal polysaccharide vaccine	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
<input type="checkbox"/> Menactra, tetravalent meningococcal conjugate vaccine	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
<input type="checkbox"/> Other (specify) _____	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
<input type="checkbox"/> Not Known	<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  Unk  
 If YES, please complete the following information:

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"/>	_____	_____

**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  Unk  
 If YES, date of surgery: Mo.  Day  Year

30. Did the patient deliver a baby (vaginal or C-section)? 1  Yes 2  No 9  Unk  
 If YES, date of delivery: Mo.  Day  Year

31. Did patient have:  
 1  Varicella? 1  Surgical wound? (post operative)  
 1  Penetrating trauma? 1  Burns?  
 1  Blunt trauma?

32. COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_

**- SURVEILLANCE OFFICE USE ONLY -**

33. Was case first identified through audit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	34. CRF Status: 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Incomplete 3 <input type="checkbox"/> Edited & Correct 4 <input type="checkbox"/> Chart unavailable after 3 requests	35. Does this case have recurrent disease with the same pathogen? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If YES, previous (1st) state I.D. <input type="text"/>	36. Date reported to EIP site Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	37. Initials of S.O. _____
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Submitted By: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_