

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: ____/____/____ month day year (4 digits) Time of birth: _____ <input type="checkbox"/> Unknown (1) (times in military format)		2. Did this birth occur outside of the hospital? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) <b>IF YES</b> , 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 <b>OR</b> _____ grams	
5. Date & time of newborn discharge from hospital of birth: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) month day year (4 digits) time			
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) <b>IF YES</b> , date & time of readmission: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) month day year (4 digits) time			
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) <b>IF YES</b> , hospital ID: _____ <b>AND date &amp; time admission:</b> ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) month day year (4 digits) time			
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) <b>IF YES</b> , 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) month day year (4 digits) time	
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) <b>IF YES</b> , 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) month day year (4 digits) time	
16. Was duration of membrane rupture ≥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)	

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, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0802). Do not send the completed form to this address.

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 (1)

**IF YES, 1<sup>st</sup> recorded T ≥ 100.4 F or 38.0 C at:** \_\_\_ / \_\_\_ / \_\_\_ \_\_\_ \_\_\_  Unknown (1)  
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 1<sup>st</sup> administered: (before delivery) \_\_\_ / \_\_\_ / \_\_\_ \_\_\_ \_\_\_  Unknown (9)  
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 1<sup>st</sup> 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</u> (list most recent first):	<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</u> (list most recent first):	<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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_