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

2012 Active Bacterial Core Surveillance (ABCs) Case Report

A Core Component of the Emerging Infections Program Network

– SHADED AREAS FOR OFFICE USE ONLY –

Form Approved
OMB No. 0920-XXXX (for CDC)
Exp. Date xx/xx/20xx

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 ☐☐☐☐

6. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

7a. Where was the patient a resident at time of initial culture?

1 ☐ Private residence 4 ☐ Homeless 7 ☐ Non-medical ward
2 ☐ Long term care facility 5 ☐ Incarcerated 8 ☐ Other(specify) _____
3 ☐ Long term acute care facility 6 ☐ College dormitory 9 ☐ Unknown

7b. If resident of a facility, what was the name of the facility? _____

8a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

8b. If YES, hospital I.D.: ☐☐☐☐☐☐

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

10a. AGE: ☐☐☐

10b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

11. SEX: 1 ☐ Male 2 ☐ Female

12a. ETHNIC ORIGIN: 1 ☐ Hispanic or Latino 2 ☐ Not Hispanic or Latino 9 ☐ Unknown

12b. RACE: (Check all that apply)
1 ☐ White 1 ☐ Asian
1 ☐ Black 1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ American Indian or Alaska Native 1 ☐ Unknown

13a. WEIGHT: _____lbs_____ oz OR _____ kg OR ☐ Unknown

13b. HEIGHT: _____ft _____ in OR _____ cm OR ☐ Unknown

13c. BMI: ___ ___ . ___ OR ☐ Unknown

14. TYPE OF INSURANCE: (Check all that apply)
1 ☐ Private 1 ☐ Military 1 ☐ Other(specify) _____
1 ☐ Medicare 1 ☐ Indian Health Service (IHS) 1 ☐ Uninsured
1 ☐ Medicaid/state assistance program 1 ☐ Incarcerated 1 ☐ Unknown

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

16. If patient died, was the culture obtained on autopsy? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

17a. At time of first positive culture, patient was:
1 ☐ Pregnant 3 ☐ Neither
2 ☐ Postpartum 9 ☐ Unknown

17b. If pregnant or postpartum, what was the outcome of fetus:
1 ☐ Survived, no apparent illness 4 ☐ Abortion/stillbirth 9 ☐ Unknown
2 ☐ Survived, clinical infection 5 ☐ Induced abortion
3 ☐ Live birth/neonatal death 6 ☐ Still pregnant

18. 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)

19. 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

20a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:
1 ☐ Neisseria meningitidis 4 ☐ Listeria monocytogenes
2 ☐ Haemophilus influenzae 5 ☐ Group A Streptococcus
3 ☐ Group B Streptococcus 6 ☐ Streptococcus pneumoniae

20b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: (specify)
_____
_____

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

22. DATE FIRST POSITIVE CULTURE COLLECTED: (Date Specimen Collected) Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

23. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)
1 ☐ Placenta 1 ☐ Middle ear
1 ☐ Amniotic fluid 1 ☐ Sinus
1 ☐ Wound

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

24. UNDERLYING CAUSES OR PRIOR ILLNESSES: *(Check all that apply* OR *if* NONE *or* CHART UNAVAILABLE, *check appropriate box)* 1☐None 1☐Unknown

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

– *IMPORTANT* – PLEASE COMPLETE FOR THE RELEVANT ORGANISM –

INFLUENZA **25. Did this patient have a positive flu test 10 days prior to or following any ABCs positive culture?** 1☐Yes 2☐No 9☐Unknown

HAEMOPHILUS INFLUENZAE

26a. 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				

26b. Were records obtained to verify vaccination history? *(<5 years of age with Hib/unknown serotype, 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)* _____

26c. 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

27. What was the serogroup?
1☐A 3☐C 5☐W135 9☐Unknown
2☐B 4☐Y 6☐Not groupable 8☐Other *(specify)* _____

28. Is patient currently attending college? (15 – 24 years only)
1☐Yes 2☐No 9☐Unknown

29. Did patient receive meningococcal vaccine? 1☐Yes 2☐No 9☐Unknown

If YES, please complete the following information:

DOSE	DATE GIVEN (Mo. Day Year)	VACCINE NAME	MANUFACTURER	LOT NUMBER
1				
2				
3				

STREPTOCOCCUS PNEUMONIAE

30. Did patient receive pneumococcal vaccine?
1☐Yes 2☐No 9☐Unknown

If YES, please note which pneumococcal vaccine was received: *(Check all that apply)*
1☐ Prevnar®, 7-valent Pneumococcal Conjugate Vaccine (PCV7)
1☐ Prevnar-13®, 13-valent Pneumococcal Conjugate Vaccine (PCV13)
1☐ Pneumovax®, 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)
1☐ Vaccine type not specified

If between ≥3 months and <18 years of age and an isolate is available for serotyping, please complete the Invasive Pneumococcal Disease in Children expanded form.

GROUP A STREPTOCOCCUS *(#31–33 refer to the 7 days prior to first positive culture)*

31. Did the patient have surgery or any skin incision? 1☐Yes 2☐No 9☐Unknown

If YES, date of surgery or skin incision: Mo. Day Year

32. Did the patient deliver a baby (vaginal or C-section)?
1☐Yes 2☐No 9☐Unknown

If YES, date of delivery: Mo. Day Year

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

34. COMMENTS: _____

– SURVEILLANCE OFFICE USE ONLY –

35. Was case first identified through audit?
1☐Yes 2☐No 9☐Unknown

36. CRF Status:
1☐ Complete
2☐ Incomplete
3☐ Edited & Correct
4☐ Chart unavailable after 3 requests

37. Does this case have recurrent disease with the same pathogen?
1☐Yes 2☐No 9☐Unknown

If YES, previous (1st) state I.D.:

38. Date reported to EIP site: Mo. Day Year

39. Initials of S.O.:

Submitted By: _____ Phone No. : ( )_____ Date:____/____/____

Physician's Name: _____ Phone No. : ( )_____