

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



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

- SHADED AREAS FOR OFFICE USE ONLY -

1. STATE (Residence of Patient) <input type="text"/>	2. COUNTY (Residence of Patient) <input type="text"/>	3. STATE I.D.: <input type="text"/>	4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: <input type="text"/>	4b. HOSPITAL I.D. WHERE PATIENT TREATED: <input type="text"/>	
5. WAS PATIENT HOSPITALIZED? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If YES, date of admission: Mo. Day Year <input type="text"/> Date of discharge: Mo. Day Year <input type="text"/>			6. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		
7a. Where was the patient a resident at time of initial culture? 1 <input type="checkbox"/> Private residence 4 <input type="checkbox"/> Homeless 7 <input type="checkbox"/> Non-medical ward 2 <input type="checkbox"/> Long term care facility 5 <input type="checkbox"/> Incarcerated 8 <input type="checkbox"/> Other (specify) _____ 3 <input type="checkbox"/> Long term acute care facility 6 <input type="checkbox"/> College dormitory 9 <input type="checkbox"/> Unknown			7b. If resident of a facility, what was the name of the facility? <input type="text"/>	8a. Was patient transferred from another hospital? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	
9. DATE OF BIRTH: Mo. Day Year <input type="text"/>		10a. AGE: <input type="text"/>	11. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	12a. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown	
10b. Is age in day/month/year? 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.		12b. RACE (Check all that apply) 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Black 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Unknown			
13a. WEIGHT: _____ lbs _____ oz OR _____ kg OR <input type="checkbox"/> Unknown	14. TYPE OF INSURANCE (Check all that apply) 1 <input type="checkbox"/> Private 1 <input type="checkbox"/> Military 1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Medicare 1 <input type="checkbox"/> Indian Health Service (IHS) 1 <input type="checkbox"/> Uninsured 1 <input type="checkbox"/> Medicaid/state assistance program 1 <input type="checkbox"/> Incarcerated 1 <input type="checkbox"/> Unknown				
13b. HEIGHT: _____ ft _____ in OR _____ cm OR <input type="checkbox"/> Unknown	15. OUTCOME 1 <input type="checkbox"/> Survived 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown				
13c. BMI: _____ OR <input type="checkbox"/> Unknown	16. If patient died, was the culture obtained on autopsy? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				
17a. At time of first positive culture, patient was: 1 <input type="checkbox"/> Pregnant 3 <input type="checkbox"/> Neither 2 <input type="checkbox"/> Postpartum 9 <input type="checkbox"/> Unknown	17b. If pregnant or postpartum, what was the outcome of fetus: 1 <input type="checkbox"/> Survived, no apparent illness 4 <input type="checkbox"/> Abortion/stillbirth 9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Survived, clinical infection 5 <input type="checkbox"/> Induced abortion 3 <input type="checkbox"/> Live birth/neonatal death 6 <input type="checkbox"/> 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: <input type="text"/> (wks) Birth weight: <input type="text"/> (gms)		
19. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply) 1 <input type="checkbox"/> Bacteremia without focus 1 <input type="checkbox"/> Peritonitis 1 <input type="checkbox"/> Endometritis 1 <input type="checkbox"/> Meningitis 1 <input type="checkbox"/> Pericarditis 1 <input type="checkbox"/> STSS 1 <input type="checkbox"/> Otitis media 1 <input type="checkbox"/> Septic abortion 1 <input type="checkbox"/> Necrotizing fasciitis 1 <input type="checkbox"/> Pneumonia 1 <input type="checkbox"/> Chorioamnionitis 1 <input type="checkbox"/> Puerperal sepsis 1 <input type="checkbox"/> Cellulitis 1 <input type="checkbox"/> Septic arthritis 1 <input type="checkbox"/> Septic shock 1 <input type="checkbox"/> Epiglottitis 1 <input type="checkbox"/> Osteomyelitis 1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Hemolytic uremic syndrome (HUS) 1 <input type="checkbox"/> Empyema 1 <input type="checkbox"/> Abscess (not skin) 1 <input type="checkbox"/> Endocarditis 1 <input type="checkbox"/> Unknown			20a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: 1 <input type="checkbox"/> Neisseria meningitidis 4 <input type="checkbox"/> Listeria monocytogenes 2 <input type="checkbox"/> Haemophilus influenzae 5 <input type="checkbox"/> Group A Streptococcus 3 <input type="checkbox"/> Group B Streptococcus 6 <input type="checkbox"/> Streptococcus pneumoniae		
21. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Muscle/Fascia/Tendon 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Joint 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> Other normally sterile site (specify) _____			22. DATE FIRST POSITIVE CULTURE COLLECTED: (Date Specimen Collected) Mo. Day Year <input type="text"/>		23. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 1 <input type="checkbox"/> Placenta 1 <input type="checkbox"/> Middle ear 1 <input type="checkbox"/> Amniotic fluid 1 <input type="checkbox"/> Sinus 1 <input type="checkbox"/> Wound

Public reporting burden of this collection of information is estimated to average 20 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-XXXX). Do not send the completed form to this address.

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

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

**- 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			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"/>			

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			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"/>			

**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:

32. Did the patient deliver a baby (vaginal or C-section)?

1  Yes 2  No 9  Unknown

If YES, date of delivery:

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:

39. Initials of S.O.:

\_\_\_\_\_

Submitted By: \_\_\_\_\_ Phone No. : ( \_\_\_\_\_ ) \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Physician's Name: \_\_\_\_\_ Phone No. : ( \_\_\_\_\_ ) \_\_\_\_\_