

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

2013 ACTIVE BACTERIAL CORE
SURVEILLANCE (ABCs) CASE REPORT
A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK



OMB No. 0920-0978

- SHADED AREAS FOR OFFICE USE ONLY -

1. STATE: (Residence of Patient)
2. STATE I.D.:
3. DATE FIRST POSITIVE CULTURE COLLECTED (Date Specimen Collected)
4. Date reported to EIP site:
5. CRF Status:
6. COUNTY: (Residence of Patient)
7a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED:
7b. HOSPITAL I.D. WHERE PATIENT TREATED:
8. DATE OF BRTH:
9a. AGE:
9b. Is age in day/mo/yr?
10. SEX:
11a. ETHNIC ORIGIN:
11b. RACE: (Check all that apply)
12a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:
12b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: (specify)
13. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)
14. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)
INFLUENZA 15. Did this patient have a positive flu test 10 days prior to or following any ABCs positive culture?
16. WAS PATIENT HOSPITALIZED? If YES, date of admission: Date of discharge:
17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?
18a. Where was the patient a resident at time of initial culture?
18b. If resident of a facility, what was the name of the facility?
19a. Was patient transferred from another hospital?
19b. If YES, hospital I.D.:
20a. WEIGHT:
20b. HEIGHT:
20c. BMI:
21. TYPE OF INSURANCE: (Check all that apply)
22. OUTCOME:
23. If patient died, was the culture obtained on autopsy?
24a. At time of first positive culture, patient was:
24b. If pregnant or postpartum, what was the outcome of fetus:
25. If patient <1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only.
26. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply)

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

- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISM -

HAEMOPHILUS INFLUENZAE 28a. 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

28b. 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"/>			

28c. 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) _____

NEISSERIA MENINGITIDIS 29. What was the serogroup? 1 A 2 B 3 C 4 Y 5 W135 6 Not groupable 7 Unknown 8 Other (specify) _____

30. Is patient currently attending college? (15 - 24 years only) 1 Yes 2 No 9 Unknown

31. 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 32. 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 (#33-35 refer to the 14 days prior to first positive culture)

33. 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

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

If YES, date of delivery: Mo. Day Year

35. Did patient have:

1 Varicella 1 Surgical wound (post operative)
1 Penetrating trauma 1 Burns
1 Blunt trauma

If YES to any of the above, record the number of days prior to the first positive culture (if > 1, use the most recent skin injury)

1 0-7 days 2 8-14 days

36. COMMENTS: _____

- SURVEILLANCE OFFICE USE ONLY -

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

38. Does this case have recurrent disease with the same pathogen? 1 Yes 2 No 9 Unknown
If YES, previous (1st) state I.D.:

39. Initials of S.O.: _____

Submitted By: _____ Phone No.: () _____ Date: ____/____/____
Physician's Name: _____ Phone No.: () _____