

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

2014 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"/> Complement Deficiency	1 <input type="checkbox"/> IVDU, Current	1 <input type="checkbox"/> Plegias/Paralysis
1 <input type="checkbox"/> Alcohol Abuse, Current	1 <input type="checkbox"/> CSF Leak	1 <input type="checkbox"/> IVDU, Past	1 <input type="checkbox"/> Premature Birth (specify gestational age at birth) <input type="text"/> <input type="text"/> (wks)
1 <input type="checkbox"/> Alcohol Abuse, Past	1 <input type="checkbox"/> Current Smoker	1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> Seizure/Seizure Disorder
1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Deaf/Profound Hearing Loss	1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Sickle Cell Anemia
1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> Multiple Sclerosis	1 <input type="checkbox"/> Solid Organ Malignancy
1 <input type="checkbox"/> Bone Marrow Transplant (BMT)	1 <input type="checkbox"/> Diabetes Mellitus	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Solid Organ Transplant
1 <input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Neuromuscular Disorder	1 <input type="checkbox"/> Splenectomy/Asplenia
1 <input type="checkbox"/> Chronic Kidney Disease	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Systemic Lupus Erythematosus (SLE)
1 <input type="checkbox"/> Current Chronic Dialysis	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> Parkinson's Disease	1 <input type="checkbox"/> Other prior illness (specify) _____
1 <input type="checkbox"/> Chronic Skin Breakdown	1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma	1 <input type="checkbox"/> Other Drug Use, Current	_____
1 <input type="checkbox"/> Cirrhosis/Liver Failure	1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Other Drug Use, Past	_____
1 <input type="checkbox"/> Cochlear Implant	1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)	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 3  C 5  W135 9  Unknown  
2  B 4  Y 6  Not groupable 8  Other \_\_\_\_\_

**30. Is patient currently attending college?** 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<sup>®</sup> 7-valent Pneumococcal Conjugate Vaccine (PCV7)

1  Prevnar-13<sup>®</sup> 13-valent Pneumococcal Conjugate Vaccine (PCV13)

1  Pneumovax<sup>®</sup> 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  Blunt trauma 1  Burns

**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. : ( ) \_\_\_\_\_