

NEONATAL INFECTION EXPANDED TRACKING FORM

Infant's Name: _____ (Last, First, M.I.) Infant's Chart No.: _____
 Mother's Name: _____ (Last, First, M.I.) Mother's Chart No.: _____
 Mother's Date of Birth: ___/___/___ Culture date: _____ Hospital Name: _____
month day year (4 digits)

-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: ___/___/___ <small>month day year (4 digits)</small> Time of birth: _____ <input type="checkbox"/> Unknown (1) <small>(times in military format)</small>	2. Did this birth occur outside of the hospital? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES , 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)	
3a. Gestational age of infant at birth in completed weeks: ___ (do not round up)	3b. Date of maternal last menstrual period (LMP): ___/___/___ <small>month day year (4 digits)</small> <input type="checkbox"/> Unknown (1)	4. Birth weight: ___ lbs ___ oz OR _____ grams
5. Date & time of newborn discharge from hospital of birth: ___/___/___ ___:___ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>		
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? (<i>for GBS cases only</i>): <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) IF YES , date & time of readmission: ___/___/___ ___:___ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>		
8. Was the infant admitted to a different hospital from home? (<i>for GBS cases only</i>): <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) IF YES , hospital ID: _____ AND date & time of admission: ___/___/___ ___:___ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>		
9a. Were any ICD-9 codes reported in the discharge diagnosis of the infant's chart? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)		
9b. IF YES , Were any of the following ICD-9 codes reported in the discharge diagnosis of the chart? (<i>Check all that apply</i>) <input type="checkbox"/> 041.02: Streptococcus group b (1) <input type="checkbox"/> 038.0: Streptococcus septicemia (1) <input type="checkbox"/> 041.0: Streptococcus, unspecified (1) <input type="checkbox"/> 320.2: Streptococcal meningitis (1)		
9c. Were any ICD-10 codes reported in the discharge diagnosis of the infant's chart? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)		
9d. IF YES , were any of the following ICD-10 codes reported in the discharge diagnosis of the chart? (<i>Check all that apply</i>) <input type="checkbox"/> A40.1: Sepsis due to streptococcus, group B (1) <input type="checkbox"/> B36.1: Sepsis of newborn to other unspecified streptococci (1) <input type="checkbox"/> A40.9: Streptococcus sepsis, unspecified (1) <input type="checkbox"/> B95.1: Streptococcus, group b as the cause of disease classified elsewhere (1) <input type="checkbox"/> B36: Bacterial sepsis of newborn (1) <input type="checkbox"/> B95.5: Unspecified streptococcus as the cause of disease classified elsewhere (1) <input type="checkbox"/> B36.0: Sepsis of newborn due to streptococcus, group B (1) <input type="checkbox"/> G00.2: Streptococcal meningitis (1)		
10. Did the baby receive breast milk from the mother? (<i>for late-onset GBS cases only</i>): <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES , did the baby receive breast milk before onset of GBS <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 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(0920-0978). **Do not send the completed form to this address.**

Maternal Information

11. Maternal admission date & time: <u> </u> / <u> </u> / <u> </u> <u> </u> : <u> </u> : <u> </u> <div style="margin-left: 100px; margin-top: -10px;"><small>month day year (4 digits) time</small></div>	<input type="checkbox"/> Unknown (1)
12. Maternal age at delivery (years): <u> </u> <u> </u> 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) IF YES, was a previous maternal history of anaphylaxis noted? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	
15. Date & time of membrane rupture: <u> </u> / <u> </u> / <u> </u> <u> </u> : <u> </u> : <u> </u> <div style="margin-left: 100px; margin-top: -10px;"><small>month day year (4 digits) time</small></div>	<input type="checkbox"/> Unknown (1)
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)	
18. Type of rupture: <input type="checkbox"/> Spontaneous (1) <input type="checkbox"/> Artificial (2)	
19. Type of delivery: <i>(Check all that apply)</i> <input type="checkbox"/> Vaginal (1) <input type="checkbox"/> Vaginal after previous C-section (1) <input type="checkbox"/> Primary C-section (1) <input type="checkbox"/> Repeat C-section (1) <input type="checkbox"/> Forceps (1) <input type="checkbox"/> Vacuum (1) <input type="checkbox"/> Unknown (1) If delivery was by C-section: Did labor begin before C-section? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) Did membrane rupture happen before C-section? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)	
20. Intrapartum fever (T ≥ 100.4 F or 38.0 C): <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES, 1st recorded T ≥ 100.4 F or 38.0 C at: <u> </u> / <u> </u> / <u> </u> <u> </u> : <u> </u> : <u> </u> <input type="checkbox"/> Unknown (1) <div style="margin-left: 100px; margin-top: -10px;"><small>month day year (4 digits) time</small></div>	
21. Were antibiotics given to the mother intrapartum? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES, answer a-b and Questions 22-23	
a) Date & time antibiotics 1 st administered: (before delivery) <u> </u> / <u> </u> / <u> </u> <u> </u> : <u> </u> : <u> </u> <input type="checkbox"/> Unknown (9) <div style="margin-left: 100px; margin-top: -10px;"><small>month day year (4 digits) time</small></div>	
b) Antibiotic 1: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: <u> </u> / <u> </u> / <u> </u> Stop date (if applicable): <u> </u> / <u> </u> / <u> </u>	
Antibiotic 2: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: <u> </u> / <u> </u> / <u> </u> Stop date (if applicable): <u> </u> / <u> </u> / <u> </u>	
Antibiotic 3: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: <u> </u> / <u> </u> / <u> </u> Stop date (if applicable): <u> </u> / <u> </u> / <u> </u>	
Antibiotic 4: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: <u> </u> / <u> </u> / <u> </u> Stop date (if applicable): <u> </u> / <u> </u> / <u> </u>	
Antibiotic 5: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: <u> </u> / <u> </u> / <u> </u> Stop date (if applicable): <u> </u> / <u> </u> / <u> </u>	
Antibiotic 6: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: <u> </u> / <u> </u> / <u> </u> Stop date (if applicable): <u> </u> / <u> </u> / <u> </u>	

22. Interval between receipt of 1st antibiotic and delivery: _____ (hours) _____ (minutes) _____ (days)*
 *Day variable should only be completed if the number of hours >24

23. What was the reason for administration of intrapartum antibiotics? (Check all that apply)

<input type="checkbox"/> GBS prophylaxis (1)	<input type="checkbox"/> Prolonged latency (1)	<input type="checkbox"/> Mitral valve prolapse prophylaxis (1)
<input type="checkbox"/> Suspected amnionitis/ chorioamnionitis (1)	<input type="checkbox"/> C-section prophylaxis (1)	<input type="checkbox"/> Other (1)
		<input type="checkbox"/> Unknown (1)

24. Did mother have chorioamnionitis or suspected chorioamnionitis? Yes (1) No (0)

*****Questions 25–33 should only be completed for early- and late-onset GBS cases*****

25. Did mother receive prenatal care? Yes (1) No (0) Unknown (9)

26. Please record the following: the total number of prenatal visits AND the first and last visit dates to the prenatal as recorded in the labor and delivery chart
 No. of visits: ____ First visit: ____/____/____ Last visit: ____/____/____ Unknown (1)
month day year (4 digits) month day year (4 digits)

27. Estimated gestational age (EGA) at last documented prenatal visit: ____ . ____ (weeks)

28. GBS bacteriuria during this pregnancy? Yes (1) No (0) Unknown (9)
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)

29. Previous infant with invasive GBS disease? Yes (1) No (0) Unknown (9)

30. Previous pregnancy with GBS colonization? Yes (1) No (0) Unknown (9)

31a. 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>Test Result</u> (Do not include urine here!)
1. ____/____/____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9)
2. ____/____/____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9)

31b. 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)

32a. 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>Test Result</u> (Do not include urine here!)
____/____/____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9)

32b. 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)

33. Were GBS test results available to care givers at the time of delivery? Yes (1) No (0) Unknown (9)

34. COMMENTS: _____

35. Neonatal Infection Expanded Form Tracking Status:

Complete (1) Partial (2) Chart unavailable (3) Edited & corrected (4)