Patient's Name <u>:</u>		CIERIAE CORE SORVEIL	LANCE CASE REPORT -	Phone No ·( )			
Address	(Last, First, MI.)		Patient				
Address:							
(City, State)		(Zip Code)	Hospita	al <u>:</u>			
Patient identifier information is not transmitted DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION ATLANTA, GA 30333 A CORI	2015 AC SURVEILLAN e component of th	CE (ABCs)			OMB No. 0920-0978		
1. STATE: (Residence of Patient)     2. STATE I.D.:	3. DATE FIRST POSITI (Date Spec Mo. Day	VE CULTURE COLLE imen Collected) Year	CTED 4. Date reported to E	Year 1 Comple	is: tee 3 Edited & Correct lete 4 Chart unavailable after 3 requests		
6. COUNTY: (Residence of Patient)		7a. HOSPITAL/LAB CULTURE IDE		7b. HOSPITAL I.D. W PATIENT TREATI			
Mo. Day Year	a. AGE:	<b>10. SEX:</b> 1	11a. ETHNIC ORIGIN: 1 Hispanic or Latino 2 Not Hispanic or Latin 9 Unknown	11b. RACE: (Check all that a 1 White 1 Black 1 American Indian or Alaska Native	1 Asian 1 Native Hawaiian or Other Pacific Islander		
12a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:       1 <t< td=""></t<>							
13. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)         1       Blood       1       Peritoneal fluid       1       Bone       1       Joint         1       CSF       1       Pericardial fluid       1       Muscle/Fascia/Tendon       1       Pleural fluid         1       Other normally sterile site (specify)       1       Internal body site (specify)				14. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)         1       Placenta       1       Wound       1       Sinus         1       Amniotic fluid       1       Middle ear			
INFLUENZA 15. Did this patient have a positive flu test 10 days prior to or following any ABCs positive culture? 1 Yes 2 No 9 Unknown							
16. WAS PATIENT HOSPI TALIZED?     If YES, date of admission: Mo.     Date of discharge: Mo.     17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?       1     Yos     2     No     9     Unknown							
1 Yes 2 No				No 9 Unknown			
1       Yes       2       No       Image: Constraint of the patient of the	of initial culture? ess 7 Non-medical wa rated 8 Other(specify)_	18b			19b. If YES, hospital I.D.:		
18a. Where was the patient a resident at time of         1       Private residence       4         2       Long term care facility       5	of initial culture? ess 7 Non-medical wa rated 8 Other( <i>specify</i> )_ e dormitory 9 Unknown	18b	I Yes 2	19a.Was patient transferred from another hospital? 1 Yes 2 No	19b. If YES, hospital I.D.:		
18a. Where was the patient a resident at time of         1       Private residence       4         2       Long term care facility       5         3       Long term acute care facility 6       College         20a. WEIGHT:	of initial culture?         ess       7         Non-medical wa         rated       8         Other(specify)         edormitory       9         Unknown       1         known       1         Medic         1       Medic	Ird 18b	1       Yes       2         .If resident of a facility, what was the name of the facility?         all that apply)         1       Military         1       Indian Health	19a. Was patient transferred from another hospital? 1 Yes 2 No 9 Unknown 1 Other(spe Service (IHS) 1 Uninsured 1 Unknown	cify)		
18a. Where was the patient a resident at time of 1         1 Private residence       4         2 Long term care facility       5         3 Long term acute care facility 6       College         20a. WEIGHT:	of initial culture?         ess       7         Non-medical wa         rated       8         Other(specify)         edormitory       9         Unknown       1         known       1         Medic         1       Medic	Ind 18b	1       Yes       2         .If resident of a facility, what was the name of the facility?         all that apply)         1       Military         1       Indian Health	19a. Was patient transferred from another hospital?         1       Yes       2       No         9       Unknown         1       Other(spe         Service (IHS)       1       Unknown	cify)		
18a. Where was the patient a resident at time of         1       Private residence       4         2       Long term care facility       5         3       Long term acute care facility 6       College         20a. WEIGHT:	of initial culture?         of initial culture?         ess       7         Non-medical wa         rated       8         Other (specify)         e dormitory       9         Unknown       21. TYPE OF IN         known       1         Wedic         Unknown       23. If part         24b. If pregnant or postpart	Ind Ind Ind Ind Ind Ind Ind Ind	1       Yes       2         .If resident of a facility, what was the name of the facility?         all that apply)       1       Military         1       Indian Health       1         program       1       Incarcerated         culture obtained on autopsy?       1       Incarcerated         sutcome of fetus:       1       Unknown         tion/stillbirth       9       Unknown	19a. Was patient transferred from another hospital?         1 Yes       No         9 Unknown         1 Other(spe         5ervice (IHS)       1 Uninsured         1 Yes       2 No         1 Other(spe         5ervice (IHS)       1 Uninsured         1 Yes       2 No         2       1 Other(spe         1       1 No         1       1 No         1       1 No         1       2 No         1       1 Service (IHS)         1       1 No         1       1 No	cify)		
18a. Where was the patient a resident at time of 1         1       Private residence       4         1       Private residence       4         2       Long term care facility       5         3       Long term acute care facility       6         20a. WEIGHT:	of initial culture?         ess       7         nated       8         of initial culture?         ess       7         Non-medical warred         rated       8         Other(specify)         e dormitory       9         Unknown       21. TYPE OF IN         1       Private         1       Medic         1       Medic         Unknown       23. If path         24b. If pregnant or postparter       1         1       Survived, no apparer         2       Survived, clinical infe         3       Live birth/neonatal c         ISM: (Check all that apply)       Hemolytic uremic         Hemolytic uremic       1         Abscess (not skin)       1	Ird       18b         Ird       18b         Ird          NSURANCE: (Check          e:          tient died, was the cont illness       4 Abor         ection       5 Induce         death       6 Still p         rditis       1 Se	1       Yes       2         If resident of a facility, what was the name of the facility?         all that apply)       1       Military         1       Indian Health       1         program       1       Incarcerated         culture obtained on autopsy?       1       Incarcerated         culture obtained on autopsy?       1       Unknown         teon/stillbirth       9       Unknown         ted abortion       1       Endocarditi         ptic arthritis       1       Endocarditi	19a. Was patient transferred from another hospital?         1 Yes 2 No         9 Unknown         1 Other(spe         5ervice (IHS)         1 Uninsured         1 Yes 2 No         2 Duknown         2 Duknown         1 Uninsured         1 Yes 2 No         2 Duknown         2 Duknown         2 Duknown         1 Yes 2 No         2 Duknown         2 Duknown         1 Yes 2 No         2 Duknown         2 Duknown         1 Yes 2 No         2 Duknown         1 Gestational age:         (wks)         s       1 Necrotizing fasciitis         is       1 Puerperal sepsis	cify) 9 Unknown age, indicate gestational age gnant, indicate gestational Birth weight: (gms)		

27. UNDERYING 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	count <200 1 Complement Deficiency 1 IVDU, Current		rrent	1 Plegias/Paralysis			
1 🗌 Alcohol Abuse, Current	1 🗌 CSF Leak	1 🗌 IVDU, Pas	st	1 Premature Birth (specify gestational			
1 🔄 Alcohol Abuse, Past	1 🗌 Current Smoker	1 🗌 Leukemia	a	age at birth) (wks)			
1 🔄 Asthma	1 🗌 Deaf/Profound Hearing			1 Seizure/Seizure Disorder			
1 Atherosclerotic Cardiovascular Disease	1 🗌 Dementia	1 Multiple S		1 🔄 Sickle Cell Anemia 1 🦳 Solid Organ Malignancy			
(ASCVD)/CAD	1 🗌 Diabetes Mellitus	= '	c Syndrome	1 Solid Organ Transplant			
1 Bone Marrow Transplant (BMT)	1 🗌 Emphysema/COPD	1 🔛 Neuromu 1 🗌 Obesity	ıscular Disorder	1 Splenectomy/Asplenia			
1 Cerebral Vascular Accident (CVA)/Stroke				1 Systemic Lupus Erythematosus (SLE)			
1 Current Chronic Dialysis	1 HIV Infection	1 Parkinsor		1 Other prior illness (specify)			
1 Chronic Skin Breakdown	1 Hodgkin's Disease/Lymp		ug Use, Current ug Use, Past				
1 Cirrhosis/Liver Failure	1 🗌 Immunoglobulin Deficie 1 🔲 Immunosuppressive The		al Neuropathy				
1 🗌 Cochlear Implant	Chemotherapy, Radiatic		anneuropathy				
		SE COMPLETE FOR THE RI		5M			
HAEMOPHILUS INFLUENZAE		SE COMPLETE FOR THE RI	LLE VANT ORGANI.	- 1910			
28a. What was the serotype? 1 b 2	lot 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 'un	known' did 1 Yes 2	No 9 Unknown		28c.Were records obtained to verify			
patient receive Haemophilus influenzae	b vaccine? If YES, please c	complete the list below.		<b>vaccination history?</b> (<5 years of age with Hib/unknown serotype, only)			
DOSE DATE GIVEN	VACCINE NAME	MANUFACTURER	LOT NUMBER	with Hib/unknown serotype, only)			
Mo. Day Year -				1 Yes 2 No			
				If YES, what was the source of the			
2				information? (Check all that apply)			
				1 🗌 Vaccine Registry			
3							
				1 Healthcare Provider			
		·		1 Other( <i>specify</i> )			
NEISSERIA MENINGITIDIS			STREPTOCOCCUS PN	ELIMONIAE			
	_			e pneumococcal vaccine?			
<b>29.</b> What was the 1 A 3 C 5 W serogroup?			_ · _	9 Unknown			
	ot groupable 8 Other		1 Yes 2 No	9 🛄 Unknown			
30. Is patient currently attending college?	1 Yes 2 No 9 Un	hknown	If YES, please note wi	hich pneumococcal vaccine was received:			
31. Did patient receive meningococcal vaccine			(Check all that apply)				
51. Did patient receive meningococcal vaccine							
	If YES, please complete the	1 Prevnar <sup>®</sup> ,7-valent Pneumococcal Conjugate Vaccine (PCV7)					
DOSE DATE GIVEN	VACCINE NAME MANUFACT	1 Prevnar-13 <sup>®</sup> , 13-valent Pneumococcal Conjugate Vaccine (PCV13)					
Mo. Day Year —		1 Pneumovax <sup>®</sup> , 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)					
1				·			
			1 🗌 Vaccine type not	specified			
2			If between ≥2 months	s and<5 years of age and an isolate is available for			
	serotyping, please complete the Invasive Pneumococcal Disease in						
3			Children expanded fo	orm.			
	r to the 14 days	4. Did the patient deliver a baby	(vaginal or C-section)?	35. Did patient have:			
prior to first j		1 Varicella 1 Surgical wound					
	2 No 9 Unknown	1 Yes 2 No 9 Unknow	wn	(post operative)			
or any skin incision?				1 Penetrating trauma			
Mo.	Day Year	Mo. Day	Year	1 🗌 Blunt trauma			
		f YES,		If YES to any of the above, record the number of			
If YES, date of surgery or skin incision:				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 ON LY -							
37.Was case first 1 Yes 2 No	38. Does this case have	1 Yes 2 No If YES, pre		39. Initials of			
identified through audit? 9 Unknown	recurrent disease with the same pathogen?		I.D.:	S.O.:			
	the same participant						
Submitted By:		Phone No. :	( )	Date: / /			
Physician's Name:		Phone No. :	( )				