

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

2015 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?
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[®] 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 ≥2 months and <5 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. : () _____