– ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT –

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

2016 SURVEILLANCE FOR NON-INVASIVE PNEUMOCOCCAL PNEUMONIA (SNiPP)

CASE REPORT FORM

– SHADED AREAS FOR OFFICE USE ONLY –

Expiration Date: 02/28/2019

OMB No. 0920-0978

1. STATE: *(Residence of Patient)* ☐☐

2. STATE I.D.: ☐☐☐☐☐☐☐

3a. DATE FIRST POSITIVE URINE ANTIGEN TEST COLLECTED *(Date Specimen Collected)* Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

3b. TYPE OF TEST
1 ☐ Binax Now
2 ☐ BD Directigen
3 ☐ Other *(specify)* _____
9 ☐ Unknown

4. CRF Status:
1 ☐ Complete 3 ☐ Edited & Correct
2 ☐ Incomplete 4 ☐ Chart unavailable after 3 requests

5. COUNTY: *(Residence of Patient)* _____

6a. HOSPITAL/LAB I.D. WHERE UAT IDENTIFIED: ☐☐☐☐☐

6b. HOSPITAL I.D. WHERE PATIENT TREATED: ☐☐☐☐☐

7. DATE OF BIRTH: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

8a. AGE: ☐☐☐

9. SEX:
1 ☐ Male
2 ☐ Female

10a. ETHNIC ORIGIN:
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

10b. RACE: *(Check all that apply)*
1 ☐ White
1 ☐ Black
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ Unknown

11a. WHERE WAS THEPATIENT A RESIDENT AT THE TIME OF POSITIVE UAT?:
1 ☐ Private residence
2 ☐ Long term care facility
3 ☐ Long term acute care facility
4 ☐ Homeless
5 ☐ Incarcerated
6 ☐ College dormitory
7 ☐ Non-medical ward
8 ☐ Other *(specify)* _____
9 ☐ Unknown

11b. If resident of a facility, what was the name of the facility? _____

12a. HOSPITAL ADMISSION DATE Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

12b. HOSPITAL DISCHARGE DATE (From second hospital, if transferred) Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

12c. Was this patient admitted to the ICU during hospitalization?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

13a. WEIGHT: _____lbs_____ oz OR _____ kg OR ☐ Unknown

13b. HEIGHT: _____ft _____ in OR _____ cm OR ☐ Unknown

13c. BMI: ___ ___ . ___ OR ☐ Unknown

14. OUTCOME: 1 ☐ Survived 2 ☐ Died 9 ☐ Unknown

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

16. DID THE PATIENT HAVE A CHEST CT OR CHEST X-RAY WITHIN 72 HOURS OF THEIR POSITIVE UAT?:
1 ☐ CT 2 ☐ X-ray 3 ☐ Both 4 ☐ Neither 9 ☐ Unknown

If yes, check all that apply from the radiology report:
1 ☐ Pneumonia/bronchopneumonia
1 ☐ Consolidation
1 ☐ Lobar (NOT interstitial) infiltrate
1 ☐ Report not available
1 ☐ Air space/alveolar density/opacity/disease
1 ☐ Empyema
1 ☐ None of the above diagnoses were listed

17a. Did patient receive pneumococcal vaccine during this hospitalization?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, please note which pneumococcal vaccine was received:
1 ☐ Prevnar-13®, 13-valent Pneumococcal Conjugate Vaccine (PCV13)
1 ☐ Pneumovax®, 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)
1 ☐ Vaccine type not specified

17b. If YES, please add date of vaccination: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐
☐ Unknown

18. WAS THE PATIENT DIAGNOSED WITH PNEUMONIA WITHIN 72 HOURS OF THE POSITIVE UAT?: 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

19. COMMENTS _____

20. INITIALS OF S.O. _____