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: __ __/__ __/__ __ __ __ (month day year (4 digits))
Culture date: ____________ ☐ Infant ☐ Mother
Mother's Prenatal Care Provider: ______________________
Clinic Name: ______________________
Hospital Name: ______________________
Estimated Due Date: : __ __/__ __/__ __ __ __
Clinic Phone Number: ______________________

- Patient identifier information is NOT transmitted to CDC -

2015 ABCs *H. Influenzae* Neonatal Sepsis Expanded Surveillance Form

Indicate type of HiNSES case:

☐ Neonatal (infant) - complete Q1-9b, then skip to maternal section (Q12-31)

☐ Pregnant or post-partum (if pregnant or post-partum, specify outcome of pregnancy):

- ☐ Live Birth - complete Q1-11, then skip to maternal section (Q12-30)
- ☐ Spontaneous Abortion- complete Q1-2b, then skip to maternal section (Q12-30)
- ☐ Stillbirth - complete Q1-3, then skip to maternal section (Q12-30)
- ☐ Induced Abortion (end form)

Infant Information **Were labor & delivery records available?** ☐ **Yes (1)** ☐ **No (0)**

1. Date of live birth/stillbirth/spontaneous abortion: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) Time: ___ ___ ___ ___ (times in military format) ☐ Unknown (1)

2. Gestational age of infant live birth/stillbirth/spontaneous abortion in completed weeks: __ __ (do not round up)

2a. Determined by: ☐ Dates ☐ Physical Exam ☐ Ultrasound ☐ Unknown

2b. Date of maternal last menstrual period (LMP): __ __ /__ __ /__ __ __ __ (month day year (4 digits)) ☐ Unknown (1)

3. Birth weight: ___ lbs ___oz **OR** __ __ __ __ grams

4. Date & time of newborn discharge from hospital of birth: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

5. Was the infant transferred to another hospital following birth? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
   if YES, Hospital where infant was transferred __ __ __ __ __ ID
   AND date of transfer __ __ /__ __ /__ __ __ __ month / day / year (4 digits)
   AND date of discharge __ __ /__ __ /__ __ __ __ month / day / year (4 digits)

6. Was the infant discharged to home and readmitted to the birth hospital? ☐ Yes (1) ☐ No (0)
   IF YES, date & time of readmission: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (9)
   AND date of discharge __ __ /__ __ /__ __ __ __ month / day / year (4 digits)

7. Was the infant admitted to a different hospital from home? ☐ Yes (1) ☐ No (0) IF YES, hospital ID: __ __ __ __ __
   AND date & time of admission: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)
   AND date of discharge __ __ /__ __ /__ __ __ __ month / day / year (4 digits)

8. Outcome of infant : ☐ Survived (1) ☐ Died (2) ☐ Unknown (9)

8a. If survived, did the infant have the following neurologic or medical sequelae evident on discharge (check all that apply)
☐ Seizure disorder ☐ Hearing impairment ☐ Requiring oxygen ☐ None

9. Was the infant admitted to the NICU during hospitalization? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

9a. If infant was discharged home and readmitted, was infant admitted to NICU during rehospitalization?
☐ Yes (1) ☐ No (0) ☐ Unknown (9)

9b. If yes, to either 9 or 9a, total number of days in the NICU. __ __ __

*Questions 10-11: Only for live births of pregnant and post-partum HiNSES cases

10. From time of birth to date of discharge, did the infant have a temperature $\geq$100.4 F/38 C? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

10a. If yes, were any bacterial cultures performed from time of birth to date of discharge? __ Yes _No

10b. If cultures performed from time of birth to date of discharge, list the culture date(s), source(s), and result(s).

	Culture Date	Culture Source	Results
#1.	__ __ / __ __ / __ __ __ __	__ Blood __ CSF __ Other (specify)	☐ Positive (specify organism) ________ ☐ Negative ☐ Result unknown
#2.	__ __ / __ __ / __ __ __ __	__ Blood _ CSF __ Other (specify)	☐ Positive (specify organism) ________ ☐ Negative ☐ Result unknown

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 30329, ATTN: PRA(0920-0978)

10c. If any sterile site culture positive for Hi, list ABCs State ID assigned to infant case. __ __ __ __ __ __ __

*For live births of pregnant and postpartum HiNSES cases only:

11. Were ***any*** ICD-9 codes reported in the discharge diagnosis of the infant's chart?

☐ Yes (1) ☐ No (0) ☐ Unknown (9)

11a. IF YES, Were any of the following ICD-9 codes reported in the discharge diagnosis of the chart? (*Check all that apply*)

☐ 771.81: Septicemia of newborn
☐ 995.91: Sepsis
☐ 038.41 Septicemia due to H. influenzae
☐ 482.2: Pneumonia due to H. influenzae
☐ 320.0: Haemophilus meningitis
☐ 762.7: Chorioamnionitis affecting fetus or newborn
☐ 670.22 Puerperal sepsis, delivered with mention of postpartum complication

11b. Were ***any*** ICD-10 codes reported in the discharge diagnosis of the infant's chart?

☐ Yes (1) ☐ No (0) ☐ Unknown (9)

11c. IF YES, were any of the following ICD-10 codes reported in the discharge diagnosis of the chart? (*Check all that apply)*

☐ A41.3: Sepsis due to H. influenzae
☐ J14: Pneumonia due to H. influenzae
☐ G00.0: Haemophilus meningitis
☐ P36.8: Other bacterial sepsis of newborn
☐ P36.9: Bacterial sepsis of newborn, unspecified
☐ P02.7: Chorioamnionitis
☐ O85: Puerperal sepsis
☐ O75.3: Sepsis during labor

Maternal Information

12. Maternal admission date & time: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

13. Maternal age at delivery (years): __ __ years

14. Number of prior pregnancies __ __

15. Any prior history of preterm births? (< 37 weeks gestational age) ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

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

17. 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: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) Last visit: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) ☐ Unknown (1)

18. Estimated gestational age (EGA) at last documented prenatal visit: ___ ___ . ___ ___ (weeks) ☐ Unknown (1)

19. Did mother have a prior history of penicillin allergy? ☐ Yes (1) ☐ No (0)

IF YES, was a previous maternal history of anaphylaxis noted? ☐ Yes (1) ☐ No (0)

20. Date & time of membrane rupture: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

21. Was duration of membrane rupture ≥ 18 hours? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

22. If membranes ruptured at <37 weeks, did membranes rupture before onset of labor? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

23. Type of rupture: ☐ Spontaneous (1) ☐ Artificial (2) ☐ Unknown (9)

23a. If artificial rupture, reason for rupture (check all that apply)

☐ Fetal distress
☐ Suspected chorioamnionitis
☐ Preclampsia/eclampsia/hypertension
☐ Maternal bleeding
☐ Gestational diabetes
☐ Severe fetal growth restriction
☐ Post-term pregnancy
☐ Other, specify ____________________
☐ Unknown

24. Type of delivery: *(Check all that apply)*

☐ Vaginal (1) ☐ Vaginal after previous C-section (1) ☐ Primary C-section (1) ☐ Repeat C-section (1)

☐ Forceps (1) ☐ Vacuum (1) ☐ Unknown (1)

If delivery was by C-section: Did labor begin before C-section? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

Did membrane rupture happen before C-section? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

24a. If delivery by ***primary*** C-section was it scheduled or emergency? ☐ Scheduled ☐ Emergency

24b. If ***emergency primary*** C-section. What was the reason? (check all that apply)

☐ Placenta previa/abruption ☐ Cord prolapse ☐ Eclampsia//preclampsia/hypertension ☐ Unknown

☐ Uterine rupture ☐ Fetal distress ☐ Diabetes ☐ Other (specify) ______________

☐ Breech position ☐ Failure to progress ☐ Maternal infection

25. Intrapartum fever (T ≥ 100.4 F or 38.0 C): ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

IF YES, 1st recorded T ≥ 100.4 F or 38.0 C at: __ __ / __ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

25a. If intrapartum fever present, were any bacterial cultures performed during labor? __ Yes __ No

25b. If cultures performed during labor, list the culture date(s) during labor, source(s), and result(s)?

	Culture Date	Culture Source	Results
#1.	__ __ / __ __ / __ __ __ __	__ Blood __ Vaginal __ Urine __ Cervical __ Placental __ Amniotic Fluid __ Other (specify)	☐ Positive (specify organism) ______________ ☐ Negative ☐ Result unknown
#2.	__ __ / __ __ / __ __ __ __	__ Blood __ Vaginal __ Urine __ Cervical __ Placental __ Amniotic Fluid __ Other (specify)	☐ Positive (specify organism) ______________ ☐ Negative ☐ Result unknown

25c. If any sterile site cultures were positive for H. Influenzae, list ABCs State ID assigned to maternal case. __ __ __ __ __ __ __

26. Were antibiotics given to the mother intrapartum? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

IF YES, answer a-b and Questions 27-28

a) Date & time antibiotics 1st administered: (before delivery) __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (9)

b) Antibiotic 1: ____________________________ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: ______

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 2: ____________________________ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: ______

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 3: ____________________________ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: ______

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 4: ____________________________ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: ______

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 5: ____________________________ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: ______

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 6: ____________________________ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: ______

Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

27. Interval between receipt of 1st antibiotic and delivery: ___ ___ ___ (hours) ___ ___ (minutes) ___ ___ (days)*

Day variable should only be completed if the number of hours >24

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

☐ GBS prophylaxis (1)
☐ Suspected amnionitis/ chorioamnionitis (1)
☐ Prolonged latency (1)
☐ C-section prophylaxis (1)
☐ Mitral valve prolapse prophylaxis (1)
☐ Other (1)
☐ Unknown (1)

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

30. During the intrapartum period did the mother have any of the following symptoms or diagnoses? (check all that apply)

☐ Uterine tenderness
☐ Foul smelling amniotic fluid
☐ Maternal tachycardia (>100 beats/min)
☐ Fetal tachycardia (>160 beats/min)
☐ Maternal WBC >20 or 20,000
☐ Urinary tract infection

Questions 31-32d apply only to mothers of HiNSES infant cases

31. Post-partum fever (temperature ≥ 100.4 F/38 C)? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

31a. If yes, were any bacterial cultures performed post-partum? __ Yes __ No

31b. If cultures performed post-partum, list the culture date(s), source(s) and result(s).

	Culture Date	Culture Source	Results
#1.	__ __ / __ __ / __ __ __ __	__ Blood __ Vaginal __ Urine __ Cervical __ Placental __ Amniotic Fluid __ Other (specify)	☐ Positive (specify organism) ______________ ☐ Negative ☐ Result unknown
#2.	__ __ / __ __ / __ __ __ __	__ Blood __ Vaginal __ Urine __ Cervical __ Placental __ Amniotic Fluid __ Other (specify)	☐ Positive (specify organism) ______________ ☐ Negative ☐ Result unknown

31c: If any sterile site cultures were positive for H. influenzae,list ABCs State ID assigned to maternal case. __ __ __ __ __ __ __

31d: Were any of the following ICD-9 or ICD-10 codes reported in the discharge diagnoses of the mother's chart?

ICD-9

☐ 995.91: Sepsis
☐ 038.41 Septicemia due to H. influenzae
☐ 482.2: Pneumonia due to H. influenzae
☐ 320.0: Haemophilus meningitis
☐ 762.7: Chorioamnionitis affecting fetus or newborn
☐ 670.22: Puerperal sepsis, delivered, with mention of postpartum complication
☐ 670.20: Puerperal sepsis, unspecified as to episode of care or not applicable
☐ 670.24: Puerperal sepsis, postpartum condition or complication

ICD-10

☐ A41.3: Sepsis due to H. influenzae
☐ J14: Pneumonia due to H. influenzae
☐ G00.0: Haemophilus meningitis
☐ P02.7: Chorioamnionitis
☐ O85: Puerperal sepsis
☐ O75.3: Sepsis during labor

32. COMMENTS: ____

____

____

____

33. HiNSES Form Tracking Status

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