

Person Filling Out Form: _____ Culture date: ___/___/___ Infant Mother **STATE ID:** _____
(Last, First, M.I.) month / day / year (4 digits)

Infant's Name: _____ Estimated Mother's Prenatal Care Provider: _____
(Last, First, M.I.)

Infant's Chart No.: _____ Due Date: ___/___/___ Clinic Name: _____
month / day / year (4 digits)

Mother's Name: _____ Mother's Clinic Phone Number: _____
(Last, First, M.I.)

Mother's Chart No.: _____ Date of Birth: ___/___/___ Hospital Name: _____
month / day / year (4 digits)

- Patient identifier information is NOT transmitted to CDC -

2017 ABCs H. Influenzae Neonatal Sepsis Expanded Surveillance Form



Indicate type of HINSES case:

Neonatal (infant) - complete #1-9b, 12-31

Pregnant or post-partum (specify outcome of pregnancy)

- Live Birth (hospitalized) - complete #1-29
- Stillbirth (hospitalized)- complete #1-3, 12-29
- Spontaneous Abortion - complete #1-2b, 12-18, and 28-29
- Home delivery (live or still births) - end form
- Induced Abortion - end form
- Pregnancy outcome unknown - end form

Other maternal cases (specify)

- Hi from a sterile site in stillbirth - complete # 1-3, 12-31
- Fetal death associated with placenta/amniotic fluid - complete #1-3, 12-29

Form Approved 0920-0978

Infant Information

Were labor & delivery records available? Yes (1) No (0)

1. Date of live birth/stillbirth/spontaneous abortion: ___/___/___ Time: _____ Unknown (9)
month / day / year (4 digits) (times in military format)

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 (9)

3. Birth weight: ___ lbs ___ oz **OR** _____ grams

4. Date & time of newborn discharge from hospital of birth: ___/___/___ _____ Unknown (9)
month / day / year (4 digits) time

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) Unknown (9)
 AND date of discharge ___/___/___ month / day / year (4 digits) Unknown (9)

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

7. Was the infant discharge to home and readmitted to a different hospital? Yes (1) No (0) Unknown (9)
 If YES, hospital ID: _____
 AND date & time of admission: ___/___/___ _____ time Unknown (9)
month / day / year (4 digits)
 AND date of discharge ___/___/___ month / day / year (4 digits) Unknown (9)

8. Outcome of infant : Survived (1) Died (2) Unknown (9)
 If infant Died, specify Date of Death ___/___/___ month / day / year (4 digits) Unknown (9)

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

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

9a. If infant 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. _____ Unknown (9)

*** 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 100.4 F/38 C? Yes (1) No (0) Unknown (9)

10a. Were any bacterial cultures performed from time of birth to date of discharge? Yes (1) No (0)

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

*For neonates hospitalized for > 7 days, list cultures from time of birth through day 7 of life

Culture Date	Culture Source	Results
#1. ___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative <input type="checkbox"/> Result unknown
#2. ___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative <input type="checkbox"/> Result unknown

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

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)

<input type="checkbox"/> None of the codes listed were found in chart	<input type="checkbox"/> 320.0: Haemophilus meningitis
<input type="checkbox"/> 771.81: Septicemia of newborn	<input type="checkbox"/> 762.7: Chorioamnionitis affecting fetus or newborn
<input type="checkbox"/> 995.91: Sepsis	<input type="checkbox"/> 670.22 Puerperal sepsis, delivered w/ postpartum
<input type="checkbox"/> 038.41 Septicemia due to H. influenzae	<input type="checkbox"/> Other ICD-9 codes (specify) _____
<input type="checkbox"/> 482.2: Pneumonia due to H. influenzae	

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)

<input type="checkbox"/> None of the codes listed were found in the chart	<input type="checkbox"/> P36.9: Bacterial sepsis of newborn, unspecified
<input type="checkbox"/> A41.3: Sepsis due to H. influenzae	<input type="checkbox"/> P02.7: Chorioamnionitis
<input type="checkbox"/> J14: Pneumonia due to H. influenzae	<input type="checkbox"/> O85: Puerperal sepsis
<input type="checkbox"/> G00.0: Haemophilus meningitis	<input type="checkbox"/> O75.3: Sepsis during labor
<input type="checkbox"/> P36.8: Other bacterial sepsis of newborn	<input type="checkbox"/> B96.3 H. influenzae as cause of disease classd elswhr
	<input type="checkbox"/> Other ICD-10 codes (specify) _____

Maternal Information

12. Maternal admission date & time: ____ / ____ / ____ - ____ - ____ Unknown (9) Not Applicable/
month day year (4 digits) time Patient not hospitalized

13. Maternal age at delivery / spontaneous abortion (years): ____ years

14. Number of prior pregnancies ____ Unknown (9)

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 total number of prenatal visits AND the first and last visit dates to the prenatal provider as recorded in the chart
 No. of visits: ____ First visit: ____ / ____ / ____ Last visit: ____ / ____ / ____ Unknown (9)
month day year (4 digits) month day year (4 digits)

18. Estimated gestational age (EGA) at last documented prenatal visit: ____ . ____ (weeks) Unknown (9)

19. Date & time of membrane rupture: ____ / ____ / ____ - ____ - ____ Unknown (9)
month day year (4 digits) time

20. Was duration of membrane rupture ~ 18 hours? Yes (1) No (0) Unknown (9)

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

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

22a. If artificial rupture, reason for rupture (check all that apply)

<input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Fetal distress	<input type="checkbox"/> Gestational diabetes
	<input type="checkbox"/> Suspected chorioamnionitis	<input type="checkbox"/> Severe fetal growth restriction
	<input type="checkbox"/> Preclampsia/eclampsia/hypertension	<input type="checkbox"/> Post-term pregnancy
	<input type="checkbox"/> Maternal bleeding	<input type="checkbox"/> Other, specify _____

23. Type of delivery: (Check all that apply)

<input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Vaginal after previous C-section (VBAC)	<input type="checkbox"/> Primary C-section
	<input type="checkbox"/> Forceps	<input type="checkbox"/> Vacuum	<input type="checkbox"/> Repeat C-section

23a. If delivery was by C-section: Did labor begin before C-section? Yes (1) No (0) Unknown (9)

23b. If delivery was by C-section: Did membrane rupture happen before C-section? Yes (1) No (0) Unknown (9)

23c. If delivery by C-section was it scheduled or emergency? Scheduled Emergency Unknown (9)

23d. If **emergency** C-section. What was the reason? (check all that apply)

Unknown (9) Placenta previa/abruption Cord prolapse Eclampsia/preclampsia/hypertension
 Uterine rupture Fetal distress Diabetes
 Breech position Failure to progress Maternal infection
 Other(specify) _____

24. 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)

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

IF YES, answer 25. a-b and Questions 26-27

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

b)

No.	Antibiotic Name	Route of Administration			# Doses given before delivery	Start Date	Stop Date (if applicable)
		IV(1)	IM(2)	PO(3)			
1							
2							
3							
4							
5							
6							

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

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

Unknown (9) Intrapartum fever (≥ 100.4 F/38 C) Suspected amnionitis/chorioamnionitis
 Prolonged latency Mitral valve prolapse prophylaxis
 C-section prophylaxis Other (specify) _____
 GBS prophylaxis

28. Did mother have chorioamnionitis or suspected chorioamnionitis during the intrapartum period or in the week prior to spontaneous abortion? Yes (1) No (0) Unknown (9)

29. During the intrapartum period or in the week prior to spontaneous abortion did the mother have any of the following symptoms or diagnoses? (check all that apply)

Unknown (9) Uterine tenderness Maternal tachycardia (>100 beats/min)
 Foul smelling amniotic fluid Fetal tachycardia (>160 beats/min)
 Urinary tract infection Intrapartum fever (≥ 100.4 F/38 C)
 Maternal WBC >20 or 20,000

***Questions 30-31e apply only to mothers of HiNSES infant cases & cases of Hi from sterile site in stillbirth**

30. 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: ___ / ___ / ___ ___ : ___ : ___ Unknown (9)
month day year (4 digits) time

30a. Were any bacterial cultures performed **during labor**? Yes No

30b. If cultures performed **during labor**, list the culture date(s) during labor, source(s), and result(s)?

Culture Date	Culture Source	Results
#1. ___ / ___ / _____	<input type="checkbox"/> Blood <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Placental <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative <input type="checkbox"/> Result unknown
#2. ___ / ___ / _____	<input type="checkbox"/> Blood <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Placental <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative <input type="checkbox"/> Result unknown

30c. If any sterile site cultures collected **during labor** were positive for H. Influenzae, list ABCs State ID assigned to maternal case. _____

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

31a. 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. ___ / ___ / _____	<input type="checkbox"/> Blood <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Placental <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative <input type="checkbox"/> Result unknown
#2. ___ / ___ / _____	<input type="checkbox"/> Blood <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Placental <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative <input type="checkbox"/> Result unknown

31c. If any sterile site cultures collected **post-partum** were positive for ~~PEB~~ ^{PEB}, list ABCs State ID assigned to maternal case. _____

31d. Were any ICD-9 or ICD-10 codes reported in the discharge diagnoses of the mother's chart?
 Yes (1) No (0) Unknown (9)

31e. If any ICD-9 or ICD-10 codes reported in the discharge diagnoses of the mother's chart: *(Check all that apply)*

ICD-9	ICD-10
<input type="checkbox"/> None of the listed ICD-9 codes found in chart	<input type="checkbox"/> None of the listed ICD-10 codes found in chart
<input type="checkbox"/> 995.91: Sepsis	<input type="checkbox"/> A41.3: Sepsis due to H. influenzae
<input type="checkbox"/> 038.41 Septicemia due to H. influenzae	<input type="checkbox"/> J14: Pneumonia due to H. influenzae
<input type="checkbox"/> 482.2: Pneumonia due to H. influenzae	<input type="checkbox"/> G00.0: Haemophilus meningitis
<input type="checkbox"/> 320.0: Haemophilus meningitis	<input type="checkbox"/> P02.7: Chorioamnionitis
<input type="checkbox"/> 762.7: Chorioamnionitis affecting fetus or newborn	<input type="checkbox"/> O85: Puerperal sepsis
<input type="checkbox"/> 670.22: Puerperal sepsis, delivered, w/ postpartum	<input type="checkbox"/> O75.3: Sepsis during labor
<input type="checkbox"/> 670.20: Puerperal sepsis, unspecified	<input type="checkbox"/> B96.3 H. influenzae as cause of disease classd elswhr
<input type="checkbox"/> 670.24: Puerperal sepsis, postpartum	<input type="checkbox"/> Other ICD-10 codes (specify) _____
<input type="checkbox"/> Other ICD-9 codes (specify) _____	

32. COMMENTS: _____

33. HiNSES Form Tracking Status Complete (1) Partial (2) Chart unavailable (3) Edited & corrected (4)