– 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

2017 ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK

Form Approved
0920-0978

– SHADED AREAS FOR OFFICE USE ONLY –

1. STATE: *(Patient Residence)* ☐☐

2. STATE I.D.: ☐☐☐☐☐☐☐☐

3a. Was a culture performed? 1 ☐ Yes, Positive 2 ☐ Yes, Negative 3 ☐ No

3b. DATE FIRST POSITIVE CULTURE COLLECTED Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

3c. DATE FIRST POSITIVE Culture Independent Diagnostic Test (CIDT, e.g. PCR) COLLECTED Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

3d. TYPE OF CIDT: 1 ☐ Biofire Meningitis Panel 9 ☐ Unknown 2 ☐ Other _____

4. Date reported to EIP site: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

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

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

7a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: ☐☐☐☐☐

7b. HOSPITAL I.D. WHERE PATIENT TREATED: ☐☐☐☐☐

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

9a. AGE: ☐☐☐

9b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

10. SEX: 1 ☐ Male 2 ☐ Female

11a. ETHNIC ORIGIN: 1 ☐ Hispanic or Latino 2 ☐ Not Hispanic or Latino 9 ☐ Unknown

11b. 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

12a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:
1 ☐ *Neisseria meningitidis* 2 ☐ *Haemophilus influenzae* 3 ☐ Group B *Streptococcus* 4 ☐ *Listeria monocytogenes* 5 ☐ Group A *Streptococcus* 6 ☐ *Streptococcus pneumoniae*

12b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: *(specify)* _____

13. STERILE SITES FROM WHICH ORGANISM ISOLATED: *(Check all that apply)*
1 ☐ Blood 1 ☐ CSF 1 ☐ Peritoneal fluid 1 ☐ Bone 1 ☐ Muscle/Fascia/Tendon 1 ☐ Joint 1 ☐ Pleural fluid 1 ☐ Pericardial 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

13b. CIDT STERILE SITE FROM WHICH ORGANISM WAS DETECTED: 1 ☐ CSF 1 ☐ Other _____

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 HOSPITALIZED? 1 ☐ Yes 2 ☐ No
If YES, date of admission: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐
Date of discharge: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

18a. Where was the patient a resident at time of initial culture?
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

18b. If resident of a facility, what was the name of the facility? _____
Facility ID: _____

19a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

19b. If YES, hospital I.D.: ☐☐☐☐☐

20a. WEIGHT: _____lbs_____ oz OR _____ kg OR ☐ Unknown

20b. HEIGHT: _____ft _____ in OR _____ cm OR ☐ Unknown

20c. BMI: ___ ___ . ___ OR ☐ Unknown

21. TYPE OF INSURANCE: *(Check all that apply)*
1 ☐ Private 1 ☐ Medicare 1 ☐ Medicaid/state assistance program 1 ☐ Military 1 ☐ Indian Health Service (IHS) 1 ☐ Incarcerated 1 ☐ Other *(specify)* _____ 1 ☐ Uninsured 1 ☐ Unknown

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

22a. If survived, patient discharged to: 1 ☐ Home 2 ☐ LTC/SNF 3 ☐ LTACH 4 ☐ Other _____ 9 ☐ Unknown

If discharged to LTC/SNF or LTACH, what is the Facility ID _____

23. If patient died, was the culture obtained on autopsy? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

24a. At time of first positive culture, patient was: 1 ☐ Pregnant 2 ☐ Postpartum 3 ☐ Neither 9 ☐ Unknown

24b. If pregnant or postpartum, what was the outcome of fetus:
1 ☐ Survived, no apparent illness 2 ☐ Survived, clinical infection 3 ☐ Live birth/neonatal death 4 ☐ Abortion/stillbirth 5 ☐ Induced abortion 6 ☐ Still pregnant 9 ☐ Unknown

24c. ☐ Mark if this is a HiNSES fetal death with placenta and/or amniotic fluid isolate, a stillbirth, or neonate <22 wks gestation.

25. If patient <1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only.
Gestational age: ☐☐ *(wks)* Birth weight: ☐☐☐☐ *(gms)*

26. TYPES OF INFECTION CAUSED BY ORGANISM: *(Check all that apply)*
1 ☐ Bacteremia without Focus 1 ☐ Meningitis 1 ☐ Otitis media 1 ☐ Pneumonia 1 ☐ Cellulitis 1 ☐ Epiglottitis 1 ☐ Hemolytic uremic syndrome (HUS) 1 ☐ Abscess (not skin) 1 ☐ Peritonitis 1 ☐ Pericarditis 1 ☐ Septic abortion 1 ☐ Chorioamnionitis 1 ☐ Septic arthritis 1 ☐ Osteomyelitis 1 ☐ Empyema 1 ☐ Endocarditis 1 ☐ Endometritis 1 ☐ STSS 1 ☐ Necrotizing fasciitis 1 ☐ Puerperal sepsis 1 ☐ Septic shock 1 ☐ Other *(specify)* _____ 1 ☐ Unknown

CDC 52.15A REV. 2016

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

27. 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/TIA
1☐ Chronic Kidney Disease
1☐ Chronic Liver Disease/cirrhosis
1☐ Current Chronic Dialysis
1☐ Chronic Skin Breakdown
1☐ Cochlear Implant
1☐ Complement Deficiency
1☐ Connective Tissue Disease (Lupus, etc.) CSF
1☐ Leak
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, etc.)
1☐ Eculizumab (Soliris) - *N.men. cases only*
1☐ IVDU, Current
1☐ IVDU, Past
1☐ Leukemia
1☐ Multiple Myeloma
1☐ Multiple Sclerosis
1☐ Myocardial Infarction
1☐ Nephrotic Syndrome
1☐ Neuromuscular Disorder
1☐ Obesity
1☐ Other Drug Use, Current
1☐ Other Drug Use, Past
1☐ Parkinson's Disease
1☐ Peptic Ulcer Disease
1☐ Peripheral Neuropathy
1☐ Peripheral Vascular Disease
1☐ Plegias/Paralysis
1☐ Premature Birth (specify gestational age at birth) ☐☐ (wks)
1☐ Seizure/Seizure Disorder
1☐ Sickle Cell Anemia
1☐ Smoker (current)
1☐ Solid Organ Malignancy
1☐ Solid Organ Transplant
1☐ Splenectomy/Asplenia
1☐ Other prior illness (specify): _____

– 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 Mo.	Day	Year	VACCINE NAME	MANUFACTURER	LOT NUMBER
1						
2						
3						
4						

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 2☐ B 3☐ C 4☐ Y 5☐ W135 6☐ Not Groupable 8☐ Other _____ 9☐ Unknown

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, complete the table**

DOSE	TYPE	DATE GIVEN Mo.	Day	Year	NAME	MANUFACTURER	LOT NUMBER
1							
2							
3							
4							
5							
6							

Type Codes: 1= ACWY conjugate (Menactra, Menveo, MenHibrix) 2= ACWY polysaccharide (Menomune) 3= B (Bexsero, Trumenba) 9= Unknown

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.

31b. If survived, did patient have any of the following sequelae evident upon discharge? (check all that apply) 1☐ None 1☐ Unknown
1☐ Hearing deficits 1☐ Amputation (digit) 1☐ Amputation (limb) 1☐ Seizures 1☐ Paralysis or spasticity 1☐ Skin Scarring/necrosis 1☐ *Other (specify)* _____

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 ☐☐☐☐
9☐ Unknown date

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 ☐☐☐☐
9☐ Unknown date

35. Did patient have:
1☐ Varicella
1☐ Penetrating trauma
1☐ Blunt trauma
1☐ Surgical wound *(post operative)*
1☐ Burns

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 9☐ Unknown days

36. COMMENTS: _____

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.: ( ) _____