– 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

2019 ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM

Form Approved
0920-0978

– SHADED AREAS FOR OFFICE USE ONLY –

1. STATE: *(Patient Residence)* ☐☐

2. STATE I.D.: ☐☐☐☐☐☐☐☐

3. PATIENT I.D.: _____

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 7 ☐ QA Review Change

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

	T1 Test Type	T2 Date of Specimen Collection (Mo. Day Year)	T3 Test Method (non-culture)	T4 Site from which organism isolated	T5 Bacterial Species Isolated*	T6 Test Result	T7 Isolate/Specimen Available?	T8 If isolate/specimen not available, why not?
1								
2								
3								
2								

* For other bacterial pathogens (i.e. non-ABCs), write-in pathogen name

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 4 ☐ Homeless 7 ☐ Non-medical ward
2 ☐ Long term care facility 5 ☐ Incarcerated 8 ☐ Other *(specify)* _____
3 ☐ Long term acute care facility 6 ☐ College dormitory 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 5 ☐ Left AMA 9 ☐ Unknown

If discharged to LTC/SNF or LTACH, list Facility ID _____ 4 ☐ Other, Specify _____

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 4 ☐ Abortion/stillbirth 9 ☐ Unknown
2 ☐ Survived, clinical infection 5 ☐ Induced abortion
3 ☐ Live birth/neonatal death 6 ☐ Still pregnant

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

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 ☐ Asthma
1 ☐ Atherosclerotic CVD (ASCVD)/CAD
1 ☐ Bone Marrow Transplant (BMT)
1 ☐ CVA/Stroke/TIA
1 ☐ Chronic Hepatitis C
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 ☐ HbA1C _____(%), Date ___/___/_____
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. only
1 ☐ Leukemia
1 ☐ Multiple Myeloma
1 ☐ Multiple Sclerosis
1 ☐ Myocardial Infarction
1 ☐ Nephrotic Syndrome
1 ☐ Neuromuscular Disorder
1 ☐ Obesity
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 ☐ Solid Organ Malignancy
1 ☐ Solid Organ Transplant
1 ☐ Splenectomy/Asplenia
1 ☐ Other prior illness (specify): _____

SUBSTANCE USE, CURRENT

27c. SMOKING: *(check all that apply)* 1 ☐ None 1 ☐ Unknown 1 ☐ Tobacco 1 ☐ E-Nicotine Delivery System 1 ☐ Marijuana

27c. ALCOHOL ABUSE: 1 ☐ Yes 0 ☐ No 9 ☐ Unknown

27d. OTHER SUBSTANCES: *(check all that apply)* 1 ☐ None 1 ☐ Unknown

	Documented Use Disorder (DUD)/Abuse?	Mode of delivery: *(check all that apply)*
1 ☐ Marijuana/cannabinoid (other than smoking)	1 ☐ DUD or Abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ non-IDU 1 ☐ Unknown
1 ☐ Opioid, DEA schedule I (e.g., heroin)	1 ☐ DUD or Abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ non-IDU 1 ☐ Unknown
1 ☐ Opioid, DEA schedule II - IV (e.g., methadone, oxycodone)	1 ☐ DUD or Abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ non-IDU 1 ☐ Unknown
1 ☐ Cocaine or methamphetamine	1 ☐ DUD or Abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ non-IDU 1 ☐ Unknown
1 ☐ Other* (specify): _____	1 ☐ DUD or Abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ non-IDU 1 ☐ Unknown
1 ☐ Unknown substance	1 ☐ DUD or Abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ non-IDU 1 ☐ Unknown

*Includes hallucinogens (LSD, mushrooms, etc.), club drugs (MDMA, GHB, etc.), dissociative drugs (ketamine, etc.), inhalants

– 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 influenza* b vaccine? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If YES, please complete the list below.

DOSE	DATE GIVEN Mo.	Day	Year	VACCINE NAME / MANUFACTURER
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 ☐ Medical Chart
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**

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

	DOSE TYPE	DATE GIVEN Mo.	Day	Year	VACCINE NAME / MANUFACTURER
1					
2					
3					
4					

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 IPD 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. : ( ) _____

VALUE SETS for LAB REPEATING GROUP

T1 - Test Type
1=PCR
2=Culture
3=Antigen
4=Immunohistochemistry
5=Latex agglutination
7=Other
9=unknown

T3 - Test Method (if non-culture)
1=Biofire Filmarray Meningitis/Encephalitis Panel
2=other
3=Biofire Filmarray Blood Culture ID (BCID) Panel
4=Verigene Gram + Blood Culture (BCT) Test
5=Bruker MALDI Biotyper CA System
6=BD Directigen Meningitis Combo Test Kit
7=ThermoFisher Wellcogen Bacterial Antigen Rapid
8=Alere BinaxNOW Antigen Card
9=Unknown

T4 - Site of organism isolation
1=Amniotic fluid
2=Blood
3=Bone
4=Brain
5=CSF
6=Heart
7=Other Sterile Site
8=Joint
9=unknown
10=Kidney
11=Liver
12=Lung
13=Lymph node
14=Middle ear
15=Muscle/Fascia/Tendon
16=Ovary
17=Pancreas
18=Pericardial Fluid
19=Peritoneal Fluid
20=Placenta
21=Pleural fluid
22=Respiratory secretion
23=Sinus
24=Spleen
25=Sputum
26=Vitreous
27=Wound
28=Unknown

T5 - Bacterial Species Isolated*
1=*Neisseria meningitidis*
2=*Haemophilus influenzae*
3=Group B Streptococcus
5=Group A Streptococcus
6=*Streptococcus pneumoniae*

T6 -Test Result
1=Positive
0=Negative

T7 - Isolate/Specimen Available
1=Yes
2=N0

T8 - No Isolate/Specimen, why not
1=N/A at Hospital Lab 2=N/A at State Lab
3=Hospital refuses
4=Isolate Discrepancy (2x)
5=No DNA (non-viable)

* For other bacterial pathogens (i.e. non-ABCs) write-in pathogen name