

Patient's Name: (Last, First, MI.) Phone No.: () Patient Chart No.: Address: (Number, Street, Apt. No.) Hospital: (City, State) (Zip Code)

- 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: 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: 9a. AGE: 9b. Is age in day/mo/yr? 10. SEX: 11a. ETHNIC ORIGIN: 11b. RACE: (Check all that apply)

Table with 8 columns: T1 Test Type, T2 Date of Specimen Collection, 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?

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

16. WAS PATIENT HOSPITALIZED? If YES, date of admission: Date of discharge: 17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?

18a. Where was the patient a resident at time of initial culture? 18b. If resident of a facility, what was the name of the facility? 19a. Was patient transferred from another hospital? 19b. If YES, hospital I.D.:

20a. WEIGHT: 20b. HEIGHT: 20c. BMI: 21. TYPE OF INSURANCE: (Check all that apply)

22. OUTCOME: 23. If patient died, was the culture obtained on autopsy? 22a. If survived, patient discharged to: If discharged to LTC/SNF or LTACH, list Facility ID

24a. At time of first positive culture, patient was: 24b. If pregnant or postpartum, what was the outcome of fetus? 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. 26. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply)

27. UNDERLYING CAUSES OR PRIOR ILLNESSES: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) 1 None 1 Unknown

1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> Complement Deficiency	1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Peripheral Neuropathy
1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Connective Tissue Disease (Lupus, etc.) CSF	1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, etc.)	1 <input type="checkbox"/> Peripheral Vascular Disease
1 <input type="checkbox"/> Atherosclerotic CVD (ASCVD)/CAD	1 <input type="checkbox"/> Leak	1 <input type="checkbox"/> Eculizumab (Soliris) - N.men. only	1 <input type="checkbox"/> Plegias/Paralysis
1 <input type="checkbox"/> Bone Marrow Transplant (BMT)	1 <input type="checkbox"/> Deaf/Profound Hearing Loss	1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> Premature Birth (specify gestational age at birth) <input type="text"/> (wks)
1 <input type="checkbox"/> CVA/Stroke/TIA	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Seizure/Seizure Disorder
1 <input type="checkbox"/> Chronic Hepatitis C	1 <input type="checkbox"/> Diabetes Mellitus,	1 <input type="checkbox"/> Multiple Sclerosis	1 <input type="checkbox"/> Sick Cell Anemia
1 <input type="checkbox"/> Chronic Kidney Disease	1 <input type="checkbox"/> HbA1C _____ (%), Date ___/___/___	1 <input type="checkbox"/> Myocardial Infarction	1 <input type="checkbox"/> Solid Organ Malignancy
1 <input type="checkbox"/> Chronic Liver Disease/cirrhosis	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Solid Organ Transplant
1 <input type="checkbox"/> Current Chronic Dialysis	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Neuromuscular Disorder	1 <input type="checkbox"/> Splenectomy/Asplenia
1 <input type="checkbox"/> Chronic Skin Breakdown	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Other prior illness (specify):
1 <input type="checkbox"/> Cochlear Implant	1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma	1 <input type="checkbox"/> Parkinson's Disease	
		1 <input type="checkbox"/> Peptic Ulcer Disease	

SUBSTANCE USE, CURRENT

27c. SMOKING: 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

1 <input type="checkbox"/> Marijuana/cannabinoid (other than smoking)	1 <input type="checkbox"/> DUD or Abuse	1 <input type="checkbox"/> IDU	1 <input type="checkbox"/> Skin popping	1 <input type="checkbox"/> non-IDU	1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin)	1 <input type="checkbox"/> DUD or Abuse	1 <input type="checkbox"/> IDU	1 <input type="checkbox"/> Skin popping	1 <input type="checkbox"/> non-IDU	1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, DEA schedule II - IV (e.g., methadone, oxycodone)	1 <input type="checkbox"/> DUD or Abuse	1 <input type="checkbox"/> IDU	1 <input type="checkbox"/> Skin popping	1 <input type="checkbox"/> non-IDU	1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Cocaine or methamphetamine	1 <input type="checkbox"/> DUD or Abuse	1 <input type="checkbox"/> IDU	1 <input type="checkbox"/> Skin popping	1 <input type="checkbox"/> non-IDU	1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Other* (specify): _____	1 <input type="checkbox"/> DUD or Abuse	1 <input type="checkbox"/> IDU	1 <input type="checkbox"/> Skin popping	1 <input type="checkbox"/> non-IDU	1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Unknown substance	1 <input type="checkbox"/> DUD or Abuse	1 <input type="checkbox"/> IDU	1 <input type="checkbox"/> Skin popping	1 <input type="checkbox"/> non-IDU	1 <input type="checkbox"/> Unknown

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

- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISM -

<p>HAEMOPHILUS INFLUENZAE</p> <p>28a. What was the serotype?</p> <p>1 <input type="checkbox"/> b 2 <input type="checkbox"/> Not Typeable 3 <input type="checkbox"/> a</p> <p>4 <input type="checkbox"/> c 5 <input type="checkbox"/> d 6 <input type="checkbox"/> e 7 <input type="checkbox"/> f</p> <p>8 <input type="checkbox"/> Other (specify) _____</p> <p>9 <input type="checkbox"/> Not Tested or Unknown</p>	<p>28b. If <15 years of age and serotype 'b' or 'unknown' did patient receive Haemophilus influenza b vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>If YES, please complete the list below.</p> <table border="0"> <tr> <td>DOSE</td> <td>Mo.</td> <td>Day</td> <td>Year</td> <td>VACCINE NAME / MANUFACTURER</td> </tr> <tr> <td>1</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td>_____</td> </tr> <tr> <td>2</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td>_____</td> </tr> <tr> <td>3</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td>_____</td> </tr> <tr> <td>4</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td>_____</td> </tr> </table>	DOSE	Mo.	Day	Year	VACCINE NAME / MANUFACTURER	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	4	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	<p>28c. Were records obtained to verify vaccination history? (<5 years of age with Hib/unknown serotype, only) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>If YES, what was the source of the information? (Check all that apply)</p> <p>1 <input type="checkbox"/> Medical Chart</p> <p>1 <input type="checkbox"/> Vaccine Registry</p> <p>1 <input type="checkbox"/> Healthcare Provider</p> <p>1 <input type="checkbox"/> Other (specify) _____</p>
DOSE	Mo.	Day	Year	VACCINE NAME / MANUFACTURER																							
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4	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____																							

<p>NEISSERIA MENINGITIDIS</p> <p>29. What was the serogroup?</p> <p>1 <input type="checkbox"/> A 2 <input type="checkbox"/> B 3 <input type="checkbox"/> C 4 <input type="checkbox"/> Y 5 <input type="checkbox"/> W135</p> <p>6 <input type="checkbox"/> Not Groupable 8 <input type="checkbox"/> Other _____ 9 <input type="checkbox"/> Unknown</p>	<p>30. Is patient currently attending college?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	<p>STREPTOCOCCUS PNEUMONIAE</p> <p>32. Did patient receive pneumococcal vaccine?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>If YES, please note which pneumococcal vaccine was received: (Check all that apply)</p> <p>1 <input type="checkbox"/> Prevnar®, 7-valent Pneumococcal Conjugate Vaccine (PCV7)</p> <p>1 <input type="checkbox"/> Prevnar-13®, 13-valent Pneumococcal Conjugate Vaccine (PCV13)</p> <p>1 <input type="checkbox"/> Pneumovax®, 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)</p> <p>1 <input type="checkbox"/> Vaccine type not specified</p> <p>If between .2 months and <5 years of age and an isolate is available for serotyping, please complete the IPD in Children expanded form.</p>																									
<p>31. Did patient receive meningococcal vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>If YES, complete the table</p> <table border="0"> <tr> <td>Type Codes:</td> <td>DOSE</td> <td>TYPE</td> <td>DATE GIVEN</td> <td>VACCINE NAME / MANUFACTURER</td> </tr> <tr> <td>1= ACWY conjugate (Menactra, Menveo, MenHibrix)</td> <td>1</td> <td>_____</td> <td>Mo. Day Year</td> <td>_____</td> </tr> <tr> <td>2= ACWY polysaccharide (Menomune)</td> <td>2</td> <td>_____</td> <td><input type="text"/></td> <td>_____</td> </tr> <tr> <td>3= B (Bexsero, Trumenba)</td> <td>3</td> <td>_____</td> <td><input type="text"/></td> <td>_____</td> </tr> <tr> <td>9= Unknown</td> <td>4</td> <td>_____</td> <td><input type="text"/></td> <td>_____</td> </tr> </table>	Type Codes:	DOSE	TYPE	DATE GIVEN	VACCINE NAME / MANUFACTURER	1= ACWY conjugate (Menactra, Menveo, MenHibrix)	1	_____	Mo. Day Year	_____	2= ACWY polysaccharide (Menomune)	2	_____	<input type="text"/>	_____	3= B (Bexsero, Trumenba)	3	_____	<input type="text"/>	_____	9= Unknown	4	_____	<input type="text"/>	_____		
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9= Unknown	4	_____	<input type="text"/>	_____																							

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) _____

<p>GROUP A STREPTOCOCCUS (#33-35 refer to the 14 days prior to first positive culture)</p> <p>33. Did the patient have surgery or any skin incision? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>If YES, date of surgery or skin incision: Mo. Day Year</p> <p><input type="text"/></p> <p>9 <input type="checkbox"/> Unknown date</p>	<p>34. Did the patient deliver a baby (vaginal or C-section)?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>If YES, date of delivery: Mo. Day Year</p> <p><input type="text"/></p> <p>9 <input type="checkbox"/> Unknown date</p>	<p>35. Did patient have:</p> <p>1 <input type="checkbox"/> Varicella 1 <input type="checkbox"/> Surgical wound (post operative)</p> <p>1 <input type="checkbox"/> Penetrating trauma 1 <input type="checkbox"/> Burns</p> <p>1 <input type="checkbox"/> Blunt trauma</p> <p>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)</p> <p>1 <input type="checkbox"/> 0-7 days 2 <input type="checkbox"/> 8-14 days 9 <input type="checkbox"/> Unknown days</p>
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36. COMMENTS: _____

37. Was case first identified through audit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	38. Does this case have recurrent disease with the same pathogen? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	If YES, previous (1st) state I.D.: <input type="text"/>	39. Initials of S.O.: _____
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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 | 19=Peritoneal Fluid |
| 2=Blood | 20=Placenta |
| 3=Bone | 21=Pleural fluid |
| 4=Brain | 22=Respiratory secretion |
| 5=CSF | 23=Sinus |
| 6=Heart | 24=Spleen |
| 7=Other Sterile Site | 25=Sputum |
| 8=Joint | 26=Vitreous |
| 9=unknown | 27=Wound |
| 10=Kidney | 28=Unknown |
| 11=Liver | |
| 12=Lung | |
| 13=Lymph node | |
| 14=Middle ear | |
| 15=Muscle/Fascia/Tendon | |
| 16=Ovary | |
| 17=Pancreas | |
| 18=Pericardial Fluid | |

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=NO

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