

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

2020 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) 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) 1 White 1 Black 1 American Indian or Alaska Native 1 Asian 1 Native Hawaiian or Other Pacific Islander 1 Unknown

Table with 7 columns: T1 Test Type, T2 Date of Specimen Collection, T3 Test Method (non-culture), T3a Hospital/Lab I.D. where test identified, T4 Site from which organism isolated, T5 Bacterial Species Isolated\*, T6 Test Result. Includes rows for 1, 2, 3, &.

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? T7 Isolate/ Specimen Available? T8 Isolate/ specimen N/A, why not? T9 Shipped to CDC? T10 If shipped, accession #

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: 23. 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. 24d. Mark if this is a GBS Blood Spot Study case that lives outside ABCs catchment area 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"/> Connective Tissue Disease (Lupus, etc.)	1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, etc.)	1 <input type="checkbox"/> Peripheral Neuropathy
1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> CSF Leak	1 <input type="checkbox"/> Eculizumab (Soliris) - N.men. only	1 <input type="checkbox"/> Peripheral Vascular Disease
1 <input type="checkbox"/> Atherosclerotic CVD (ASCVD)/CAD	1 <input type="checkbox"/> Deaf/Profound Hearing Loss	1 <input checked="" type="checkbox"/> Ravulizumab (Ultomiris) - N.men. only	1 <input type="checkbox"/> Plegias/Paralysis
1 <input type="checkbox"/> Bone Marrow Transplant (BMT)	1 <input type="checkbox"/> Dementia	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"/> Diabetes Mellitus,	1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Seizure/Seizure Disorder
1 <input type="checkbox"/> Chronic Hepatitis C	1 <input type="checkbox"/> HbA1C _____(%), Date ____/____/____	1 <input type="checkbox"/> Multiple Sclerosis	1 <input type="checkbox"/> Sick Cell Anemia
1 <input type="checkbox"/> Chronic Kidney Disease	1 <input type="checkbox"/> Emphysema/COPD	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"/> Heart Failure/CHF	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Solid Organ Transplant
1 <input type="checkbox"/> Current Chronic Dialysis	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> Neuromuscular Disorder	1 <input type="checkbox"/> Splenectomy/Asplenia
1 <input type="checkbox"/> Chronic Skin Breakdown	1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Other prior illness (specify): _____
1 <input type="checkbox"/> Cochlear Implant	1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Parkinson's Disease	
1 <input type="checkbox"/> Complement Deficiency		1 <input type="checkbox"/> Peptic Ulcer Disease	

**SUBSTANCE USE, CURRENT**

**27b. 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"/> Documented Use Disorder (DUD)/Abuse	Mode of delivery: (check all that apply)			
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 checked="" type="checkbox"/> Opioid, NOS	1 <input checked="" type="checkbox"/> DUD or Abuse	1 <input checked="" type="checkbox"/> IDU	1 <input checked="" type="checkbox"/> Skin popping	1 <input checked="" type="checkbox"/> non-IDU	1 <input checked="" type="checkbox"/> Unknown
1 <input type="checkbox"/> Cocaine	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 checked="" type="checkbox"/> 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

**- 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	Mo.	DATE GIVEN	Year	VACCINE NAME / MANUFACTURER	DOSE	Mo.	DATE GIVEN	Year	VACCINE NAME / MANUFACTURER
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	4	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____

<p><b>NEISSERIA MENINGITIDIS</b></p> <p><b>29. What was the serogroup?</b></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><b>30. Is patient currently attending college?</b></p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	<p><b>STREPTOCOCCUS PNEUMONIAE</b></p> <p><b>32. Did patient receive pneumococcal vaccine?</b></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 &lt;5 years of age and an isolate is available for serotyping, please complete the IPD in Children expanded form.</p>																									
<p><b>31. Did patient receive meningococcal vaccine?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 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. <input type="text"/> Day <input type="text"/> Year <input type="text"/></td> <td>_____</td> </tr> <tr> <td>2= ACWY polysaccharide (Menomune)</td> <td>2</td> <td>_____</td> <td>Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/></td> <td>_____</td> </tr> <tr> <td>3= B (Bexsero, Trumenba)</td> <td>3</td> <td>_____</td> <td>Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/></td> <td>_____</td> </tr> <tr> <td>9= Unknown</td> <td>4</td> <td>_____</td> <td>Mo. <input type="text"/> Day <input type="text"/> Year <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. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	_____	2= ACWY polysaccharide (Menomune)	2	_____	Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	_____	3= B (Bexsero, Trumenba)	3	_____	Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	_____	9= Unknown	4	_____	Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	_____
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3= B (Bexsero, Trumenba)	3	_____	Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	_____																							
9= Unknown	4	_____	Mo. <input type="text"/> Day <input type="text"/> Year <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><b>GROUP A STREPTOCOCCUS</b> (#33-35 refer to the 14 days prior to first positive culture)</p> <p><b>33. Did the patient have surgery or any skin incision?</b> 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. <input type="text"/> Day <input type="text"/> Year <input type="text"/></p> <p>9 <input type="checkbox"/> Unknown date</p>	<p><b>34. Did the patient deliver a baby (vaginal or C-section)?</b></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. <input type="text"/> Day <input type="text"/> Year <input type="text"/></p> <p>9 <input type="checkbox"/> Unknown date</p>	<p><b>35. Did patient have:</b></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 &gt; 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:** \_\_\_\_\_

<b>37. Was case first identified through audit?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>38. Does this case have recurrent disease with the same pathogen?</b> 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"/>	<b>39. Initials of S.O.:</b> _____
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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
- 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**

**Sterile Sites**

- 1=Blood
- 2=Bone
- 3=Brain
- 4=CSF
- 5=Heart
- 6=Joint
- 7=Kidney
- 8=Other Sterile Site
- 9=unknown
- 10=Liver
- 11=Lymph node
- 12=Muscle/Fascia/Tendon
- 13=Ovary
- 14=Pancreas
- 15=Pericardial Fluid

- 16=Peritoneal Fluid
- 17=Pleural fluid
- 18=Spleen
- 19=Vascular Tissue
- 20=Vitreous fluid

**Non-Sterile Sites**

- 21=Amniotic fluid
- 24=Placenta
- 27=Wound

**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 Available**

- 1=Yes
- 2=No

**T8 - No Isolate, 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)
- 6=Isolate N/A for collection

**T9 - Shipped to CDC?**

- 1=Yes
- 0=No

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