

NEONATAL INFECTION EXPANDED TRACKING FORM

Infant's Name: _____ (Last, First, M.I.) Infant's Chart No.: _____
 Mother's Name: _____ (Last, First, M.I.) Mother's Chart No.: _____
 Mother's Date of Birth: ___/___/___ Culture date: _____ Hospital Name: _____
month day year (4 digits)

-Patient identifier information is NOT transmitted to CDC-

**ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)
 NEONATAL INFECTION EXPANDED TRACKING FORM**



Form Approved
0920-0978

STATEID _____ **HOSPITAL ID** (of birth; if home birth leave blank) _____

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

| | | |
|---|--|---|
| 1. Date of Birth: ___/___/___ <small>month day year (4 digits)</small> Time of birth: _____ <input type="checkbox"/> Unknown (1) <small>(times in military format)</small> | 2. Did this birth occur outside of the hospital? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES , please check one: <input type="checkbox"/> Home Birth (1) <input type="checkbox"/> Birthing Center (2) <input type="checkbox"/> En route to hospital (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9) | |
| 3a. Gestational age of infant at birth in completed weeks: _____ <small>(do not round up)</small> | 3b. Date of maternal last menstrual period (LMP): ___/___/___ <small>month day year (4 digits)</small> <input type="checkbox"/> Unknown (1) | 3c. Gestational age determined by: <input type="checkbox"/> Dates (1) <input type="checkbox"/> Physical Exam (2) <input type="checkbox"/> Ultrasound (3) <input type="checkbox"/> Unknown (9) |
| 4. Birth weight: ___ lbs ___ oz OR _____ grams | 5. Date & time of newborn discharge from hospital of birth: ___/___/___ <small>month day year (4 digits)</small> ___:___ <input type="checkbox"/> Unknown (1) | 6. Outcome: <input type="checkbox"/> Survived (1) <input type="checkbox"/> Died (2) <input type="checkbox"/> Unknown (9) |

*****Questions 7-10b should only be completed for early- and late-onset GBS cases*****

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

8. Was the infant admitted to a different hospital from home? Yes (1) No (0)
IF YES, hospital ID: _____
AND date & time of admission: ___/___/___
month day year (4 digits) ___:___ Unknown (1)

9a. Were **any** ICD-9 codes reported in the discharge diagnosis of the infant's chart? Yes (1) No (0) Unknown (9)

9b. **IF YES**, Were any of the following ICD-9 codes reported in the discharge diagnosis of the chart? (*Check all that apply*)
 041.02: Streptococcus group b (1) 038.0: Streptococcus septicemia (1)
 041.0: Streptococcus, unspecified (1) 320.2: Streptococcal meningitis (1)

9c. Were **any** ICD-10 codes reported in the discharge diagnosis of the infant's chart? Yes (1) No (0) Unknown (9)

9d. **IF YES**, were any of the following ICD-10 codes reported in the discharge diagnosis of the chart? (*Check all that apply*)
 A40.1: Sepsis due to streptococcus, group B (1) P36.1: Sepsis of newborn to other unspecified streptococci (1)
 A40.8: Other Streptococcal sepsis (1) B95.1: Streptococcus, group b as the cause of disease classified elsewhere (1)
 A40.9: Streptococcus sepsis, unspecified (1) B95.5: Unspecified streptococcus as the cause of disease classified elsewhere (1)
 A49.1: Streptococcal infection, unspecified site (1) G00.2: Streptococcal meningitis (1)
 P36: Bacterial sepsis of newborn (1)
 P36.0: Sepsis of newborn due to streptococcus, group B (1)

10. Did the baby receive breast milk from the mother? (**for late-onset GBS cases only**): Yes (1) No (0) Unknown (9)
IF YES, did the baby receive breast milk before onset of GBS Yes (1) No (0) Unknown (9)

10a. Did the infant receive antibiotics anytime during the birth hospitalization? Yes (1) No (0) Unknown (9)

10b. IF YES, was it a beta-lactam? Yes (1) No (0) Unknown (9)

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30329, ATTN: PRA(0920-0978). **Do not send the completed form to this address.**

Maternal Information

11. Maternal admission date & time: ___/___/___ ___:___:___ Unknown (1)
month day year (4 digits) time

12. Maternal age at delivery (years): ___ years 12a. Number of prior pregnancies ___ Unknown (9)

13. Maternal blood type: A (1) B (2) AB (3) O (4)

14. 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)

14a. MATERNAL UNDERLYING OR PRIOR ILLNESSES: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) None Unknown

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

15. Date & time of membrane rupture: ___/___/___ ___:___:___ Unknown (1)
month day year (4 digits) time

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

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

18. Type of rupture: Spontaneous (1) Artificial (2)

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

Vaginal (1) Vaginal after previous C-section (1) Primary C-section (1) Repeat C-section (1)
 Forceps (1) Vacuum (1) Unknown (1)

If delivery was by C-section:

Did labor begin before C-section? Yes (1) No (0) Unknown (9)
Did membrane rupture happen before C-section? Yes (1) No (0) Unknown (9)

20. 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 (1)
month day year (4 digits) time

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

IF YES, answer 21a-b and Questions 22-23

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

b) Antibiotic 1: _____ IV (1) IM (2) PO (3) # doses given before delivery: _____
Start date: ___/___/___ Stop date (if applicable): ___/___/___

Antibiotic 2: _____ IV (1) IM (2) PO (3) # doses given before delivery: _____
Start date: ___/___/___ Stop date (if applicable): ___/___/___

Antibiotic 3: _____ IV (1) IM (2) PO (3) # doses given before delivery: _____
Start date: ___/___/___ Stop date (if applicable): ___/___/___

Antibiotic 4: _____ IV (1) IM (2) PO (3) # doses given before delivery: _____
Start date: ___/___/___ Stop date (if applicable): ___/___/___

Antibiotic 5: _____ IV (1) IM (2) PO (3) # doses given before delivery: _____
Start date: ___/___/___ Stop date (if applicable): ___/___/___

Antibiotic 6: _____ IV (1) IM (2) PO (3) # doses given before delivery: _____
Start date: ___/___/___ Stop date (if applicable): ___/___/___

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

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

| | | |
|--|--|--|
| <input type="checkbox"/> GBS prophylaxis (1) | <input type="checkbox"/> Prolonged latency (1) | <input type="checkbox"/> Mitral valve prolapse prophylaxis (1) |
| <input type="checkbox"/> Suspected amnionitis/ chorioamnionitis (1) | <input type="checkbox"/> C-section prophylaxis (1) | <input type="checkbox"/> Other (1) |
| | | <input type="checkbox"/> Unknown (1) |

24. Did mother have chorioamnionitis or suspected chorioamnionitis? Yes (1) No (0)

*****Questions 25–33 should only be completed for early- and late-onset GBS cases*****

25. Did mother receive prenatal care? Yes (1) No (0) Unknown (9)

26. Please record the following: the total number of prenatal visits AND the first and last visit dates to the prenatal as recorded in the labor and delivery chart
 No. of visits: ____ First visit: ____/____/____ Last visit: ____/____/____ Unknown (1)
month day year (4 digits) month day year (4 digits)

27. Estimated gestational age (EGA) at last documented prenatal visit: ____ . ____ (weeks)

28. GBS bacteriuria during this pregnancy? Yes (1) No (0) Unknown (9)
IF YES, what order of magnitude was the colony count?
 0 (1) <10,000 (2) 10k–<25,000 (3) 25k–<50,000 (4) 50k–<75,000 (5) 75k–<100,000 (6)
 ≥100,000 (7) Unknown (9)

29. Previous infant with invasive GBS disease? Yes (1) No (0) Unknown (9)

30. Previous pregnancy with GBS colonization? Yes (1) No (0) Unknown (9)

31a. Was maternal group B strep colonization screened for BEFORE admission (in prenatal care)?
 Yes (1) No (0) Unknown (9)

IF YES, list dates, test type, and test results below:

| <u>Test date</u> (list most recent first): | <u>Test type:</u> | <u>Test Result</u> (Do not include urine here!) |
|--|---|---|
| 1. ____/____/____ | <input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9) | <input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9) |
| 2. ____/____/____ | <input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9) | <input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9) |

31b. If the *most recent* test was GBS positive was antimicrobial susceptibility performed BEFORE admission (in prenatal care)?
 Yes (1) No (0) Unknown (9)

IF YES, Was the isolate resistant to clindamycin? Yes (1) No (0) Unknown (9)

Was the isolate resistant to erythromycin? Yes (1) No (0) Unknown (9)

32a. Was maternal group B strep colonization screened for AFTER admission (before delivery)? Yes (1) No (0) Unknown (9)

IF YES, list date of most recent test, test type and test results below:

| <u>Test date</u> (list most recent first): | <u>Test type:</u> | <u>Test Result</u> (Do not include urine here!) |
|--|---|---|
| ____/____/____ | <input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9) | <input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9) |

32b. If the *most recent* test was GBS positive, was antimicrobial susceptibility performed AFTER admission?

Yes (1) No (0) Unknown (9)

IF YES, Was the isolate resistant to clindamycin? Yes (1) No (0) Unknown (9)

Was the isolate resistant to erythromycin? Yes (1) No (0) Unknown (9)

33. Were GBS test results available to care givers at the time of delivery? Yes (1) No (0) Unknown (9)

34. COMMENTS: _____

35. Neonatal Infection Expanded Form Tracking Status:

Complete (1) Incomplete (2) Edited & corrected (3) Chart unavailable after 3 requests (4)