

Person Filling Out Form: _____ Culture date: ____/____/____ Infant Mother **STATE ID:** _____
(Last, First, M.I.) month / day / year (4 digits)

Infant's Name: _____ Estimated Mother's Prenatal Care Provider: _____
(Last, First, M.I.)

Infant's Chart No.: _____ Due Date: ____/____/____ Clinic Name: _____
month / day / year (4 digits)

Mother's Name: _____ Mother's Clinic Phone Number: _____
(Last, First, M.I.)

Mother's Chart No.: _____ Date of Birth: ____/____/____ Hospital Name: _____
month / day / year (4 digits)

- Patient identifier information is NOT transmitted to CDC -

2019 ABCs H. Influenzae Neonatal Sepsis Expanded Surveillance Form



Form Approved
0920-0978

Indicate type of HINSES case:

Neonatal: infant (sterile isolates only) - complete #1-31

Maternal cases: pregnant or post-partum (sterile isolates only)

Fetal Cases (any gestational age - specify isolate/outcome):

Live Birth (hospitalized) - complete #1-31

Stillbirth (hospitalized)- complete #1-3,12-31

Spontaneous Abortion - complete #1-2b,12-18, and 28-31

Home delivery (any outcome) - end form

Induced Abortion - end form

Pregnancy outcome unknown - end form

Hi from sterile site in stillbirth - complete #1-3, 12-31

Fetal death *Hi* isolated from placenta/amniotic fluid:

Stillbirth - complete #1-3,12-31

Spontaneous abortion - complete #1-2b,12-18, and 28-31

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

Infant Information

1. Date of live birth/stillbirth/spontaneous abortion: ____/____/____ Time: _____ Unknown (9)
month / day / year (4 digits) (times in military format)

2. Gestational age of infant live birth/stillbirth/spontaneous abortion in completed weeks: ____ (do not round up)

2a. Determined by: Dates Physical Exam Ultrasound Unknown

2b. Date of maternal last menstrual period (LMP): ____/____/____ month / day / year (4 digits) Unknown (9)

3. Birth weight: ____ lbs ____ oz **OR** _____ grams

4. Date & time of newborn discharge from hospital of birth: ____/____/____ _____ Unknown (9)
month / day / year (4 digits) time

5. Was the infant transferred to another hospital following birth? Yes (1) No (0) Unknown (9)
 If YES, Hospital where infant was transferred _____ ID
 AND date of transfer ____/____/____ month / day / year (4 digits) Unknown (9)
 AND date of discharge ____/____/____ month / day / year (4 digits) Unknown (9)

6. Was the infant discharged to home and readmitted to the birth hospital? Yes (1) No (0) Unknown (9)
 If YES, date & time of readmission: ____/____/____ _____ Unknown (9)
month / day / year (4 digits) time
 AND date of discharge ____/____/____ month / day / year (4 digits) Unknown (9)

7. Was the infant discharge to home and readmitted to a different hospital? Yes (1) No (0) Unknown (9)
 If YES, hospital ID: _____
 AND date & time of admission: ____/____/____ _____ time Unknown (9)
month / day / year (4 digits)
 AND date of discharge ____/____/____ month / day / year (4 digits) Unknown (9)

8. Outcome of infant : Survived (1) Died (2) Unknown (9)
 If infant Died, specify Date of Death ____/____/____ month / day / year (4 digits) Unknown (9)

8a. If survived, did the infant have the following neurologic or medical sequelae evident on discharge (*Check all that apply*)
 None Seizure disorder Hearing impairment Requiring oxygen

9. Was the infant admitted to the NICU during hospitalization following birth? Yes (1) No (0) Unknown (9)

9a. If infant readmitted, was infant admitted to NICU during rehospitalization? Yes (1) No (0) Unknown (9)

9b. If yes, to either 9 or 9a, total number of days in the NICU. ____ Unknown (9)

10. **From time of birth to date of discharge**, did the infant have a temperature ≥ 100.4 F/38 C? Yes (1) No (0) Unknown (9)

*** Questions 10a-c: Only for live births of pregnant and post-partum HiNSES cases**

10a. Were any bacterial cultures performed on infant **from time of birth to date of discharge**? Yes (1) No (0)

10b. If cultures performed **from time of birth to date of discharge**^{*}, list the culture date(s), source(s), and result(s).
^{*}For neonates hospitalized for > 7 days, list cultures from time of birth through day 7 of life

Culture Date	Culture Source	Results
#1. ____/____/____	<input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative <input type="checkbox"/> Result unknown
#2. ____/____/____	<input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative <input type="checkbox"/> Result unknown

10c. If any sterile site culture positive for Hi, list ABCs State ID assigned to infant case. _____

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

11a. If YES, Were any of the following ICD-9 codes reported in the discharge diagnosis of the chart? (Check all that apply)

<input type="checkbox"/> None of the codes listed were found in chart	<input type="checkbox"/> 320.0: Haemophilus meningitis
<input type="checkbox"/> 771.81: Septicemia of newborn	<input type="checkbox"/> 762.7: Chorioamnionitis affecting fetus or newborn
<input type="checkbox"/> 995.91: Sepsis	<input type="checkbox"/> 670.22 Puerperal sepsis, delivered w/ postpartum
<input type="checkbox"/> 038.41 Septicemia due to <i>H. influenzae</i>	<input type="checkbox"/> Other ICD-9 codes (specify) _____
<input type="checkbox"/> 482.2: Pneumonia due to <i>H. influenzae</i>	

11b. Were **any** ICD-10 codes reported in the discharge diagnosis of the infant's chart? Yes (1) No (0) Unknown (9)

11c. IF YES, were any of the following ICD-10 codes reported in the discharge diagnosis of the chart? (Check all that apply)

<input type="checkbox"/> None of the codes listed were found in the chart	<input type="checkbox"/> P36.9: Bacterial sepsis of newborn, unspecified
<input type="checkbox"/> A41.3: Sepsis due to <i>H. influenzae</i>	<input type="checkbox"/> P02.7: Chorioamnionitis
<input type="checkbox"/> J14: Pneumonia due to <i>H. influenzae</i>	<input type="checkbox"/> O85: Puerperal sepsis
<input type="checkbox"/> G00.0: Haemophilus meningitis	<input type="checkbox"/> O75.3: Sepsis during labor
<input type="checkbox"/> P36.8: Other bacterial sepsis of newborn	<input type="checkbox"/> B96.3 <i>H. influenzae</i> as cause of disease classd elswhr
	<input type="checkbox"/> Other ICD-10 codes (specify) _____

Maternal Information

12. Maternal admission date & time: ____ / ____ / ____ - ____ : ____ Unknown (9) Not Applicable/
month day year (4 digits) time Patient not hospitalized

13. Maternal age at delivery / spontaneous abortion (years): ____ years

14. Number of prior pregnancies ____ Unknown (9)

15. Any prior history of preterm births? (< 37 weeks gestational age) Yes (1) No (0) Unknown (9)

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

17. Please record: the total number of prenatal visits AND the first and last visit dates to the prenatal provider as recorded in the chart
 No. of visits: ____ First visit: ____ / ____ / ____ Last visit: ____ / ____ / ____ Unknown (9)
month day year (4 digits) month day year (4 digits)

18. Estimated gestational age (EGA) at last documented prenatal visit: ____ . ____ (weeks) Unknown (9)

19. Date & time of membrane rupture: ____ / ____ / ____ - ____ : ____ Unknown (9)
month day year (4 digits) time

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

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

22. Type of rupture: Spontaneous (1) Artificial (2) Unknown (9)

22a. If artificial rupture, reason for rupture (check all that apply)

<input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Fetal distress	<input type="checkbox"/> Gestational diabetes
	<input type="checkbox"/> Suspected chorioamnionitis	<input type="checkbox"/> Severe fetal growth restriction
	<input type="checkbox"/> Preclampsia/eclampsia/hypertension	<input type="checkbox"/> Post-term pregnancy
	<input type="checkbox"/> Maternal bleeding	<input type="checkbox"/> Other, specify _____

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

<input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Vaginal after previous C-section (VBAC)	<input type="checkbox"/> Primary C-section
	<input type="checkbox"/> Forceps	<input type="checkbox"/> Vacuum	<input type="checkbox"/> Repeat C-section

23a. If delivery was by C-section: Did labor begin before C-section? Yes (1) No (0) Unknown (9)

23b. If delivery was by C-section: Did membrane rupture happen before C-section? Yes (1) No (0) Unknown (9)

23c. If delivery by C-section was it scheduled or emergency? Scheduled (1) Emergency (2) Unknown (9)

23d. If **emergency** C-section. What was the reason? (check all that apply)

<input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Placenta previa/abruption	<input type="checkbox"/> Cord prolapse	<input type="checkbox"/> Eclampsia/preclampsia/hypertension
	<input type="checkbox"/> Uterine rupture	<input type="checkbox"/> Fetal distress	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Breech position	<input type="checkbox"/> Failure to progress	<input type="checkbox"/> Maternal infection
			<input type="checkbox"/> Other(specify) _____

24. 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)

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

IF YES, answer 25. a-b and Questions 26-27

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

b)

No.	Antibiotic Name	Route of Administration			# Doses given before delivery	Start Date	Stop Date (if applicable)
		IV(1)	IM(2)	PO(3)			
1							
2							
3							
4							
5							
6							

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

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

<input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Intrapartum fever (≥ 100.4 F/38 C)	<input type="checkbox"/> Suspected amnionitis/chorioamnionitis
	<input type="checkbox"/> Prolonged latency	<input type="checkbox"/> Mitral valve prolapse prophylaxis
	<input type="checkbox"/> C-section prophylaxis	<input type="checkbox"/> Other (specify) _____
	<input type="checkbox"/> GBS prophylaxis	

28. Did mother have chorioamnionitis or suspected chorioamnionitis during the intrapartum period or in the week prior to spontaneous abortion? Yes (1) No (0) Unknown (9)

29. During the intrapartum period or in the week prior to spontaneous abortion did the mother have any of the following symptoms or diagnoses? (check all that apply)

<input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Uterine tenderness	<input type="checkbox"/> Maternal tachycardia (>100 beats/min)
<input type="checkbox"/> None listed	<input type="checkbox"/> Foul smelling amniotic fluid	<input type="checkbox"/> Fetal tachycardia (>160 beats/min)
	<input type="checkbox"/> Urinary tract infection	<input type="checkbox"/> Intrapartum fever (≥ 100.4 F/38 C)
		<input type="checkbox"/> Maternal WBC >20 or 20,000

30. Maternal 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 (9)
month day year (4 digits) time

30a. Were any bacterial cultures performed on mother **during labor/end of pregnancy**? Yes (1) No (0)

30b. If cultures performed **during labor/end of pregnancy**, list the culture date(s) during labor, source(s), and result(s)?

Culture Date	Culture Source	Results
#1. ___/___/_____	<input type="checkbox"/> Blood <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Placental <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative _____ <input type="checkbox"/> Result unknown _____
#2. ___/___/_____	<input type="checkbox"/> Blood <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Placental <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative _____ <input type="checkbox"/> Result unknown _____

30c. If any sterile site cultures collected **during labor/end of pregnancy** were positive for H. Influenzae, list ABCs State ID assigned to maternal case. _____

31. Maternal post-partum fever (temperature ≥ 100.4 F/38 C)? Yes (1) No (0) Unknown (9)

31a. Were any bacterial cultures performed on mother **post-partum/post pregnancy loss**? Yes (1) No (0)

31b. If cultures performed **post-partum/post pregnancy loss**, list the culture date(s) source(s) and result(s).

Culture Date	Culture Source	Results
#1. ___/___/_____	<input type="checkbox"/> Blood <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Placental <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative _____ <input type="checkbox"/> Result unknown _____
#2. ___/___/_____	<input type="checkbox"/> Blood <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Placental <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Positive (specify organism) _____ <input type="checkbox"/> Negative _____ <input type="checkbox"/> Result unknown _____

31c. If any sterile site cultures collected **post-partum/post pregnancy loss** were positive for ~~PLA~~ ^{PLA} ~~^~~ [^] ~~;~~ [;] ~~æ~~ ^æ, list ABCs State ID assigned to maternal case. _____

31d. Were any ICD-9 or ICD-10 codes reported in the discharge diagnoses of the mother's chart?
 Yes (1) No (0) Unknown (9)

31e. If any ICD-9 or ICD-10 codes reported in the discharge diagnoses of the mother's chart: *(Check all that apply)*

ICD-9	ICD-10
<input type="checkbox"/> None of the listed ICD-9 codes found in chart	<input type="checkbox"/> None of the listed ICD-10 codes found in chart
<input type="checkbox"/> 995.91: Sepsis	<input type="checkbox"/> A41.3: Sepsis due to <i>H. influenzae</i>
<input type="checkbox"/> 038.41 Septicemia due to <i>H. influenzae</i>	<input type="checkbox"/> J14: Pneumonia due to <i>H. influenzae</i>
<input type="checkbox"/> 482.2: Pneumonia due to <i>H. influenzae</i>	<input type="checkbox"/> G00.0: Haemophilus meningitis
<input type="checkbox"/> 320.0: Haemophilus meningitis	<input type="checkbox"/> P02.7: Chorioamnionitis
<input type="checkbox"/> 762.7: Chorioamnionitis affecting fetus or newborn	<input type="checkbox"/> O85: Puerperal sepsis
<input type="checkbox"/> 670.22: Puerperal sepsis, delivered, w/ postpartum	<input type="checkbox"/> O75.3: Sepsis during labor
<input type="checkbox"/> 670.20: Puerperal sepsis, unspecified	<input type="checkbox"/> B96.3 <i>H. influenzae</i> as cause of disease classd elswhr
<input type="checkbox"/> 670.24: Puerperal sepsis, postpartum	<input type="checkbox"/> Other ICD-10 codes (specify) _____
<input type="checkbox"/> Other ICD-9 codes (specify) _____	

32. COMMENTS: _____

33. HiNSES Form Tracking Status Complete (1) Partial (2) Chart unavailable (3) Edited & corrected (4)