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

Infant's Name: _____ (Last, First, M.I.) Estimated Due Date: __ __ /__ __ /__ __ __ __ month / day / year (4 digits) Mother's Prenatal Care Provider: _____

Infant's Chart No.: _____ Clinic Name: _____

Mother's Name: _____ (Last, First, M.I.) Mother's Date of Birth: ____ /____ /_____ month / day / year (4 digits) Clinic Phone Number: _____

Mother's Chart No.: _____ Hospital Name: _____

- 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)
- ☐ 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

☐ Fetal Cases (any gestational age - specify isolate/outcome):
- ☐ 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: __ __ /__ __ /__ __ __ __ month day year (4 digits) Time: _____ (times in military format) ☐ Unknown (9)

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: __ __ /__ __ /__ __ __ __ month day year (4 digits) __ __ __ __ time ☐ Unknown (9)

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: __ __ /__ __ /__ __ __ __ month day year (4 digits) __ __ __ __ time ☐ Unknown (9)
   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: __ __ /__ __ /__ __ __ __ month / day / year (4 digits) __ __ __ __ time ☐ Unknown (9)
   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.	__ __ / __ __ / __ __ __ __	☐ Blood ☐ CSF ☐ Other (specify) _____	☐ Positive (specify organism) _____ ☐ Negative ☐ Result unknown
#2.	__ __ / __ __ / __ __ __ __	☐ Blood ☐ CSF ☐ Other (specify) _____	☐ Positive (specify organism) _____ ☐ Negative ☐ 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*)

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

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)*

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

Maternal Information

12. Maternal admission date & time: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (9) ☐ Not Applicable/ 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: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) Last visit: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) ☐ Unknown (9)

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

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

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)

- ☐ Unknown (9)
- ☐ Fetal distress
- ☐ Suspected chorioamnionitis
- ☐ Preclampsia/eclampsia/hypertension
- ☐ Maternal bleeding
- ☐ Gestational diabetes
- ☐ Severe fetal growth restriction
- ☐ Post-term pregnancy
- ☐ Other, specify _____

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

- ☐ Unknown (9)
- ☐ Vaginal
- ☐ Forceps
- ☐ Vaginal after previous C-section (VBAC)
- ☐ Vacuum
- ☐ Primary C-section
- ☐ 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)

☐ Unknown (9)
☐ Placenta previa/abruption
☐ Uterine rupture
☐ Breech position
☐ Cord prolapse
☐ Fetal distress
☐ Failure to progress
☐ Eclampsia/preclampsia/hypertension
☐ Diabetes
☐ Maternal infection
☐ 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) __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (9)

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*)

☐ Unknown (9)
☐ Intrapartum fever (≥ 100.4 F/38 C)
☐ Prolonged latency
☐ C-section prophylaxis
☐ GBS prophylaxis
☐ Suspected amnionitis/chorioamnionitis
☐ Mitral valve prolapse prophylaxis
☐ Other (specify) _____

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)

☐ Unknown (9)
☐ None listed
☐ Uterine tenderness
☐ Foul smelling amniotic fluid
☐ Urinary tract infection
☐ Maternal tachycardia (>100 beats/min)
☐ Fetal tachycardia (>160 beats/min)
☐ Intrapartum fever (≥ 100.4 F/38 C)
☐ 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: __ __ / __ __ / __ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (9)

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.	__ __ / __ __ / __ __ __ __	☐ Blood ☐ Vaginal ☐ Urine ☐ Cervical ☐ Placental ☐ Amniotic Fluid ☐ Other (specify) _____	☐ Positive (specify organism) ☐ Negative ☐ Result unknown	_____
#2.	__ __ / __ __ / __ __ __ __	☐ Blood ☐ Vaginal ☐ Urine ☐ Cervical ☐ Placental ☐ Amniotic Fluid ☐ Other (specify) _____	☐ Positive (specify organism) ☐ Negative ☐ 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.	__ __ / __ __ / __ __ __ __	☐ Blood ☐ Vaginal ☐ Urine ☐ Cervical ☐ Placental ☐ Amniotic Fluid ☐ Other (specify) _____	☐ Positive (specify organism) ☐ Negative ☐ Result unknown	_____
#2.	__ __ / __ __ / __ __ __ __	☐ Blood ☐ Vaginal ☐ Urine ☐ Cervical ☐ Placental ☐ Amniotic Fluid ☐ Other (specify) _____	☐ Positive (specify organism) ☐ Negative ☐ Result unknown	_____

31c. If any sterile site cultures collected **post-partum/post pregnancy loss** were positive for *H. influenzae*, 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
- ☐ None of the listed ICD-9 codes found in chart
- ☐ 995.91: Sepsis
- ☐ 038.41 Septicemia due to *H. influenzae*
- ☐ 482.2: Pneumonia due to *H. influenzae*
- ☐ 320.0: Haemophilus meningitis
- ☐ 762.7: Chorioamnionitis affecting fetus or newborn
- ☐ 670.22: Puerperal sepsis, delivered, w/ postpartum
- ☐ 670.20: Puerperal sepsis, unspecified
- ☐ 670.24: Puerperal sepsis, postpartum
- ☐ Other ICD-9 codes (specify)_____

ICD-10
- ☐ None of the listed ICD-10 codes found in chart
- ☐ A41.3: Sepsis due to *H. influenzae*
- ☐ J14: Pneumonia due to *H. influenzae*
- ☐ G00.0: Haemophilus meningitis
- ☐ P02.7: Chorioamnionitis
- ☐ O85: Puerperal sepsis
- ☐ O75.3: Sepsis during labor
- ☐ B96.3 *H. influenzae* as cause of disease classd elswhr
- ☐ Other ICD-10 codes (specify) _____

32. COMMENTS: _____

_____

_____

_____

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