

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

- Patient Identifier information is not transmitted to CDC -

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30333

2022 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: Mo. Day Year
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 PATIENT TREATED::
8. DATE OF BIRTH: Mo. Day Year
9a. AGE: 9b. Is age in day/mo/yr? 1 Days 2 Mos. 3 Yrs.
10. SEX: 1 Male 2 Female
11a. ETHNIC ORIGIN: 1 Hispanic or Latino 2 Not Hispanic or Latino 9 Unknown
11b. RACE: (Check all that apply) 1 White 1 Asian 1 Black 1 Native Hawaiian or Other Pacific Islander 1 Unknown 1 American Indian or Alaska Native

Table with 7 columns: T1 (Test Type), T2 (Date of Specimen Collection), T3 (Test Method), T3a (Hospital/Lab I.D.), T4 (Site from which organism isolated), T5 (Bacterial Species Isolated), T6 (Test Result). Rows 1-4.

T7 Isolate/Specimen Available? T8 If isolate/specimen N/A, why not? T9 Shipped to CDC? T10 If shipped, accession#
#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
T4 - Site 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=Vitreal 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
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 Not Needed

16. WAS PATIENT HOSPITALIZED? 1 Yes 2 No
If YES, date of admission: Mo. Day Year
Date of discharge: Mo. Day Year
17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 1 Yes 2 No 9 Unknown

18a. Where was the patient a resident at time of initial culture? 1 Private residence 4 Homeless 7 Non-medical ward 2 Long term care facility 5 Incarcerated 8 Other (specify): 3 Long term acute care facility 6 College dormitory 9 Unknown
18b. If resident of a facility, what was the name of the facility? Facility ID:
19a. Was patient transferred from another hospital? 1 Yes 2 No 9 Unknown
19b. If YES, hospital I.D.:

20a. WEIGHT: lbs oz OR kg OR Unknown
20b. HEIGHT: ft in OR cm OR Unknown
20c. BMI: OR Unknown
21. TYPE OF INSURANCE: (Check all that apply) 1 Private 1 Military 1 Other (specify) 1 Medicare 1 Indian Health Service (IHS) 1 Uninsured 1 Medicaid/state assistance program 1 Incarcerated 1 Unknown

22. OUTCOME: 1 Survived 2 Died 9 Unknown
22a. If survived, patient discharged to: 1 Home 2 LTC/SNF 3 LTACH 5 Left AMA 9 Unknown
23. If patient died, was the culture obtained on autopsy? 1 Yes 2 No 9 Unknown
If discharged to LTC/SNF or LTACH, list Facility ID: 4 Other, Specify:

24a. At time of first positive culture, patient was: 1 Pregnant 2 Postpartum 3 Neither 9 Unknown
24b. If pregnant or postpartum, what was the outcome of fetus? 1 Survived, no apparent illness 3 Live birth/neonatal death 2 Survived, clinical infection 5 Induced abortion 4 Abortion/stillbirth 9 Unknown 6 Still pregnant
24c. Mark if this is a GBS Blood Spot Study case that lives outside ABCs catchment area.

- IMPORTANT - PLEASE COMPLETE THE BACK OF THIS FORM -

Public reporting burden to collect this information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering/maintaining the data needed, and completing/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 Rd. MS D-74, Atlanta, GA, 30333, ATTN: PRA(0920-0978) Do not send the completed form to this address.

26. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply)

- | | | | | | | |
|---|---|--|--|---------------------------------------|---|---|
| <input type="checkbox"/> Abscess (not skin) | <input type="checkbox"/> Chorioamnionitis | <input type="checkbox"/> Empyema | <input type="checkbox"/> Necrotizing fasciitis | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Puerperal sepsis | <input type="checkbox"/> Septic shock |
| <input type="checkbox"/> Bacteremia without Focus | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Hemolytic uremic syndrome (HUS) | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Pericarditis | <input type="checkbox"/> Septic abortion | <input type="checkbox"/> STSS |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Epiglottitis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Otitis media | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Septic arthritis | <input type="checkbox"/> Other (specify): _____ |
| | <input type="checkbox"/> Endometritis | | | | | <input type="checkbox"/> Unknown |

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

SUBSTANCE USE, CURRENT

- 27b. SMOKING:** None Unknown Tobacco E-Nicotine Delivery System Marijuana **27c. ALCOHOL ABUSE:** Yes No Unknown

27d. OTHER SUBSTANCES: (check all that apply) None Unknown

- | | | |
|--|--|--|
| <input type="checkbox"/> Marijuana/cannabinoid (other than smoking) | <input type="checkbox"/> Documented Use Disorder (DUD)/Abuse | <input type="checkbox"/> Mode of delivery: (check all that apply) |
| <input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin) | <input type="checkbox"/> DUD or Abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Opioid, DEA schedule II - IV (e.g., methadone, oxycodone) | <input type="checkbox"/> DUD or Abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Opioid, NOS | <input type="checkbox"/> DUD or Abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> DUD or Abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> DUD or Abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other* (specify): _____ | <input type="checkbox"/> DUD or Abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Unknown substance | <input type="checkbox"/> DUD or Abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown |

- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISM -

HAEMOPHILUS INFLUENZAE

- 28a. What was the serotype?** b Not Typeable a c d e f Other (specify): _____ Not tested or Unknown

- 28b. If <15 years of age and serotype 'b' or 'unknown' did patient receive Haemophilus influenzae b vaccine?** Yes No Unknown
If YES, please complete the list below.

DOSE	DATE GIVEN	VACCINE NAME/MANUFACTURER	DOSE	DATE GIVEN	VACCINE NAME/MANUFACTURER
	Mo. Day Year			Mo. Day Year	
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"/>	_____

NEISSERIA MENINGITIDIS

- 29. What was the serogroup?**
 A B C Y W135
 Not Groupable Other: _____ Unknown

30. Is patient currently attending college?

- Yes No Unknown

STREPTOCOCCUS PNEUMONIAE

32. Did patient receive pneumococcal vaccine?

- Yes No Unknown
 If YES, please note which pneumococcal vaccine was received:
 (Check all that apply)

- Prevnar®, 7-valent Pneumococcal Conjugate Vaccine (PCV7)
 Prevnar-13®, 13-valent Pneumococcal Conjugate Vaccine (PCV13)
 Pneumovax®, 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)
 Vaccine type not specified

If between 2 months and < 5 years of age and an isolate is available for serotyping, please complete the IPD in Children expanded

31. Did patient receive meningococcal vaccine? Yes No Unknown If YES, complete the table

DOSE	TYPE	DATE GIVEN	VACCINE NAME/MANUFACTURER
		Mo. Day Year	
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"/>	_____

31b. If survived, did patient have any of the following sequelae evident upon discharge? (Check all that apply) None Unknown

- Hearing deficits Amputation (digit) Amputation (limb) Seizures Paralysis or spasticity Skin Scarring/necrosis Other (specify): _____

GROUP A STREPTOCOCCUS

(33-35 refer to the 14 days prior to first positive culture)

33. Did the patient have surgery or any skin incision?

- Yes No Unknown

If YES, date of surgery or skin incision:

Mo. Day Year

Unknown date

34. Did the patient deliver a baby

(vaginal or C-section)

- Yes No Unknown

If YES, date of delivery:

Mo. Day Year

Unknown date

35. Did patient have:

- Varicella Surgical wound (post operative)
 Penetrating trauma Burns
 Blunt trauma

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)

- 0-7 days 8-14 days Unknown days

Submitted By: _____

Phone No.: () _____

Date: ____/____/____

Physician's Name: _____

Phone No.: () _____

- 37. Was case first identified through audit?** Yes No Unknown

- 38. Does this case have recurrent disease with the same pathogen?** Yes No Unknown

If YES, previous (1st) state I.D.: _____

39. Initials of S.O. _____

36. COMMENTS: _____