

Patient's Name _____

Patient's Date of Birth ____/____/____

- Patient identifier information is not transmitted to CDC -

ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) INVASIVE PNEUMOCOCCAL DISEASE IN CHILDREN (aged ≥2 months to <5 years) AND ADULTS (aged ≥ 65 years)



OMB No. 0920-0978

StateID: _____ Date of positive culture ____/____/____ Date form completed ____/____/____

**What sources had
case vaccination
history available?**

Medical Chart _____

Primary Care Provider _____

Vaccine Registry _____

Other _____

Response Codes:

1 = Yes

2 = No

9 = Did not check

☐ Case has never received vaccines☐ Vaccination history unknown

VACCINES	Dose #	Dates of immunizations	Manufacturer	Vaccine name	Lot #
Pneumococcal conjugate vaccine	1				
	Dose #1 source: Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	2				
	Dose #2 source: Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	3				
	Dose #3 source: Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	4				
	Dose #4 source: Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	5				
	Dose #5 source: Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
Pneumococcal polysaccharide vaccine	6				
	Dose #6 source: Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	1				
	Dose #1 source: Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	2				
	Dose #2 source: Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				

****Only complete vaccination information on DTP or DTap and Hib vaccination for children aged ≥2 months to <5 years****

****For combination vaccines (e.g. Trihibit, Tetramune, ActHIB/DTwP) enter information for each vaccine component****

Diphtheria/Tetanus/ Pertussis (DTP or DTaP)	1	
	2	
	3	
	4	
	5	
Haemophilus influenzae type B (Hib)	1	
	2	
	3	
	4	

****Only complete healthcare provider source information for children aged ≥2 months to <5 years****

Health Care Provider Information

Was health care provider information available from the following sources?

Medical Chart: ☐ Yes ☐ No ☐ Did Not Check

Vaccine Registry: ☐ Yes ☐ No ☐ Did Not Check

Parent/Guardian: ☐ Yes ☐ No ☐ Did Not Check ☐ Refused

If yes to any sources,

How many providers were contacted? ____

Person completing the form (please print):

Name _____ Title _____ Phone: () _____ Fax: () _____

Please return form to: _____ Phone: () _____ Fax: () _____

Public reporting burden of this collection of information is estimated to average 10 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 30333, ATTN: PRA(0920-0978). Do not send the completed form to this address.

CDC52.15AREV.8-2018