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 ☐
	6				
	Dose #6 source:	Medical Chart ☐	Registry ☐	Primary Care Provider ☐	Other ☐
Pneumococcal polysaccharide vaccine	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: ( )_____