

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

- Patient Identifier information is not transmitted to CDC -

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

2023 ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT
A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM
-DARK SHADED AREAS FOR OFFICE USE ONLY-

Form Approved
0920-0978



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 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, 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, 9=Unknown
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: 27=Wound
T5 - Bacterial Species Isolated: 1=Neisseria meningitidis, 2=Haemophilus influenzae, 3=Group B Streptococcus, 5=Group A Streptococcus, 6=Streptococcus pneumoniae
* For other bacterial pathogens (i.e. non-ABCs), write in pathogen name
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, 2 Long term care facility, 3 Long term acute care facility, 4 Homeless, 5 Incarcerated, 6 College dormitory, 7 Non-medical ward, 8 Other (specify):, 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 Medicare, 1 Medicaid/state assistance program, 1 Military, 1 Indian Health Service (IHS), 1 Incarcerated, 1 Other (specify):, 1 Uninsured, 1 Unknown

22. OUTCOME: 1 Survived 2 Died 9 Unknown
23. If patient died, was the culture obtained on autopsy? 1 Yes 2 No 9 Unknown
22a. If survived, patient discharged to: 1 Home 2 LTC/SNF 3 LTACH 5 Left AMA 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, 2 Survived, clinical infection, 4 Abortion/stillbirth, 6 Still pregnant, 3 Live birth/neonatal death, 5 Induced abortion, 9 Unknown
25. If patient <1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only. Gestational age: (wks) Birth weight: (gms)

- 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
(check all that apply)

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 | 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"/> Opioid, DEA schedule II - IV (e.g., methadone, oxycodone) | <input type="checkbox"/> DUD or Abuse | <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"/> Cocaine | <input type="checkbox"/> DUD or Abuse | <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"/> Other* (specify): _____ | <input type="checkbox"/> DUD or Abuse | <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

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

Type Codes:	DOSE	TYPE	DATE GIVEN			VACCINE NAME/MANUFACTURER	DOSE	TYPE	DATE GIVEN			VACCINE NAME/MANUFACTURER
			Mo.	Day	Year				Mo.	Day	Year	
1= ACWY conjugate (Menactra, Menveo, MenHibrix, MenQuadfi)	1	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	4	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
2= ACWY polysaccharide (Menomune)	2	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	5	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
3= B (Bexsero, Trumenba)	3	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	6	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
9= Unknown												

- 32. 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: _____

- 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. _____

Phone No.: () _____

36. COMMENTS: _____