

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

2024 ACTIVE BACTERIAL CORE SURVEILLANCE (ABCS) CASE REPORT
A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM

Form Approved
0920-0978



- DARK 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: (Patient Residence)
6a. PLANNING REGION: (Patient Residence)

7a. HOSPITAL/LAB I.D. WHERE PATIENT TREATED:
8. DATE OF BIRTH: Mo. Day Year
9a. AGE: Mo. Day Year
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 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
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"/> 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 | <b>Mode of delivery:</b> (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:** \_\_\_\_\_