

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

2025 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: 5. CRF Status: 11. RACE and/or ETHNICITY: (Check all that apply)

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). Includes rows for specimen collection dates and test results.

T7 Isolate/Specimen Available? T8 If isolate/specimen N/A, why not? T9 Shipped to CDC? T10 If shipped, accession# #T1 - Test Type T3 - Test Method (if non-culture) T4 - Site T5 - Bacterial Species Isolated T8 - No isolate, why not

16. WAS PATIENT HOSPITALIZED? If YES, date of admission: Date of discharge: 17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?

18a. Where was the patient a resident at time of initial culture? 18b. If resident of a facility, what was the name of the facility? 19a. Was patient transferred from another hospital? 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)

22. OUTCOME: 1 Survived 2 Died 9 Unknown 23. If patient died, was the culture obtained on autopsy? 22a. If survived, patient discharged to: 1 Home 2 LTC/SNF 3 LTACH 5 Left AMA 9 Unknown

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? 25. If patient <1 month of age, indicate gestational age and birth weight.

- 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"/> Any complement inhibitor - N.men. only (specify): _____ | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Atherosclerotic CVD (ASCVD)/CAD | <input type="checkbox"/> Deaf/Profound Hearing Loss | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Plegias/Paralysis |
| <input type="checkbox"/> Bone Marrow Transplant (BMT) | <input type="checkbox"/> Dementia | <input type="checkbox"/> Multiple Myeloma | <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 Sclerosis | <input type="checkbox"/> Seizure/Seizure Disorder |
| <input type="checkbox"/> Chronic Hepatitis C | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Heart Failure/CHF | <input type="checkbox"/> Nephrotic Syndrome | <input type="checkbox"/> Solid Organ Malignancy |
| <input type="checkbox"/> Chronic Liver Disease/cirrhosis | <input type="checkbox"/> HIV Infection | <input type="checkbox"/> Neuromuscular Disorder | <input type="checkbox"/> Solid Organ Transplant |
| <input type="checkbox"/> Current Chronic Dialysis | <input type="checkbox"/> Hodgkin's Disease/Lymphoma | <input type="checkbox"/> Obesity | <input type="checkbox"/> Splenectomy/Asplenia |
| <input type="checkbox"/> Chronic Skin Breakdown | <input type="checkbox"/> Immunoglobulin Deficiency | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Cochlear Implant | | <input type="checkbox"/> Peptic Ulcer Disease | |
| <input type="checkbox"/> Complement Deficiency | | | |

SUBSTANCE USE, CURRENT

- 27b. SMOKING:** None documented Tobacco E-Nicotine delivery system Marijuana Unknown
- 27c. ALCOHOL ABUSE:** Yes None documented Unknown

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

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