

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)



StateID: _____ Date of positive culture ___ / ___ / _____ Date form completed ___ / ___ / _____ OMB No. 0920-0978

What sources had case vaccination history available? Medical Chart 1 Yes 2 No 9 Did not check Primary Care Provider 1 Yes 2 No 9 Did not check
 Vaccine Registry 1 Yes 2 No 9 Did not check Other 1 Yes 2 No 9 Did not check

1 Case has never received vaccines

2 Vaccination history unknown

Pneumococcal Vaccines for All Ages

Vaccines	Dose #	Dates of immunizations	Manufacturer	Vaccine name	Lot #	Dose Source
Pneumococcal conjugate vaccine	1	___ / ___ / ___ Month Day Year <input type="checkbox"/> Unknown date	<input type="checkbox"/> Merck <input type="checkbox"/> Wyeth/Pfizer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Prevnar™ (PCV7) <input type="checkbox"/> Prevnar 13™ (PCV13) <input type="checkbox"/> Vaxneuvance™ (PCV15) <input type="checkbox"/> Prevnar 20™ (PCV20) <input type="checkbox"/> CAPVAXIVE™ (PCV21) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> Medical Chart <input type="checkbox"/> Registry <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other
	2	___ / ___ / ___ Month Day Year <input type="checkbox"/> Unknown date	<input type="checkbox"/> Merck <input type="checkbox"/> Wyeth/Pfizer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Prevnar™ (PCV7) <input type="checkbox"/> Prevnar 13™ (PCV13) <input type="checkbox"/> Vaxneuvance™ (PCV15) <input type="checkbox"/> Prevnar 20™ (PCV20) <input type="checkbox"/> CAPVAXIVE™ (PCV21) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> Medical Chart <input type="checkbox"/> Registry <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other
	3	___ / ___ / ___ Month Day Year <input type="checkbox"/> Unknown date	<input type="checkbox"/> Merck <input type="checkbox"/> Wyeth/Pfizer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Prevnar™ (PCV7) <input type="checkbox"/> Prevnar 13™ (PCV13) <input type="checkbox"/> Vaxneuvance™ (PCV15) <input type="checkbox"/> Prevnar 20™ (PCV20) <input type="checkbox"/> CAPVAXIVE™ (PCV21) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> Medical Chart <input type="checkbox"/> Registry <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other
	4	___ / ___ / ___ Month Day Year <input type="checkbox"/> Unknown date	<input type="checkbox"/> Merck <input type="checkbox"/> Wyeth/Pfizer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Prevnar™ (PCV7) <input type="checkbox"/> Prevnar 13™ (PCV13) <input type="checkbox"/> Vaxneuvance™ (PCV15) <input type="checkbox"/> Prevnar 20™ (PCV20) <input type="checkbox"/> CAPVAXIVE™ (PCV21) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> Medical Chart <input type="checkbox"/> Registry <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other
	5	___ / ___ / ___ Month Day Year <input type="checkbox"/> Unknown date	<input type="checkbox"/> Merck <input type="checkbox"/> Wyeth/Pfizer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Prevnar™ (PCV7) <input type="checkbox"/> Prevnar 13™ (PCV13) <input type="checkbox"/> Vaxneuvance™ (PCV15) <input type="checkbox"/> Prevnar 20™ (PCV20) <input type="checkbox"/> CAPVAXIVE™ (PCV21) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> Medical Chart <input type="checkbox"/> Registry <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other
	6	___ / ___ / ___ Month Day Year <input type="checkbox"/> Unknown date	<input type="checkbox"/> Merck <input type="checkbox"/> Wyeth/Pfizer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Prevnar™ (PCV7) <input type="checkbox"/> Prevnar 13™ (PCV13) <input type="checkbox"/> Vaxneuvance™ (PCV15) <input type="checkbox"/> Prevnar 20™ (PCV20) <input type="checkbox"/> CAPVAXIVE™ (PCV21) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> Medical Chart <input type="checkbox"/> Registry <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other
Pneumococcal polysaccharide vaccine	1	___ / ___ / ___ Month Day Year <input type="checkbox"/> Unknown date	<input type="checkbox"/> Merck <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Pneumovax™ 23 (PPSV23/PPV23) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> Medical Chart <input type="checkbox"/> Registry <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other
	2	___ / ___ / ___ Month Day Year <input type="checkbox"/> Unknown date	<input type="checkbox"/> Merck <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Pneumovax™ 23 (PPSV23/PPV23) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> Medical Chart <input type="checkbox"/> Registry <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other

- IMPORTANT - PLEASE COMPLETE THE BACK OF THIS FORM -

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.

Additional Vaccines for All Ages

Vaccines	Dose #	Dates of immunizations	Vaccines	Dose #	Dates of immunizations
Influenza vaccine	Most recent	___/___/___ <input type="checkbox"/> Unknown date Month Day Year	COVID-19 vaccine	Most recent	___/___/___ <input type="checkbox"/> Unknown date Month Day Year

Additional Vaccines and Related Agents for Certain Age Groups

Complete for **adults aged ≥65 years** only:

Vaccines	Dose #	Dates of immunizations
RSV vaccine RSVpreF (ABRYOVO™, mRESVIA, or AREXVY)	1	___/___/___ <input type="checkbox"/> Unknown date Month Day Year

Complete for **children ≥2 months to <5 years** only:

Vaccines and related agents	Dose #	Dates of immunizations
RSV monoclonal antibody nirsevimab (Beyfortus™)	1	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
	2	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
Diphtheria/Tetanus/ Pertussis (DTP or DTaP)*	1	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
	2	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
	3	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
	4	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
	5	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
<i>Haemophilus influenzae</i> type B (Hib)*	1	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
	2	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
	3	___/___/___ <input type="checkbox"/> Unknown date Month Day Year
	4	___/___/___ <input type="checkbox"/> Unknown date Month Day Year

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

Person completing the form (please print):

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

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