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 ☐ Unknown date	☐ Merck ☐ Wyeth/Pfizer ☐ Other _____ ☐ Unknown	☐ Prevnar™ (PCV7) ☐ Prevnar 13™ (PCV13) ☐ Vaxneuvance™ (PCV15) ☐ Prevnar 20™ (PCV20) ☐ CAPVAXIVE™ (PCV21) ☐ Other _____ ☐ Unknown		☐ Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other
	2	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date	☐ Merck ☐ Wyeth/Pfizer ☐ Other _____ ☐ Unknown	☐ Prevnar™ (PCV7) ☐ Prevnar 13™ (PCV13) ☐ Vaxneuvance™ (PCV15) ☐ Prevnar 20™ (PCV20) ☐ CAPVAXIVE™ (PCV21) ☐ Other _____ ☐ Unknown		☐ Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other
	3	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date	☐ Merck ☐ Wyeth/Pfizer ☐ Other _____ ☐ Unknown	☐ Prevnar™ (PCV7) ☐ Prevnar 13™ (PCV13) ☐ Vaxneuvance™ (PCV15) ☐ Prevnar 20™ (PCV20) ☐ CAPVAXIVE™ (PCV21) ☐ Other _____ ☐ Unknown		☐ Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other
	4	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date	☐ Merck ☐ Wyeth/Pfizer ☐ Other _____ ☐ Unknown	☐ Prevnar™ (PCV7) ☐ Prevnar 13™ (PCV13) ☐ Vaxneuvance™ (PCV15) ☐ Prevnar 20™ (PCV20) ☐ CAPVAXIVE™ (PCV21) ☐ Other _____ ☐ Unknown		☐ Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other
	5	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date	☐ Merck ☐ Wyeth/Pfizer ☐ Other _____ ☐ Unknown	☐ Prevnar™ (PCV7) ☐ Prevnar 13™ (PCV13) ☐ Vaxneuvance™ (PCV15) ☐ Prevnar 20™ (PCV20) ☐ CAPVAXIVE™ (PCV21) ☐ Other _____ ☐ Unknown		☐ Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other
	6	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date	☐ Merck ☐ Wyeth/Pfizer ☐ Other _____ ☐ Unknown	☐ Prevnar™ (PCV7) ☐ Prevnar 13™ (PCV13) ☐ Vaxneuvance™ (PCV15) ☐ Prevnar 20™ (PCV20) ☐ CAPVAXIVE™ (PCV21) ☐ Other _____ ☐ Unknown		☐ Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other
Pneumococcal polysaccharide vaccine	1	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date	☐ Merck ☐ Other _____ ☐ Unknown	☐ Pneumovax™ 23 (PPSV23/PPV23) ☐ Other _____ ☐ Unknown		☐ Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other
	2	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date	☐ Merck ☐ Other _____ ☐ Unknown	☐ Pneumovax™ 23 (PPSV23/PPV23) ☐ Other _____ ☐ Unknown		☐ Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other

- IMPORTANT – PLEASE COMPELETE THE BACK OF THIS FORM -

Additional Vaccines for All Ages					
Vaccines	Dose #	Dates of immunizations	Vaccines	Dose #	Dates of immunizations
Influenza vaccine	Most recent	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date	COVID-19 vaccine	Most recent	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date

Additional Vaccines and Related Agents for Certain Age Groups

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

Vaccines	Dose #	Dates of immunizations
RSV vaccine RSVpreF (ABRYSVO™, mRESVIA, or AREXVY)	1	__ __ / __ __ / __ __ __ __ Month Day Year ☐ Unknown date

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

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

*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: ( ) _____