* Patient identifier information is NOT transmitted to CDC

NEONATAL INFECTION EXPANDED TRACKING FORM

*Infant's Name: _____ (Last, First, M.I.)

*Infant's Chart No.: _____

*Mother's Name: _____ (Last, First, M.I.)

*Mother's Chart No.: _____

*Mother's Date of Birth: __ __ /__ __ /__ __ __ __ (month day year (4 digits))

*Hospital Name: _____

ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)
NEONATAL INFECTION EXPANDED TRACKING FORM

Form Approved
0920-0978

STATEID __ __ __ __ __ __ __ **HOSPITAL ID (of birth; if home birth leave blank)** __ __ __ __ __

Infant Information **Were labor & delivery records available?** ☐ Yes (1) ☐ No (0)

Date & time of positive culture: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (times in military format)

1. Date of Birth: __ __ /__ __ /__ __ __ __ (month day year (4 digits))
   Time of birth: __ __ __ __ (time) ☐ Unknown (1)

2. Did this birth occur outside of the hospital?
   ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
   IF YES, please check one: ☐ Home Birth (1) ☐ Birthing Center (2) ☐ En route to hospital (3) ☐ Other (4) ☐ Unknown (9)

3a. Gestational age of infant at birth in completed weeks:
__ __ (do not round up)

3b. Date of maternal last menstrual period (LMP): ☐ Unknown (1)
__ __ /__ __ /__ __ __ __ (month day year (4 digits))

3c. Gestational age determined by:
☐ Dates (1) ☐ Physical Exam (2) ☐ Ultrasound (3) ☐ Assisted Reproductive Technology (4) ☐ Unknown (9)

4. Birth weight:
___ lbs ___oz **OR** __ __ __ __ grams

5. Date & time of newborn discharge from hospital of birth:
__ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

6. Was patient admitted to the ICU during hospitalization?
☐ Yes (1) ☐ No (0) ☐ Unknown (9)

IF YES,
Date & time of admission: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)
Date & time of discharge: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

******Questions 7-10b should only be completed for early- and late-onset GBS cases******

7. Was the infant discharged to home and readmitted to the birth hospital? ☐ Yes (1) ☐ No (0)
IF YES, date & time of readmission: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

8. Was the infant admitted to a different hospital from home? ☐ Yes (1) ☐ No (0)
IF YES, hospital ID: ___ ___ ___ ___ ___
AND date & time of admission: __ __ /__ __ /__ __ __ __ (month day year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

9a. Were ***any*** ICD-10 codes reported in the discharge diagnosis of the infant's chart? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

9b. **IF YES,** were any of the following ICD-10 codes reported in the discharge diagnosis of the chart? (Check all that apply)

- ☐ A40.1: Sepsis due to streptococcus, group B (1)
- ☐ A40.8: Other Streptococcal sepsis (1)
- ☐ A40.9: Streptococcus sepsis, unspecified (1)
- ☐ A49.1: Streptococcal infection, unspecified site (1)
- ☐ P36: Bacterial sepsis of newborn (1)
- ☐ P36.0: Sepsis of newborn due to streptococcus, group B (1)
- ☐ P36.1: Sepsis of newborn to other unspecified streptococci (1)
- ☐ P36.9: Bacterial sepsis of newborn, unspecified (1)
- ☐ B95.1: Streptococcus, group b as the cause of disease classified elsewhere (1)
- ☐ B95.5: Unspecified streptococcus as the cause of disease classified elsewhere (1)
- ☐ G00.2: Streptococcal meningitis (1)

10. Did the baby receive breast milk from the mother? (***for late-onset GBS cases only***): ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
IF YES, did the baby receive breast milk before onset of GBS ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

10a. Did the infant receive antibiotics anytime during the birth hospitalization? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
10b. **IF YES**, was it a beta-lactam? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

Maternal Information

11. Maternal admission date & time: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

12. Maternal age at delivery (years): __ __ years | 12a. Number of prior pregnancies __ __ ☐ Unknown (9)

13. Maternal blood type: ☐ Unknown (9) ☐ A (1) ☐ B (2) ☐ AB (3) ☐ O (4)

14. Did mother have a prior history of penicillin allergy? ☐ Yes (1) ☐ No (0)
IF YES, was a previous maternal history of anaphylaxis noted? ☐ Yes (1) ☐ No (0)

14a. MATERNAL UNDERLYING OR PRIOR ILLNESSES: *(Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box)* 1 ☐ None 1 ☐ Unknown

1 ☐ AIDS or CD4 count <200
1 ☐ Asthma
1 ☐ Atherosclerotic CVD (ASCVD)/CAD
1 ☐ Bone Marrow Transplant (BMT)
1 ☐ CVA/Stroke/TIA
1 ☐ Chronic Hepatitis C
1 ☐ Chronic Kidney Disease
1 ☐ Chronic Liver Disease/cirrhosis
1 ☐ Current Chronic Dialysis
1 ☐ Chronic Skin Breakdown
1 ☐ Complement Deficiency
1 ☐ Connective Tissue Disease (Lupus, etc.)
1 ☐ CSF Leak
1 ☐ Dementia
1 ☐ Diabetes Mellitus, HbA1C _____(%), Date ___/___/_____
1 ☐ Emphysema/COPD
1 ☐ Heart Failure/CHF
1 ☐ HIV Infection
1 ☐ Hodgkin's Disease/Lymphoma
1 ☐ Immunoglobulin Deficiency
1 ☐ Immunosuppressive Therapy (Steroids, etc.)
1 ☐ Leukemia
1 ☐ Multiple Myeloma
1 ☐ Multiple Sclerosis
1 ☐ Myocardial Infarction
1 ☐ Nephrotic Syndrome
1 ☐ Neuromuscular Disorder
1 ☐ Obesity
1 ☐ Parkinson's Disease
1 ☐ Peptic Ulcer Disease
1 ☐ Peripheral Neuropathy
1 ☐ Peripheral Vascular Disease
1 ☐ Plegias/Paralysis
1 ☐ Seizure/Seizure Disorder
1 ☐ Sickle Cell Anemia
1 ☐ Solid Organ Malignancy
1 ☐ Solid Organ Transplant
1 ☐ Splenectomy/Asplenia

15. Date & time of membrane rupture: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

16. Was duration of membrane rupture ≥18 hours? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

17. If membranes ruptured at <37 weeks, did membranes rupture before onset of labor? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

18. Type of rupture: ☐ Spontaneous (1) ☐ Artificial (2) ☐ Unknown (9)

19. Type of delivery: *(Check all that apply)*
☐ Vaginal (1) ☐ Vaginal after previous C-section (1) ☐ Primary C-section (1) ☐ Repeat C-section (1)
☐ Forceps (1) ☐ Vacuum (1) ☐ Unknown (1)

If delivery was by C-section:
Did labor begin before C-section? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
Did membrane rupture happen before C-section? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

20. Intrapartum fever (T ≥ 100.4 F or 38.0 C): ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
IF YES, 1st recorded T ≥ 100.4 F or 38.0 C at: __ __ / __ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (1)

21. Were antibiotics given to the mother intrapartum? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

IF YES, answer 21a-b and Questions 22-23

a) Date & time antibiotics 1st administered: (before delivery) __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time) ☐ Unknown (9)

b) Antibiotic 1: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____
Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 2: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____
Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 3: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____
Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 4: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____
Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 5: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____
Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

Antibiotic 6: _____ ☐ IV (1) ☐ IM (2) ☐ PO (3) # doses given before delivery: _____
Start date: __ __ /__ __ /__ __ __ __ Stop date (if applicable): __ __ /__ __ /__ __ __ __

22. Interval between receipt of 1st antibiotic and delivery: ___ ___ ___ (hours) ___ ___ (minutes) ___ ___ (days)*
**Day variable should only be completed if the number of hours >24*

23. What was the reason for administration of intrapartum antibiotics? (*Check all that apply*)
☐ GBS prophylaxis (1) ☐ Prolonged latency (1) ☐ Mitral valve prolapse prophylaxis (1)
☐ Suspected amnionitis/ chorioamnionitis (1) ☐ C-section prophylaxis (1) ☐ Other (1)
☐ Unknown (1)

24. Did mother have chorioamnionitis or suspected chorioamnionitis? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

******Questions 25–33 should only be completed for early- and late-onset GBS cases******

25. Did mother receive prenatal care? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

26. Please record the following: the total number of prenatal visits AND the first and last visit dates to the prenatal as recorded in the labor and delivery chart
No. of visits: __ __ First visit: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) Last visit: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) ☐ Unknown (1)

27. Estimated gestational age (EGA) at last documented prenatal visit: ___ ___ . ___ ___ (weeks)

28. GBS bacteriuria during this pregnancy? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
IF YES, what order of magnitude was the colony count?
☐ 0 (1) ☐ <10,000 (2) ☐ 10k–<25,000 (3) ☐ 25k–<50,000 (4) ☐ 50k–<75,000 (5) ☐ 75k–<100,000 (6)
☐ ≥100,0000 (7) ☐ Unknown (9)

29. Previous infant with invasive GBS disease? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

30. Previous pregnancy with GBS colonization? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

31a. Was maternal group B strep colonization screened for BEFORE admission (in prenatal care)?
☐ Yes (1) ☐ No (0) ☐ Unknown (9)

IF YES, list dates, test type, and test results below:

Test date (list most recent first):	Test type:	Test Result (Do not include urine here!)
1. __ __ /__ __ /__ __ __ __	☐ Culture (1) ☐ PCR (2) ☐ Rapid antigen (3) ☐ Other (4) ☐ Unknown (9)	☐ Positive (1) ☐ Negative (0) ☐ Unknown (9)
2. __ __ /__ __ /__ __ __ __	☐ Culture (1) ☐ PCR (2) ☐ Rapid antigen (3) ☐ Other (4) ☐ Unknown (9)	☐ Positive (1) ☐ Negative (0) ☐ Unknown (9)

31b. If the *most recent* test was GBS positive was antimicrobial susceptibility performed BEFORE admission (in prenatal care)?
☐ Yes (1) ☐ No (0) ☐ Unknown (9)
IF YES, Was the isolate resistant to clindamycin? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)
Was the isolate resistant to erythromycin? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

32a. Was maternal group B strep colonization screened for AFTER admission (before delivery)? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

IF YES, list date of *most recent* test, test type and test results below:

Test date (list most recent first):	Test type:	Test Result (Do not include urine here!)
__ __ /__ __ /__ __ __ __	☐ Culture (1) ☐ PCR (2) ☐ Rapid antigen (3) ☐ Other (4) ☐ Unknown (9)	☐ Positive (1) ☐ Negative (0) ☐ Unknown (9)

32b. If the *most recent* test was GBS positive, was antimicrobial susceptibility performed AFTER admission?

☐ Yes (1) ☐ No (0) ☐ Unknown (9)

IF YES, Was the isolate resistant to clindamycin? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

Was the isolate resistant to erythromycin? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

33. Were GBS test results available to care givers at the time of delivery? ☐ Yes (1) ☐ No (0) ☐ Unknown (9)

34. COMMENTS: _____

_____

_____

_____

_____

35. Neonatal Infection Expanded Form Tracking Status:

☐ Complete (1) ☐ Incomplete (2) ☐ Edited & corrected (3) ☐ Chart unavailable after 3 requests (4)