

Patient's Name: (Last, First, M.I.) Address: (Number, Street, Apt. No.) (City, State) (Zip Code) Hospital: Phone No. Patient Chart No.:

- Patient identifier information is not transmitted to CDC -

DEPARTMENT OF HEALTH & HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION ATLANTA, GA 30333

ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT



A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK

- SHADED AREAS FOR OFFICE USE ONLY -

OMB No. 0920-0009

1. STATE: (Residence of Patient) 2. COUNTY: (Residence of Patient) 3. STATE I.D.: 4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: 4b. HOSPITAL I.D. WHERE PATIENT TREATED: 5. WAS PATIENT HOSPITALIZED? If YES, date of admission: Date of discharge: 6a. Was patient transferred from another hospital? 6b. If YES, hospital I.D. 7a. Was patient a resident of a nursing home or other chronic care facility at the time of first positive culture? 7b. If yes, name 8. DATE OF BIRTH: 9a. AGE: 9b. Is age in day/mo/yr? 10. SEX: 11a. ETHNIC ORIGIN: 11b. RACE: (Check all that apply) 12a. WEIGHT: 12b. HEIGHT: 13. TYPE OF INSURANCE: (check all that apply) 14. OUTCOME: 15a. At time of first positive culture, patient was: 15b. If pregnant or post-partum, what was the outcome of fetus: 16. If patient <1 month of age: Gestational age: Birthweight: 17. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply) 18a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: 18b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: (specify) 19. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply) 20. DATE FIRST POSITIVE CULTURE OBTAINED: (Date Specimen Drawn) 21. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)

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 of 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 (0920-0009). Do not send the completed form to this address.

22. UNDERLYING CAUSES OR PRIOR ILLNESS: (Check all that apply) (If none or chart unavailable, check appropriate box) 1 None 1 Unknown

1 <input type="checkbox"/> Current Smoker	1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Cirrhosis/Liver Failure	1 <input type="checkbox"/> Cochlear Implant
1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Alcohol Abuse	1 <input type="checkbox"/> Deaf/Profound Hearing Loss
1 <input type="checkbox"/> Sickle Cell Anemia	1 <input type="checkbox"/> Systemic Lupus Erythematosus (SLE)	1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	1 <input type="checkbox"/> Other Malignancy (specify) _____
1 <input type="checkbox"/> Splenectomy/Asplenia	1 <input type="checkbox"/> Diabetes Mellitus	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Organ Transplant (specify) _____
1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Other Prior Illness (specify) _____
1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)	1 <input type="checkbox"/> Renal Failure/Dialysis	1 <input type="checkbox"/> CSF Leak	
1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> IVDU	
1 <input type="checkbox"/> Hodgkin's Disease	1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> Cerebral Vascular Accident (CVA) / Stroke	
		1 <input type="checkbox"/> Complement Deficiency	

- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISMS:

<p>HAEMOPHILUS INFLUENZAE</p> <p>DOSE</p> <table border="1"> <tr> <th>Mo.</th> <th>Day</th> <th>Year</th> </tr> <tr> <td>1</td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> </tr> </table>	Mo.	Day	Year	1			2			3			4			<p>23a. If <15 years of age and serotype 'b' or 'unk' did patient receive Haemophilus influenzae b vaccine? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk</p> <p>If YES, please complete the list below.</p> <p>VACCINE NAME</p> <p>MANUFACTURER</p> <p>LOT NUMBER</p>	<p>23b. Were records obtained to verify vaccination history? (<5 years of age only)</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>If yes, what was the source of the information? (check all that apply)</p> <p>1 <input type="checkbox"/> Vaccine Registry</p> <p>1 <input type="checkbox"/> Healthcare Provider</p> <p>1 <input type="checkbox"/> Other (specify) _____</p>
	Mo.	Day	Year														
	1																
	2																
	3																
4																	

24. What was the serotype?

1 b 2 Not Typeable 3 a 4 c 5 d 6 e 7 f 8 Other (specify) _____ 9 Not Tested or Unk

<p>NEISSERIA MENINGITIDIS</p> <p>25. What was the serogroup?</p> <p>1 <input type="checkbox"/> A 3 <input type="checkbox"/> C 5 <input type="checkbox"/> W135 9 <input type="checkbox"/> Unk</p> <p>2 <input type="checkbox"/> B 4 <input type="checkbox"/> Y 6 <input type="checkbox"/> Not groupable 8 <input type="checkbox"/> Other (specify) _____</p>	<p>26. Is patient currently attending college? (15 - 24 years only)</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk</p>
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<p>27. Did patient receive meningococcal vaccine?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk</p> <p>If YES, please complete the following information:</p> <p>VACCINE NAME/MANUFACTURER</p> <p>DATE GIVEN</p> <p>LOT NUMBER</p> <p>List most recent date for each vaccine</p> <table border="1"> <tr> <th>Mo.</th> <th>Day</th> <th>Year</th> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Mo.	Day	Year												
Mo.	Day	Year													

<p>STREPTOCOCCUS PNEUMONIAE</p> <p>28. If <15 years of age did patient receive pneumococcal conjugate vaccine?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk</p> <p>If YES, please complete the following information:</p> <p>DOSE</p> <table border="1"> <tr> <th>Mo.</th> <th>Day</th> <th>Year</th> </tr> <tr> <td>1</td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> </tr> </table> <p>VACCINE NAME/MANUFACTURER</p> <p>LOT NUMBER</p>	Mo.	Day	Year	1			2			3			4		
Mo.	Day	Year													
1															
2															
3															
4															

<p>GROUP A STREPTOCOCCUS (#29-31 refer to the 7 days prior to first positive culture)</p> <p>29. Did the patient have surgery? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk</p> <p>If YES, date of surgery: Mo. Day Year</p>	<p>30. Did the patient deliver a baby (vaginal or C-section)?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk</p> <p>If YES, date of delivery: Mo. Day Year</p>	<p>31. Did patient have:</p> <p>1 <input type="checkbox"/> Varicella 1 <input type="checkbox"/> Surgical wound (post operative)</p> <p>1 <input type="checkbox"/> Penetrating trauma 1 <input type="checkbox"/> Burns</p> <p>1 <input type="checkbox"/> Blunt trauma</p>
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32. COMMENTS: _____

- SURVEILLANCE OFFICE USE ONLY -

<p>33. Was case first identified through audit?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> Unk</p>	<p>34. CRF Status:</p> <p>1 <input type="checkbox"/> Complete</p> <p>2 <input type="checkbox"/> Incomplete</p> <p>3 <input type="checkbox"/> Edited & Correct</p> <p>4 <input type="checkbox"/> Chart unavailable after 3 requests</p>	<p>35. Does this case have recurrent disease with the same pathogen?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> Unk</p> <p>If YES, previous (1st) state I.D. _____</p>	<p>36. Date reported to EIP site</p> <p>Mo. Day Year</p>	<p>37. Initials of S.O.</p> <p>_____</p>
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Submitted By: _____ Phone No.:() _____ Date: ____/____/____

Physician's Name: _____ Phone No.:() _____