NEONATAL GROUP B STREPTOCOCCAL DISEASE PREVENTION TRACKING FORM

Infant's Name: ____ Infant's Chart No.: ____________________
(Last, First, M.I.)

Mother's Name: ____ Mother's Chart No.: ____________________
(Last, First, M.I.)

Hospital Name: ____ Culture date: ________________________

***Patient identifier information is NOT transmitted to CDC ***

1/2003

NEONATAL GROUP B STREPTOCOCCAL DISEASE PREVENTION TRACKING FORM

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

Infant Information

1. Date of Birth: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits))
Time of birth: ___ ___ ___ ___ (times in military format)

2. Did this birth occur outside of the hospital? ☐ yes ☐ no ☐ unknown
! **IF YES**, please check one:
☐Home Birth ☐ Birthing Center ☐En route to hospital
☐Other ☐ Unknown

3. Gestational age in completed weeks: __ __ (do not round up)

4. Birthweight: ___ lbs ___oz **OR** __ __ __ __ grams

5. Date & time of newborn discharge after birth: __ __ /__ __ /__ __ __ __ (month / day / year (4 digits)) __ __ __ __ (time)

6. Outcome: ☐ survived ☐ died ☐ unknown

7. Readmitted to the same hospital: ☐ yes ☐ no

! **IF YES, date & time of readmission: __ __ /__ __ /__ __ __ __** (month / day / year (4 digits)) __ __ __ __ (time)

8. Admitted from home to different hospital: ☐ yes ☐ no

! **IF YES, hospital id:** ___ ___ ___ ___ ___ **AND date & time admission: __ __ /__ __ / __ __ __ __** (month / day / year (4 digits)) __ __ __ __ (time)

9. Infant discharge diagnosis:
ICD9-1 ____________________ ICD9-2 ____________________ ICD9-3 ____________________

10. Did the baby receive breast milk from the mother? ☐ yes ☐ no ☐ unknown

! **IF YES,** did the baby receive breast milk before onset of GBS infection (eg, date of first positive neonatal culture): ☐ yes ☐ no ☐ unknown

Maternal Information

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

Maternal age at delivery (years): __ __ years Maternal blood type: ☐ A ☐ B ☐ AB ☐ O

12. Did mother have a prior history of penicillin allergy? ☐ yes ☐ no ☐ unknown

!IF YES, was a previous maternal history of anaphylaxis noted? ☐ yes ☐ no ☐ unknown

13. Date & time membrane rupture: __ __ / __ __ / __ __ __ __ (month / day / year(4 digits)) __ __ __ __ (time) ☐ unknown

14. Was duration of membrane rupture $\geq$ 18 hours? ☐ yes ☐ no ☐ unknown

15. **If membranes ruptured at <37 weeks**, did membranes rupture before onset of labor? ☐ yes ☐ no ☐ unknown

16. Type of rupture: ☐ spontaneous ☐ artificial ☐ unknown

Maternal Information (continued)

17. Type of delivery: ☐ vaginal ☐ vaginal after previous C-section ☐ primary C-section ☐ repeat C-section

☐ forceps ☐ vacuum ☐ unknown

If delivery was by C-section: Did labor or contractions begin before C-section? ☐ yes ☐ no ☐ unknown

Did membrane rupture happen before C-section? ☐ yes ☐ no ☐ unknown

18. Intrapartum fever (T ≥ 100.4 F or 38.0 C): ☐ yes ☐ no ☐ unknown

! IF YES, 1st recorded T ≥ 100.4 or 38.0 C at: __ __ / __ __ / __ __ __ __ __ __ __ __
month day year (4 digits) time

19. Did mother receive prenatal care? ☐ yes ☐ no ☐ unknown

20. Was prenatal record (even partial information) in labor and delivery chart? ☐ yes ☐ no ☐ unknown

!IF YES: No. of visits:__ __ First visit:__ __ /__ __ /__ __ __ __ Last visit:__ __ /__ __ /__ __ __ __
month day year (4digits) month day year (4digits)

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

22. GBS bacteriuria during this pregnancy? ☐yes ☐ no ☐ unknown

!If yes, what order of magnitude was the colony count?
☐0 ☐<10,000 ☐10k-<25,000 ☐25k-<50,000 ☐50k-<75,000 ☐75k-<100,000 ☐≥ 100,0000 ☐ unknown

23. Previous infant with invasive GBS disease? ☐ yes ☐ no ☐ unknown

24. Previous pregnancy with GBS colonization? ☐ yes ☐ no ☐ unknown

25a. Was maternal group B strep colonization screened for BEFORE admission (in prenatal care)? ☐ yes ☐ no ☐ unknown

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

Test date (list most recent first):	Test type:	Positive culture (Do not include urine here!)
1. __ __ /__ __ /__ __ __ __	☐ culture ☐ rapid pcr ☐ rapid antigen ☐ other ☐ unknown	☐ yes ☐ no ☐ unknown
2. __ __ /__ __ /__ __ __ __	☐ culture ☐ rapid pcr ☐ rapid antigen ☐ other ☐ unknown	☐ yes ☐ no ☐ unknown

25b. If the *most recent* test was GBS positive, was antimicrobial susceptibility performed? ☐ yes ☐ no ☐ unknown

!IF YES, Was the isolate resistant to clindamycin? ☐ yes ☐ no ☐ unknown

Was the isolate resistant to erythromycin? ☐ yes ☐ no ☐ unknown

26a. Was maternal group B strep colonization screened for AFTER admission (before delivery)? ☐ yes ☐ no ☐ unknown

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

Test date (list most recent first):	Test type:	Positive culture (Do not include urine here!)
__ __ /__ __ /__ __ __ __	☐ culture ☐ rapid pcr ☐ rapid antigen ☐ other ☐ unknown	☐ yes ☐ no ☐ unknown

Maternal Information (continued)

26b. If the *most recent* test was GBS positive, was antimicrobial susceptibility performed? □ yes □ no □ unknown

!**IF YES,** Was the isolate resistant to clindamycin? □ yes □ no □ unknown

Was the isolate resistant to erythromycin? □ yes □ no □ unknown

27. Were GBS test results available to care givers at the time of delivery? □ yes □ no □ unknown

Intrapartum Antibiotics

28. Were antibiotics given to the mother intrapartum? □ yes □ no □ unknown

! **IF YES, answer a-b and Question 28-30**

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

b) Antibiotic 1:______________________________ □ IV□ IM □ PO # doses given before delivery: ______

Start date:__ __ /__ __ /__ __ __ __ Stop date (if applicable): :__ __ /__ __ /__ __ __ __

Antibiotic 2:______________________________ □ IV□ IM □ PO # doses given before delivery: ______

Start date:__ __ /__ __ /__ __ __ __ Stop date (if applicable): :__ __ /__ __ /__ __ __ __

Antibiotic 3:______________________________ □ IV□ IM □ PO # doses given before delivery: ______

Start date:__ __ /__ __ /__ __ __ __ Stop date (if applicable): :__ __ /__ __ /__ __ __ __

Antibiotic 4:______________________________ □ IV□ IM □ PO # doses given before delivery: ______

Start date:__ __ /__ __ /__ __ __ __ Stop date (if applicable): :__ __ /__ __ /__ __ __ __

Antibiotic 5:______________________________ □ IV□ IM □ PO # doses given before delivery: ______

Start date:__ __ /__ __ /__ __ __ __ Stop date (if applicable): :__ __ /__ __ /__ __ __ __

Antibiotic 6:______________________________ □ IV□ IM □ PO # doses given before delivery: ______

Start date:__ __ /__ __ /__ __ __ __ Stop date (if applicable): :__ __ /__ __ /__ __ __ __

29. Interval between receipt of 1st antibiotic and delivery: ___ ___ ___ (hours) ___ ___ (minutes)

30. What was the reason for administration of intrapartum antibiotics?

□ GBS prophylaxis □ C-section prophylaxis □ Mitral valve prolapse prophylaxis

□ Suspected amnionitis □ Other □ Unknown