

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

- 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 -

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)

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:

HAEMOPHILUS INFLUENZAE

23a. If <15 years of age and serotype 'b' or 'unk' did patient receive *Haemophilus influenzae* b vaccine? 1 Yes 2 No 9 Unk
If YES, please complete the list below.

DOSE	DATE GIVEN			VACCINE NAME	MANUFACTURER	LOT NUMBER
	Mo.	Day	Year			
1	<input type="text"/>	<input type="text"/>	<input type="text"/>			
2	<input type="text"/>	<input type="text"/>	<input type="text"/>			
3	<input type="text"/>	<input type="text"/>	<input type="text"/>			
4	<input type="text"/>	<input type="text"/>	<input type="text"/>			

23b. Were records obtained to verify vaccination history? (<5 years of age only)

1 Yes 2 No

If yes, what was the source of the information? (check all that apply)

1 Vaccine Registry

1 Healthcare Provider

1 Other (specify) _____

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

NEISSERIA MENINGITIDIS

25. What was the serogroup?

1 A 3 C 5 W135 9 Unk
2 B 4 Y 6 Not groupable 8 Other (specify) _____

26. Is patient currently attending college? (15 - 24 years only)

1 Yes 2 No 9 Unk

27. Did patient receive meningococcal vaccine?

VACCINE NAME/MANUFACTURER

DATE GIVEN

LOT NUMBER

1 Yes 2 No 9 Unk

If YES, please complete the following information:

Menomune, tetravalent meningococcal polysaccharide vaccine

Menactra, tetravalent meningococcal conjugate vaccine

Other (specify) _____

Not Known

List most recent date for each vaccine

DATE GIVEN		
Mo.	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

STREPTOCOCCUS PNEUMONIAE

28. If <15 years of age did patient receive pneumococcal conjugate vaccine?

1 Yes 2 No 9 Unk

If YES, please complete the following information:

DOSE	DATE GIVEN			VACCINE NAME/MANUFACTURER	LOT NUMBER
	Mo.	Day	Year		
1	<input type="text"/>	<input type="text"/>	<input type="text"/>		
2	<input type="text"/>	<input type="text"/>	<input type="text"/>		
3	<input type="text"/>	<input type="text"/>	<input type="text"/>		
4	<input type="text"/>	<input type="text"/>	<input type="text"/>		

GROUP A STREPTOCOCCUS

(#29-31 refer to the 7 days prior to first positive culture)

29. Did the patient have surgery? 1 Yes 2 No 9 Unk

If YES, date of surgery: Mo. Day Year

30. Did the patient deliver a baby (vaginal or C-section)?

1 Yes 2 No 9 Unk

If YES, date of delivery: Mo. Day Year

31. Did patient have:

- | | |
|---|--|
| 1 <input type="checkbox"/> Varicella | 1 <input type="checkbox"/> Surgical wound (post operative) |
| 1 <input type="checkbox"/> Penetrating trauma | 1 <input type="checkbox"/> Burns |
| 1 <input type="checkbox"/> Blunt trauma | |

32. COMMENTS: _____

- SURVEILLANCE OFFICE USE ONLY -

33. Was case first identified through audit?

1 Yes 2 No
9 Unk

34. CRF Status:

- 1 Complete
2 Incomplete
3 Edited & Correct
4 Chart unavailable after 3 requests

35. Does this case have recurrent disease with the same pathogen?

1 Yes 2 No
9 Unk

If YES, previous (1st) state I.D.

36. Date reported to EIP site

Mo. Day Year

37. Initials of S.O.

Submitted By: _____ Phone No.:() _____ Date: ____/____/____

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