– ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT –

Patient's Name: _____ (Last, First, MI.) Phone No.:( ) _____

Address: _____ (Number, Street, Apt. No.) Patient Chart No.: _____

_____ (City, State) _____ (Zip Code) Hospital: _____

– Patient identifier information is not transmitted to CDC –

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30329

2015 Active Bacterial Core Surveillance (ABCs) Case Report

A Core Component of the Emerging Infections Program Network

OMB No. 0920-0978

– SHADED AREAS FOR OFFICE USE ONLY –

1. STATE: *(Residence of Patient)* ☐☐

2. STATE I.D.: ☐☐☐☐☐☐☐

3. DATE FIRST POSITIVE CULTURE COLLECTED *(Date Specimen Collected)* Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

4. Date reported to EIP site: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

5. CRF Status: 1 ☐ Complete 3 ☐ Edited & Correct 2 ☐ Incomplete 4 ☐ Chart unavailable after 3 requests

6. COUNTY: *(Residence of Patient)* _____

7a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: ☐☐☐☐☐

7b. HOSPITAL I.D. WHERE PATIENT TREATED: ☐☐☐☐☐☐

8. DATE OF BRTH: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

9a. AGE: ☐☐☐

9b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

10. SEX: 1 ☐ Male 2 ☐ Female

11a. ETHNIC ORIGIN: 1 ☐ Hispanic or Latino 2 ☐ Not Hispanic or Latino 9 ☐ Unknown

11b. RACE: *(Check all that apply)* 1 ☐ White 1 ☐ Black 1 ☐ American Indian or Alaska Native 1 ☐ Asian 1 ☐ Native Hawaiian or Other Pacific Islander 1 ☐ Unknown

12a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:
1 ☐ *Neisseria meningitidis* 3 ☐ Group B *Streptococcus* 5 ☐ Group A *Streptococcus*
2 ☐ *Haemophilus influenzae* 4 ☐ *Listeria monocytogenes* 6 ☐ *Streptococcus pneumoniae*

12b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: *(specify)* _____

13. STERILE SITES FROM WHICH ORGANISM ISOLATED: *(Check all that apply)*
1 ☐ Blood 1 ☐ Peritoneal fluid 1 ☐ Bone 1 ☐ Joint
1 ☐ CSF 1 ☐ Pericardial fluid 1 ☐ Muscle/Fascia/Tendon 1 ☐ Pleural fluid
1 ☐ Other normally sterile site (specify)_____ 1 ☐ Internal body site *(specify)*_____

14. OTHER SITES FROM WHICH ORGANISM ISOLATED: *(Check all that apply)*
1 ☐ Placenta 1 ☐ Wound 1 ☐ Sinus
1 ☐ Amniotic fluid 1 ☐ Middle ear

INFLUENZA 15. Did this patient have a positive flu test 10 days prior to or following any ABCs positive culture? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

16. WAS PATIENT HOSPITALIZED? 1 ☐ Yes 2 ☐ No
If YES, date of admission: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐
Date of discharge: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

18a. Where was the patient a resident at time of initial culture?
1 ☐ Private residence 4 ☐ Homeless 7 ☐ Non-medical ward
2 ☐ Long term care facility 5 ☐ Incarcerated 8 ☐ Other *(specify)* _____
3 ☐ Long term acute care facility 6 ☐ College dormitory 9 ☐ Unknown

18b. If resident of a facility, what was the name of the facility? _____

19a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

19b. If YES, hospital I.D.: ☐☐☐☐☐

20a. WEIGHT: _____lbs_____ oz OR _____ kg OR ☐ Unknown

20b. HEIGHT: _____ft _____ in OR _____ cm OR ☐ Unknown

20c. BMI: ___ ___ . ___ OR ☐ Unknown

21. TYPE OF INSURANCE: *(Check all that apply)*
1 ☐ Private 1 ☐ Medicare 1 ☐ Medicaid/state assistance program 1 ☐ Military 1 ☐ Indian Health Service (IHS) 1 ☐ Incarcerated 1 ☐ Other *(specify)* _____ 1 ☐ Uninsured 1 ☐ Unknown

22. OUTCOME: 1 ☐ Survived 2 ☐ Died 9 ☐ Unknown

23. If patient died, was the culture obtained on autopsy? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

24a. At time of first positive culture, patient was:
1 ☐ Pregnant 3 ☐ Neither
2 ☐ Postpartum 9 ☐ Unknown

24b. If pregnant or postpartum, what was the outcome of fetus:
1 ☐ Survived, no apparent illness 4 ☐ Abortion/stillbirth 9 ☐ Unknown
2 ☐ Survived, clinical infection 5 ☐ Induced abortion
3 ☐ Live birth/neonatal death 6 ☐ Still pregnant

25. If patient <1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only.
Gestational age: ☐☐ *(wks)* Birth weight: ☐☐☐☐ *(gms)*

26. TYPES OF INFECTION CAUSED BY ORGANISM: *(Check all that apply)*
1 ☐ Bacteremia without Focus 1 ☐ Meningitis 1 ☐ Otitis media 1 ☐ Pneumonia 1 ☐ Cellulitis 1 ☐ Epiglottitis 1 ☐ Hemolytic uremic syndrome (HUS) 1 ☐ Abscess (not skin) 1 ☐ Peritonitis 1 ☐ Pericarditis 1 ☐ Septic abortion 1 ☐ Chorioamnionitis 1 ☐ Septic arthritis 1 ☐ Osteomyelitis 1 ☐ Empyema 1 ☐ Endocarditis 1 ☐ Endometritis 1 ☐ STSS 1 ☐ Necrotizing fasciitis 1 ☐ Puerperal sepsis 1 ☐ Septic shock 1 ☐ Other *(specify)* _____ 1 ☐ Unknown

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

27. UNDERLYING CAUSES 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 ☐ Alcohol Abuse, Current
1 ☐ Alcohol Abuse, Past
1 ☐ Asthma
1 ☐ Atherosclerotic Cardiovascular Disease (ASCVD)/CAD
1 ☐ Bone Marrow Transplant (BMT)
1 ☐ Cerebral Vascular Accident (CVA)/Stroke
1 ☐ Chronic Kidney Disease
1 ☐ Current Chronic Dialysis
1 ☐ Chronic Skin Breakdown
1 ☐ Cirrhosis/Liver Failure
1 ☐ Cochlear Implant
1 ☐ Complement Deficiency
1 ☐ CSF Leak
1 ☐ Current Smoker
1 ☐ Deaf/Profound Hearing Loss
1 ☐ Dementia
1 ☐ Diabetes Mellitus
1 ☐ Emphysema/COPD
1 ☐ Heart Failure/CHF
1 ☐ HIV Infection
1 ☐ Hodgkin's Disease/Lymphoma
1 ☐ Immunoglobulin Deficiency
1 ☐ Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)
1 ☐ IVDU, Current
1 ☐ IVDU, Past
1 ☐ Leukemia
1 ☐ Multiple Myeloma
1 ☐ Multiple Sclerosis
1 ☐ Nephrotic Syndrome
1 ☐ Neuromuscular Disorder
1 ☐ Obesity
1 ☐ Parkinson's Disease
1 ☐ Other Drug Use, Current
1 ☐ Other Drug Use, Past
1 ☐ Peripheral Neuropathy
1 ☐ Plegias/Paralysis
1 ☐ Premature Birth (specify gestational age at birth) ☐☐ *(wks)*
1 ☐ Seizure/Seizure Disorder
1 ☐ Sickle Cell Anemia
1 ☐ Solid Organ Malignancy
1 ☐ Solid Organ Transplant
1 ☐ Splenectomy/Asplenia
1 ☐ Systemic Lupus Erythematosus (SLE)
1 ☐ Other prior illness *(specify)* _____

– IMPORTANT – PLEASE COMPLETE FOR THE RELEVANT ORGANISM –

HAEMOPHILUS INFLUENZAE

28a. 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 Unknown

28b. If <15 years of age and serotype 'b' or 'unknown' did patient receive *Haemophilus influenzae* b vaccine? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If YES, please complete the list below.

DOSE	DATE GIVEN (Mo. / Day / Year)	VACCINE NAME	MANUFACTURER	LOT NUMBER
1				
2				
3				
4				

28c. Were records obtained to verify vaccination history? *(<5 years of age with Hib/unknown serotype, 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)* _____

NEISSERIA MENINGITIDIS

29. What was the serogroup? 1 ☐ A 3 ☐ C 5 ☐ W135 9 ☐ Unknown 2 ☐ B 4 ☐ Y 6 ☐ Not groupable 8 ☐ Other _____

30. Is patient currently attending college? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

31. Did patient receive meningococcal vaccine? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If YES, please complete the following information:

DOSE	DATE GIVEN (Mo. / Day / Year)	VACCINE NAME	MANUFACTURER	LOT NUMBER
1				
2				
3				

STREPTOCOCCUS PNEUMONIAE

32. Did patient receive pneumococcal vaccine?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, please note which pneumococcal vaccine was received:
(Check all that apply)
1 ☐ Prevnar®, 7-valent Pneumococcal Conjugate Vaccine (PCV7)
1 ☐ Prevnar-13®, 13-valent Pneumococcal Conjugate Vaccine (PCV13)
1 ☐ Pneumovax®, 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)
1 ☐ Vaccine type not specified

If between less than or equal to 2 months and greater than 5 years of age and an isolate is available for serotyping, please complete the Invasive Pneumoccoccal disease in Children expanded form.

GROUP A STREPTOCOCCUS *(#33–35 refer to the 14 days prior to first positive culture)*

33. Did the patient have surgery or any skin incision? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, date of surgery or skin incision: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

34. Did the patient deliver a baby *(vaginal or C-section)*?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, date of delivery: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

35. Did patient have:
1 ☐ Varicella
1 ☐ Penetrating trauma
1 ☐ Blunt trauma
1 ☐ Surgical wound *(post operative)*
1 ☐ Burns

If YES to any of the above, record the number of days prior to the first positive culture
(if > 1, use the most recent skin injury)
1 ☐ 0-7 days 2 ☐ 8-14 days

36. COMMENTS: _____

– SURVEILLANCE OFFICE USE ONLY –

37. Was case first identified through audit? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

38. Does this case have recurrent disease with the same pathogen? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If YES, previous (1st) state I.D.: ☐☐☐☐☐☐☐

39. Initials of S.O.: _____

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

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