– 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 30333

# 2016 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 BIRTH:** 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*
2 ☐ *Haemophilus influenzae*
3 ☐ Group B *Streptococcus*
4 ☐ *Listeria monocytogenes*
5 ☐ Group A *Streptococcus*
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 ☐ CSF
1 ☐ Peritoneal fluid
1 ☐ Pericardial fluid
1 ☐ Bone
1 ☐ Muscle/Fascia/Tendon
1 ☐ Joint
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 ☐ Amniotic fluid
1 ☐ Wound
1 ☐ Middle ear
1 ☐ Sinus

**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
2 ☐ Long term care facility
3 ☐ Long term acute care facility
4 ☐ Homeless
5 ☐ Incarcerated
6 ☐ College dormitory
7 ☐ Non-medical ward
8 ☐ Other *(specify)* _____
9 ☐ Unknown

**18b. If resident of a facility, what was the name of the facility?** _____
**Facility ID:** _____

**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

**22a. If survived, patient discharged to:** 1 ☐ Home 2 ☐ LTC/SNF 3 ☐ LTACH 4 ☐ Other _____ 9 ☐ Unknown

**If discharged to LTC/SNF or LTACH, what is the Facility ID** _____

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

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

**24c. ☐ Mark if this is a HiNSES fetal death with placenta and/or amniotic fluid isolate, a stillbirth, or neonate <22 wks gestation.**

**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/TIA
1☐ Chronic Kidney Disease
1☐ Chronic Liver Disease/cirrhosis
1☐ Current Chronic Dialysis
1☐ Chronic Skin Breakdown
1☐ Cochlear Implant
1☐ Complement Deficiency
1☐ Connective Tissue Disease (Lupus, etc.)
1☐ CSF Leak
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☐ Myocardial Infarction
1☐ Nephrotic Syndrome
1☐ Neuromuscular Disorder
1☐ Obesity
1☐ Other Drug Use, Current
1☐ Other Drug Use, Past
1☐ Parkinson's Disease
1☐ Peptic Ulcer Disease
1☐ Peripheral Neuropathy
1☐ Peripheral Vascular Disease
1☐ Plegias/Paralysis
1☐ Premature Birth (specify gestational age at birth) ☐☐(wks)
1☐ Seizure/Seizure Disorder
1☐ Sickle Cell Anemia
1☐ Smoker (current)
1☐ Solid Organ Malignancy
1☐ Solid Organ Transplant
1☐ Splenectomy/Asplenia
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 2☐ B 3☐ C 4☐ Y 5☐ W135 6☐ Not Groupable 8☐ Other _____ 9☐ Unknown

**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, complete the table**

| DOSE | TYPE | DATE GIVEN Mo. | Day | Year | NAME | MANUFACTURER | LOT NUMBER |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |

Type Codes: 1= ACWY conjugate (Menactra, Menveo, MenHibrix) 2= ACWY polysaccharide (Menomune) 3= B (Bexsero, Trumenba) 9= Unknown

**STREPTOCOCCUS PNEUMONIAE**

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 ≥2 months and < 5 years of age and an isolate is available for serotyping, please complete the Invasive Pneumococcal Disease in Children expanded form.**

**31b. If survived, did patient have any of the following sequelae evident upon discharge?** (check all that apply) 1☐ None 1☐ Unknown

1☐ Hearing deficits 1☐ Amputation (digit) 1☐ Amputation (limb) 1☐ Seizures 1☐ Paralysis or spasticity 1☐ Skin Scarring/necrosis 1☐ Other *(specify)* _____

**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:** _____



**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. S.O. Initials** _____

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

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