– 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

# 2019 ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

## A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM

Form Approved
0920-0978

– SHADED AREAS FOR OFFICE USE ONLY –

**1. STATE:** *(Patient Residence)* ☐☐

**2. STATE I.D.:** ☐☐☐☐☐☐☐

**3. PATIENT I.D.:** _____

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

**5. CRF Status:**
1 ☐ Complete 2 ☐ Incomplete 3 ☐ Edited & Correct
4 ☐ Chart unavailable after 3 requests 7 ☐ QA Review Change

**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

| | T1 Test Type | T2 Date of Specimen Collection | T3 Test Method (non-culture) | T4 Site from which organism isolated | T5 Bacterial Species Isolated* | T6 Test Result | T7 Isolate/Specimen Available? | T8 If isolate/specimen not available, |
|---|---|---|---|---|---|---|---|---|
| 1 | | ☐☐ ☐☐ ☐☐☐☐ | | | | | | |
| 2 | | ☐☐ ☐☐ ☐☐☐☐ | | | | | | |
| 3 | | ☐☐ ☐☐ ☐☐☐☐ | | | | | | |
| 4 | | ☐☐ ☐☐ ☐☐☐☐ | | | | | | |

* For other bacterial pathogens (i.e. non-ABCs), write-in pathogen name

**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

**22a. If survived, patient discharged to:** 1 ☐ Home 2 ☐ LTC/SNF 3 ☐ LTACH 5 ☐ Left AMA 9 ☐ Unknown

**If discharged to LTC/SNF or LTACH, list Facility ID** _____ 4 ☐ Other, Specify _____

**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 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 death
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☐ Asthma
1☐ Atherosclerotic CVD (ASCVD)/CAD
1☐ Bone Marrow Transplant (BMT)
1☐ CVA/Stroke/TIA
1☐ Chronic Hepatitis C
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☐ HbA1C _____(%), Date ___/___/_____
1☐ Emphysema/COPD
1☐ Heart Failure/CHF
1☐ HIV Infection
1☐ Hodgkin's Disease/Lymphoma
1☐ Immunoglobulin Deficiency
1☐ Immunosuppressive Therapy (Steroids, etc.)
1☐ Eculizumab (Soliris)- N.men. only
1☐ Leukemia
1☐ Multiple Myeloma
1☐ Multiple Sclerosis
1☐ Myocardial Infarction
1☐ Nephrotic Syndrome
1☐ Neuromuscular Disorder
1☐ Obesity
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☐ Solid Organ Malignancy
1☐ Solid Organ Transplant
1☐ Splenectomy/Asplenia
1☐ Other prior illness (specify): _____

## SUBSTANCE USE, CURRENT

**27b. SMOKING:** *(check all that apply)* 1☐ None 1☐ Unknown 1☐ Tobacco 1☐ E-Nicotine Delivery System 1☐ Marijuana

**27c. ALCOHOL ABUSE:** 1☐ Yes 0☐ No 9☐ Unknown

**27d. OTHER SUBSTANCES:** *(check all that apply)* 1☐ None 1☐ Unknown

| | Documented Use Disorder (DUD)/Abuse? | Mode of delivery: *(check all that apply)* |
|---|---|---|
| 1☐ Marijuana/cannibinoid (other than smoking) | 1☐ DUD or Abuse | 1☐ IDU 1☐ Skin popping 1☐ non-IDU 1☐ Unknown |
| 1☐ Opioid, DEA schedule I (e.g., heroin) | 1☐ DUD or Abuse | 1☐ IDU 1☐ Skin popping 1☐ non-IDU 1☐ Unknown |
| 1☐ Opioid, DEA schedule II - IV (e.g., methadone, oxycodone) | 1☐ DUD or Abuse | 1☐ IDU 1☐ Skin popping 1☐ non-IDU 1☐ Unknown |
| 1☐ Cocaine or methamphetamine | 1☐ DUD or Abuse | 1☐ IDU 1☐ Skin popping 1☐ non-IDU 1☐ Unknown |
| 1☐ Other* (specify): _____ | 1☐ DUD or Abuse | 1☐ IDU 1☐ Skin popping 1☐ non-IDU 1☐ Unknown |
| 1☐ Unknown substance | 1☐ DUD or Abuse | 1☐ IDU 1☐ Skin popping 1☐ non-IDU 1☐ Unknown |

*Includes hallucinogens (LSD, mushrooms, etc.), club drugs (MDMA, GHB, etc.), dissociative drugs (ketamine, etc.), inhalants

## – 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 influenza* b vaccine?** 1☐ Yes 2☐ No 9☐ Unknown
**If YES, please complete the list below.**

| DOSE | DATE GIVEN Mo. | Day | Year | VACCINE NAME / MANUFACTURER |
|---|---|---|---|---|
| 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☐ Medical Chart
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**

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

| DOSE | TYPE | DATE GIVEN Mo. | Day | Year | VACCINE NAME / MANUFACTURER |
|---|---|---|---|---|---|
| 1 | | ☐☐ | ☐☐ | ☐☐☐☐ | |
| 2 | | ☐☐ | ☐☐ | ☐☐☐☐ | |
| 3 | | ☐☐ | ☐☐ | ☐☐☐☐ | |
| 4 | | ☐☐ | ☐☐ | ☐☐☐☐ | |

### 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 2 months and <5 years of age and an isolate is available for serotyping, please complete the IPD 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 ☐☐☐☐
9☐ Unknown date

**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 ☐☐☐☐
9☐ Unknown date

**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 9☐ Unknown 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. Initials of S.O.:** _____

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

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

## VALUE SETS for LAB REPEATING GROUP

**T1 - Test Type**
1=PCR
2=Culture
3=Antigen
7=Other
9=unknown

**T3 - Test Method (if non-culture)**
1=Biofire Filmarray Meningitis/Encephalitis Panel
2=other
3=Biofire Filmarray Blood Culture ID (BCID) Panel
4=Verigene Gram + Blood Culture (BCT) Test
5=Bruker MALDI Biotyper CA System
6=BD Directigen Meningitis Combo Test Kit
7=ThermoFisher Wellcogen Bacterial Antigen Rapid
8=Alere BinaxNOW Antigen Card
9=Unknown

**T4 - Site**

**Sterile Sites**
1=Blood
2=Bone
3=Brain
4=CSF
5=Heart
6=Joint
7=Kidney
8=Other Sterile Site
9=unknown
10=Liver
11=Lung
12=Lymph node
13=Muscle/Fascia/Tendon
14=Ovary
15=Pancreas
16=Pericardial Fluid
17=Peritoneal Fluid
18=Pleural fluid
19=Spleen
20=Vascular Tissue
21=Vitreous fluid

**Non-Sterile Sites**
22=Amniotic fluid
23=Middle ear
24=Placenta
25=Sinus
26=Sputum
27=Wound

**T5 - Bacterial Species Isolated***
1=*Neisseria meningitidis*
2=*Haemophilus influenzae*
3=Group B Streptococcus
5=Group A Streptococcus
6=*Streptococcus pneumoniae*

**T6 -Test Result**
1=Positive
0=Negative

**T7 - Isolate Available**
1=Yes
2=N0

**T8 - No Isolate, why not**
1=N/A at Hospital Lab
2=N/A at State Lab
3=Hospital refuses
4=Isolate Discrepancy (2x)
5=No DNA (non-viable)

* For other bacterial pathogens (i.e. non-ABCs) write-in pathogen name