

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

- 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)
4. Date reported to EIP site:
5. CRF Status:
6. COUNTY: (Residence of Patient)
7a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED:
7b. HOSPITAL I.D. WHERE PATIENT TREATED:
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. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:
12b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: (specify)
13. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)
14. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)
INFLUENZA 15. Did this patient have a positive flu test 10 days prior to or following any ABCs positive culture?
16. WAS PATIENT HOSPITALIZED? If YES, date of admission: Date of discharge:
17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?
18a. Where was the patient a resident at time of initial culture?
18b. If resident of a facility, what was the name of the facility?
19a. Was patient transferred from another hospital?
19b. If YES, hospital I.D.:
20a. WEIGHT:
20b. HEIGHT:
20c. BMI:
21. TYPE OF INSURANCE: (Check all that apply)
22. OUTCOME:
22a. If survived, patient discharged to:
23. If patient died, was the culture obtained on autopsy?
23a. At time of first positive culture, patient was:
23b. If pregnant or postpartum, what was the outcome of fetus?
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.
26. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply)

27. UNDERLYING CAUSES OR PRIOR ILLNESSES: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) 1 None 1 Unknown

1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> Complement Deficiency	1 <input type="checkbox"/> IVDU, Current	1 <input type="checkbox"/> Peptic Ulcer Disease
1 <input type="checkbox"/> Alcohol Abuse, Current	1 <input type="checkbox"/> Connective Tissue Disease (Lupus, etc.)	1 <input type="checkbox"/> IVDU, Past	1 <input type="checkbox"/> Peripheral Neuropathy
1 <input type="checkbox"/> Alcohol Abuse, Past	1 <input type="checkbox"/> CSF Leak	1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> Peripheral Vascular Disease
1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Deaf/Profound Hearing Loss	1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Plegias/Paralysis
1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> Multiple Sclerosis	1 <input type="checkbox"/> Premature Birth (specify gestational age at birth) <input type="text"/> (wks)
1 <input type="checkbox"/> Bone Marrow Transplant (BMT)	1 <input type="checkbox"/> Diabetes Mellitus	1 <input type="checkbox"/> Myocardial Infarction	1 <input type="checkbox"/> Seizure/Seizure Disorder
1 <input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke/TIA	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Sickle Cell Anemia
1 <input type="checkbox"/> Chronic Kidney Disease	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Neuromuscular Disorder	1 <input type="checkbox"/> Smoker (current)
1 <input type="checkbox"/> Chronic Liver Disease/cirrhosis	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Solid Organ Malignancy
1 <input type="checkbox"/> Current Chronic Dialysis	1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma	1 <input type="checkbox"/> Other Drug Use, Current	1 <input type="checkbox"/> Solid Organ Transplant
1 <input type="checkbox"/> Chronic Skin Breakdown	1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Other Drug Use, Past	1 <input type="checkbox"/> Splenectomy/Asplenia
1 <input type="checkbox"/> Cochlear Implant	1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)	1 <input type="checkbox"/> Parkinson's Disease	1 <input type="checkbox"/> 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? If YES, please complete the list below.

DOSE	Mo.	Day	Year	VACCINE NAME	MANUFACTURER	LOT NUMBER
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"/>			

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	Mo.	Day	Year	NAME	MANUFACTURER	LOT NUMBER
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"/>			
5		<input type="text"/>	<input type="text"/>	<input type="text"/>			
6		<input type="text"/>	<input type="text"/>	<input type="text"/>			

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 Surgical wound (post operative)

1 Penetrating trauma 1 Burns

1 Blunt trauma 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: _____

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30329, ATTN: PRA(0920-0978). **Do not send the completed form to this address.**

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.: () _____