– 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

# 2013 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. 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 2 ☐ Incomplete 3 ☐ Edited & Correct 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 ☐ 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?** _____

**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 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

**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 Renal Insufficiency
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 ☐ Renal Failure/Dialysis
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 *(specify)* _____

**30. Is patient currently attending college?** *(15 – 24 years only)*
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 PolysaccharideVaccine (PPV23)
1 ☐ Vaccine type not specified

**If between ≥3 months and<18 years of age and an isolate is available for serotyping, please complete the Invasive Pneumococcal 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 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. : (  ) _____