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

Address: _____ (Number, Street, Apt. No., City, State) _____ (Zip Code) Hospital: _____ Patient Chart No.: _____

– Patient identifier information is not transmitted to CDC –

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

– SHADED AREAS FOR OFFICE USE ONLY –

OMB No. 0920-0009

1. STATE: (Residence of Patient) ☐☐

2. COUNTY: (Residence of Patient) _____

3. STATE I.D.: ☐☐☐☐☐☐☐

4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: ☐☐☐☐☐

4b. HOSPITAL I.D. WHERE PATIENT TREATED: ☐☐☐☐☐

5. WAS PATIENT HOSPITALIZED? 1 ☐ Yes 2 ☐ No

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

Date of discharge: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

6a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unk

6b. If YES, hospital I.D. ☐☐☐☐☐

7. Was patient admitted from a nursing home or other chronic care facility? 1 ☐ Yes 2 ☐ No 9 ☐ Unk

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

9a. AGE: ☐☐☐

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

10a. SEX: 1 ☐ Male 2 ☐ Female

10b. RACE: 1 ☐ White 2 ☐ Black 3 ☐ American Indian/ Alaskan Native 4 ☐ Asian/Pacific Islander 5 ☐ Other 9 ☐ Unk

10c. ETHNIC ORIGIN: 1 ☐ Hispanic 2 ☐ Non-Hispanic 9 ☐ Unk

11. OUTCOME: 1 ☐ Survived 2 ☐ Died 9 ☐ Unk

12. Was patient pregnant/post-partum at time of first positive culture? 1 ☐ Yes 2 ☐ No 9 ☐ Unk

If YES, outcome of fetus:
1 ☐ survived, no apparent illness
2 ☐ survived, clinical infection
3 ☐ live birth/neonatal death
4 ☐ abortion/stillbirth
5 ☐ induced abortion
9 ☐ Unk

13. If patient <1 month of age:
Gestational age: ☐☐ (wks)
Birthweight: ☐☐☐☐ (gms)

14. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply)

1 ☐ Bacteremia without Focus	1 ☐ Peritonitis	1 ☐ Endometritis
1 ☐ Meningitis	1 ☐ Pericarditis	1 ☐ STSS
1 ☐ Otitis media	1 ☐ Septic abortion	1 ☐ Necrotizing fasciitis
1 ☐ Pneumonia	1 ☐ Chorioamnionitis	1 ☐ Puerperal sepsis
1 ☐ Cellulitis	1 ☐ Septic arthritis	1 ☐ Other *(specify)*
1 ☐ Epiglottitis	1 ☐ Osteomyelitis	_____
1 ☐ Hemolytic uremic syndrome (HUS)		_____
1 ☐ Abscess		_____

15a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:

1 ☐ *Neisseria meningitidis*	4 ☐ *Listeria monocytogenes*
2 ☐ *Haemophilus influenzae*	5 ☐ Group A Streptococcus
3 ☐ Group B Streptococcus	6 ☐ *Streptococcus pneumoniae*

15b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE: *(specify)*

_____

_____

16. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)

1 ☐ Blood	1 ☐ Peritoneal fluid	1 ☐ Bone
1 ☐ CSF	1 ☐ Pericardial fluid	1 ☐ Surgical specimen
1 ☐ Pleural fluid	1 ☐ Joint	1 ☐ Surgical aspirate

1 ☐ Other normally sterile site *(specify)* _____

17. DATE FIRST POSITIVE CULTURE OBTAINED:
(Date Specimen Drawn)
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

18. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)

1 ☐ Placenta	1 ☐ Middle ear
1 ☐ Amniotic fluid	1 ☐ Sinus
1 ☐ Wound	

– *IMPORTANT* – PLEASE COMPLETE THE BACK OF THIS FORM –

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

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

19. UNDERLYING CAUSES OR PRIOR ILLNESS: *(Check all that apply)* *(If none or chart unavailable, check appropriate box)* 1 ☐ None 1 ☐ Unknown

1 ☐ Current Smoker
1 ☐ Multiple Myeloma
1 ☐ Sickle Cell Anemia
1 ☐ Splenectomy/Asplenia
1 ☐ Immunoglobulin Deficiency
1 ☐ Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)
1 ☐ Leukemia
1 ☐ Hodgkin's Disease
1 ☐ Asthma
1 ☐ Emphysema/COPD
1 ☐ Systemic Lupus Erythematosus (SLE)
1 ☐ Diabetes Mellitus
1 ☐ Nephrotic Syndrome
1 ☐ Renal Failure/Dialysis
1 ☐ HIV Infection
1 ☐ AIDS
1 ☐ Cirrhosis/Liver Failure
1 ☐ Alcohol Abuse
1 ☐ Atherosclerotic Cardiovascular Disease (ASCVD)/CAD
1 ☐ Heart Failure/CHF
1 ☐ Burns
1 ☐ CSF Leak (2° trauma/surgery)
1 ☐ IVDU
1 ☐ Other Malignancy *(specify)* _____
1 ☐ Organ Transplant *(specify)* _____
1 ☐ Other prior Illness *(specify)* _____

– *IMPORTANT* – PLEASE COMPLETE FOR THE RELEVANT ORGANISMS:

HAEMOPHILUS INFLUENZAE

20. If <15 years of age did patient receive *Haemophilus influenzae* b vaccine? 1 ☐ Yes 2 ☐ No 9 ☐ Unk **If YES, please complete the list below.**

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

21. What was the serotype?
1 ☐ b
2 ☐ Not Typeable
9 ☐ Not Tested or Unk
8 ☐ Other *(specify)* _____

NEISSERIA MENINGITIDIS

22. What was the serogroup?
1 ☐ A 3 ☐ C 5 ☐ W135 9 ☐ Unk
2 ☐ B 4 ☐ Y 6 ☐ Not groupable 8 ☐ Other *(specify)* _____

23. Is patient currently attending college? (15 – 24 years only)
1 ☐ Yes 2 ☐ No 9 ☐ Unk

STREPTOCOCCUS PNEUMONIAE

24. Oxacillin zone size: ☐☐ (mm)
Interpretation: 1 ☐ Sensitive 2 ☐ Resistant 9 ☐ Not tested or Unk

25. Penicillin E-test MIC results ☐☐☐•☐☐☐
Interpretation: 1 ☐ S 2 ☐ I 3 ☐ R 9 ☐ Not tested or Unk

26. Penicillin broth MIC results ☐☐☐☐•☐☐☐
Interpretation: 1 ☐ S 2 ☐ I 3 ☐ R 9 ☐ Not tested or Unk

27. Has patient received 23-valent pneumococcal polysaccharide vaccine?
1 ☐ Yes 2 ☐ No 9 ☐ Unk

If YES, list date most recently given and vaccine name
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐
VACCINE NAME: _____

How many doses has patient received? _____

28. If <15 years of age did patient receive pneumococcal conjugate vaccine? 1 ☐ Yes 2 ☐ No 9 ☐ Unk **If YES, please complete the list below.**

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

29. Does this patient have persistent disease as defined by positive sterile site cultures 2–7 days after the first positive culture?
1 ☐ Yes 2 ☐ No 9 ☐ Unk

If YES, additional culture dates:
1 Mo. ☐☐ Day ☐☐ Year ☐☐☐☐
2 Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

Sites from which *S. pneumoniae* isolated: (Check all that apply)
1 ☐ Blood 1 ☐ CSF 1 ☐ Other normally sterile site
1 ☐ Blood 1 ☐ CSF 1 ☐ Other normally sterile site

GROUP A STREPTOCOCCUS

(#30–32 refer to the 7 days prior to first positive culture)

30. Did the patient have surgery ? 1 ☐ Yes 2 ☐ No 9 ☐ Unk
If YES, date of surgery: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

31. Did the patient deliver a baby (vaginal or C-section)?
1 ☐ Yes 2 ☐ No 9 ☐ Unk
If YES, date of delivery: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

32. Did patient have:
Varicella? 1 ☐ Yes 2 ☐ No 9 ☐ Unk
Penetrating trauma? 1 ☐ Yes 2 ☐ No 9 ☐ Unk
Blunt trauma? 1 ☐ Yes 2 ☐ No 9 ☐ Unk
Surgical wound? (post operative) 1 ☐ Yes 2 ☐ No 9 ☐ Unk

– SURVEILLANCE OFFICE USE ONLY –

33. Was case first identified through audit?
1 ☐ Yes 2 ☐ No 9 ☐ Unk

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

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

36. Date reported to EIP site
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

37. COMMENTS: _____