Patient's Name (Last, first, MI): _____ Phone: _____ Pt Chart: _____

Address: _____ City, State: _____ Zip: _____ Hospital: _____

Patient identifier information is not transmitted to CDC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

2023 Active Bacterial Core Surveillance (ABCs) Case Report
A Core Component Of The Emerging Infections Program

– SHADED AREAS FOR OFFICE USE ONLY –

Form Approved 0920-0978

1. STATE: *(Patient residence)* ☐☐ | **2. STATE I.D.:** ☐☐☐☐☐☐☐ | **3. PATIENT I.D.:** _____ | **4. Date reported to EIP site:** Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

5. COUNTY: *(Residence of Patient)* _____ | **6a. HOSPITAL/LAB I.D. WHERE TEST IDENTIFIED:** ☐☐☐☐☐ | **6b. HOSPITAL I.D. WHERE PATIENT TREATED:** ☐☐☐☐☐

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

8a. AGE: ☐☐☐

8b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Years

9. Sex: 1 ☐ Male 2 ☐ Female

10a. ETHNIC ORIGIN: 1 ☐ Hispanic or Latino 2 ☐ Not Hispanic or Latino 9 ☐ Unknown

10b. RACE: *(Check all that apply)* 1 ☐ White 1 ☐ Black 1 ☐ Asian 1 ☐ Unknown 1 ☐ American Indian/Alaska Native 1 ☐ Native Hawaiian or Other Pacific Islander

TEST 1

11a. COLLECTION DATE Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

12a. PATHOGEN

☐ *Neisseria meningitidis*
☐ *Haemophilus influenzae*
☐ Group A *Streptococcus*
☐ Group B *Streptococcus*
☐ *Streptococcus pneumoniae*

13a. SOURCE

☐ Amniotic fluid (21)
☐ Blood (1)
☐ Bone (2)
☐ Brain (3)
☐ CSF (4)
☐ Heart (5)
☐ Joint (6)
☐ Kidney (7)
☐ Liver (10)
☐ Lymph node (11)
☐ Muscle/Fascia/Tendon* (12)
☐ Ovary (13)
☐ Pancreas (14)
☐ Pericardial fluid (15)
☐ Peritoneal fluid (16)
☐ Placenta (24)
☐ Pleural fluid (17)
☐ Spleen (18)
☐ Vascular tissue (19)
☐ Vitreous fluid (20)
☐ Wound* (27)
☐ Other (8)_____
☐ Unknown (9) ***GAS Only**

14a. TEST METHOD

Positive	Negative	
☐	☐	Culture
☐	☐	PCR
☐	☐	Biofire M/E Panel
☐	☐	Biofire Blood ID (BCID)
☐	☐	Verigene BCT
☐	☐	Bruker MALDI
☐	☐	BD Directigen mening
☐	☐	Antigen Thermo Fisher
☐	☐	Antigen Alere BinaxNow
☐	☐	Other_____

TEST 2

11b. COLLECTION DATE Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

12b. PATHOGEN

☐ *Neisseria meningitidis*
☐ *Haemophilus influenzae*
☐ Group A *Streptococcus*
☐ Group B *Streptococcus*
☐ *Streptococcus pneumoniae*
☐ **Other bacterial species isolated from any normally sterile site (specify):**_____

13b. SOURCE

☐ Amniotic fluid (21)
☐ Blood (1)
☐ Bone (2)
☐ Brain (3)
☐ CSF (4)
☐ Heart (5)
☐ Joint (6)
☐ Kidney (7)
☐ Liver (10)
☐ Lymph node (11)
☐ Muscle/Fascia/Tendon* (12)
☐ Ovary (13)
☐ Pancreas (14)
☐ Pericardial fluid (15)
☐ Peritoneal fluid (16)
☐ Placenta (24)
☐ Pleural fluid (17)
☐ Spleen (18)
☐ Vascular tissue (19)
☐ Vitreous fluid (20)
☐ Wound* (27)
☐ Other (8)_____
☐ Unknown (9) ***GAS Only**

14b. TEST METHOD

Positive	Negative	
☐	☐	Culture
☐	☐	PCR
☐	☐	Biofire M/E Panel
☐	☐	Biofire Blood ID (BCID)
☐	☐	Verigene BCT
☐	☐	Bruker MALDI
☐	☐	BD Directigen mening
☐	☐	Antigen Thermo Fisher
☐	☐	Antigen Alere BinaxNow
☐	☐	Other_____

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

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

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

16. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

17a. 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

17b. If resident of a facility, what was the name of the facility? _____

18a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

18b. If YES, hospital name: _____

19a. WEIGHT: _____lbs_____ oz OR _____ kg OR ☐ Unknown

19b. HEIGHT: _____ft _____ in OR _____ cm OR ☐ Unknown

19c. BMI: ___ ___ . ___ OR ☐ Unknown

20. 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

21a. OUTCOME: 1 ☐ Survived 2 ☐ Died 9 ☐ Unknown

22. If patient died, was the culture obtained on autopsy? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

21b. 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 _____ 4 ☐ Other, Specify_____

23a. At time of first positive culture, patient was: 1 ☐ Pregnant 2 ☐ Postpartum 3 ☐ Neither 9 ☐ Unknown

23b. 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

23c. ☐ **Mark if this is a GBS blood spot study case that lives outside ABCs catchment area.**

24. 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)*

25. 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

☐ History checked

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

26a. UNDERLYING CAUSES OR PRIOR ILLNESSES: *(Check all that apply* OR *if* NONE *or* CHART UNAVAILABL*E, 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.) 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 ☐ Ravulizumab (Ultomics) -) - 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

26b. SMOKING: *(check all that apply):* 1 ☐ None 1 ☐ Unknown 1 ☐ Tobacco 1 ☐ E-Nicotine Delivery System 1 ☐ Marijuana

26c. ALCOHOL ABUSE: 1 ☐ Yes 0 ☐ No 9 ☐ Unknown

26d. 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 ☐ Opioid, NOS	1 ☐ DUD or Abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ non-IDU 1 ☐ Unknown
1 ☐ Cocaine	1 ☐ DUD or Abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ non-IDU 1 ☐ Unknown
1 ☐ 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 –

GROUP A STREPTOCOCCUS *(#33–35 refer to the 14 days prior to first positive culture)*

27a. 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

27b. 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

27c. Did patient have: 1 ☐ Varicella 1 ☐ Burns 1 ☐ Penetrating trauma 1 ☐ Blunt trauma 1 ☐ Surgical wound *(post operative)*

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

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	☐☐ ☐☐ ☐☐☐☐	

NEISSERIA MENINGITIDIS

29a. What was the serogroup?

1 ☐ A 2 ☐ B 3 ☐ C 4 ☐ Y 5 ☐ W135 6 ☐ Not Groupable 8 ☐ Other _____ 9 ☐ Unknown

29b. Is patient currently attending college? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

29c. Did patient receive meningococcal vaccine? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown **If YES, complete the table**

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

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

29d. 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)* _____

31. COMMENTS: _____

32. Was case first identified through audit? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

33. Does this case have recurrent disease with the same pathogen? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, previous (1st) state I.D.: ☐☐☐☐☐☐☐

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

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