ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

☐*Neisseria meningitidis* **(report immediately by phone: 651-201-5414)** ☐**Group A** ***Streptococcus*** **Onset date:**____/____/____

☐***Haemophilus influenzae*** ☐***Streptococcus pneumoniae*** ☐**Group B** ***Streptococcus*** **Report date:**____/____/____

A. DEMOGRAPHIC INFORMATION

1.Name
Last: First: MI:

2.DOB:____/____/____ Age:_____ ☐Days ☐Months ☐Years

3.Gender: ☐M ☐F ☐Transgender ☐Unk

4.Medical record #: ____

5.Preferred language: ☐English ☐Other:________________________

6.Country of birth: ☐U.S. ☐Other:______________☐Unk

7.Address:_________________________________ ☐Unk ☐Homeless

City:_____________________ State:____ Zip:_____ County:_________

8.Phone 1st:__________________ Phone 2nd:___________________

9.Occupation:______________ **10.Parent/Guardian:**_______________

11.Ethnicity:
☐Hispanic/Latino
☐Non-Hispanic/ Non-Latino
☐Unk

12.Race (check all that apply):
☐American Indian/Alaskan Native ☐Asian
☐Black/African American ☐White
☐Native Hawaiian/Pacific Islander ☐Unk
☐Other:______________________________

13.Where was the patient a resident at the time of culture?
☐Private residence ☐Incarcerated ☐Other
☐Long term care facility ☐College dormitory ☐Unk
☐Long term acute care facility ☐Non-medical ward
Name of facility if long term care resident:_______________________

14.Type of insurance (check all that apply): ☐Unk
☐Medicare ☐Private ☐Uninsured
☐Medicaid/state assistance program ☐Incarcerated
☐Indian Health Service (IHS) ☐Other:_______________________
☐Military

B. LABORATORY AND FACILITY INFORMATION

15.Reporter:
Name: Phone:

16.Institution/Clinic: __________________ City: ___________________

17.Ordering provider:_________________ Phone:__________________

18.Primary care provider: _____________ Phone:__________________

19.Lab Name:_______________________ Phone:__________________

20.MDH contact if additional information needed (choose at least one):

☐Reporter ☐Primary care provider ☐Ordering provider ☐Lab
☐Other:____

21.Patient hospitalized? ☐Y ☐N ☐Unk

IF YES,where? ____

Admit date: ____/____/____ Discharge date: ____/____/____

22. If hospitalized, admitted to ICU? ☐Y ☐N ☐Unk

23. Patient transferred from another hospital? ☐Y ☐N ☐Unk

IF YES, hospital name:____

24.Specimen collection date: _____/_____/_____

25.Specimen source (check all normally sterile sites that apply):
☐Blood ☐CSF ☐Joint
☐Bone ☐Muscle/Fascia/Tendon ☐Pleural fluid
☐Peritoneal fluid ☐Pericardial fluid

☐Internal body site (specify):____________________________________

☐Other normally sterile site (specify): _____________________________
Other sites from which organism was isolated (check all that apply):
☐Placenta ☐Amniotic fluid ☐Middle ear
☐Wound ☐Sinus ☐Other:___________________

C. CLINICAL INFORMATION

26.Died? ☐Y ☐N ☐Unk **IF YES**: date of death:_____/_____/_____ Culture obtained at autopsy? ☐Y ☐N ☐Unk

27.Outcome of illness: ☐Survived ☐Died ☐Unk

28. At first positive culture, patient was: ☐Pregnant (due date):____/____/____ ☐Postpartum ☐Neither ☐Unk
29. If pregnant, or postpartum, outcome of fetus: ☐Survived, no apparent illness ☐Survived, clinical infection ☐Live birth/neonatal death ☐Abortion/stillbirth ☐Induced abortion ☐Still pregnant ☐Unk

30. If patient <1 month of age, indicate gestational age and birth weight.
If pregnant, indicate gestational age of fetus, only. Gestational age in weeks:_______ Birth weight in grams:_______

31.Types of Infection Caused by Organism (check all that apply):

☐Bacteremia without Focus ☐Septic Arthritis ☐Otitis Media ☐Necrotizing fasciitis
☐Meningitis ☐Osteomyelitis ☐Endometritis ☐STSS
☐Pneumonia ☐Peritonitis ☐Choriamnionitis ☐Hemolytic uremic syndrome (HUS)
☐Empyema ☐Pericarditis ☐Septic Abortion ☐Other (specify)________________
☐Cellulitis ☐Endocarditis ☐Puerperal sepsis ☐Unk
☐Abscess (not skin) ☐Epiglottitis ☐Septic Shock

32. Did this patient have a positive flu test 10 days prior to or following any invasive bacterial pathogen culture reported? ☐Yes ☐No ☐Unk
33. Other bacterial species isolated from any normally sterile site (specify):

34.Patient weight:_____lbs., _____oz. OR _____kg ☐Unk **35.Patient height:**____ft., ____in. OR ____cm ☐Unk **36.BMI:**___ ___ . ___ ☐Unk

37.Underlying causes or prior illnesses (check all that apply) IF NONE or CHART UNAVAILABLE: ☐None ☐Unk

☐AIDS or CD4 count <200
☐Alcohol Abuse
☐Asthma
☐Atherosclerotic Cardiovascular Disease (ASCVD/CAD)
☐Bone Marrow Transplant (BMT)
☐Cerebral Vascular Accident (CVA)/Stroke
☐Chronic Renal Insufficiency
☐Chronic Skin Breakdown
☐Cirrhosis/Liver Failure
☐Cochlear Implant
☐Complement Deficiency
☐CSF Leak
☐Current Smoker
☐Deaf/Profound Hearing Loss
☐Dementia
☐Diabetes Mellitus
☐Emphysema/COPD
☐Heart Failure/CHF
☐HIV Infection
☐Hodgkin's Disease/Lymphoma
☐Immunoglobulin Deficiency
☐Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)
☐IVDU
☐Leukemia
☐Multiple Myeloma
☐Multiple Sclerosis
☐Nephrotic Syndrome
☐Neuromuscular Disorder
☐Obesity
☐Parkinson's Disease
☐Peripheral Neuropathy
☐Plegias/Paralysis
☐Premature Birth: Gestational Age at Birth ____wks.
☐Renal Failure/Dialysis
☐Seizure/Seizure Disorder
☐Sickle Cell Anemia
☐Solid Organ Malignancy
☐Solid Organ Transplant
☐Splenectomy/Asplenia
☐Systemic Lupus Erythematosus (SLE)
☐Other__________________________

D. PATHOGEN AND VACCINE INFORMATION

HAEMOPHILUS INFLUENZAE

38. Serotype: ☐b ☐Not typeable ☐a ☐c ☐d ☐e ☐f ☐Other :____________ ☐Not tested/unk

39. If <15 years of age and serotype was b or unknown, did patient receive *Haemophilus influenzae* b vaccine? ☐Y ☐N ☐Unk

IF YES, Vaccine Name:	Manufacturer	Lot #	Dose	Month	Day	Year

40. For patients <5 years of age, were vaccination records obtained? ☐Y ☐N
IF YES, source of information? (check all that apply): ☐Vaccine registry ☐Healthcare provider ☐Other (specify):__________________________

NEISSERIA MENINGITIDIS

41. Serogroup: ☐A ☐B ☐C ☐Y ☐W135 ☐Not groupable ☐Other:____________ ☐Not tested/unk
42. Is patient currently attending college (15-24 years only)? ☐Y ☐N ☐Unk
43. Did patient receive meningococcal vaccine? ☐Y ☐N ☐Unk

IF YES, Vaccine Name:	Manufacturer	Lot #	Dose	Month	Day	Year

STREPTOCOCCUS PNEUMONIAE

44. Did patient receive pneumococcal vaccine? ☐Y ☐N ☐Unk

IF YES, which pneumococcal vaccines were received (check all that apply):

☐Prevnar®, 7-valent Pneumococcal Conjugate Vaccine (PCV7)
☐Pneumovax® 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)
☐Prevnar-13®, 13-valent Pneumococcal Conjugate Vaccine (PCV13)
☐Vaccine type not specified

GROUP A STREPTOCOCCUS (These questions refer to the 7 days prior to first positive culture)

45. Did patient have surgery or any skin incision? ☐Y ☐N ☐Unk **IF YES,** date of surgery or skin incision:____/____/____
46. Did patient deliver a baby? (vaginal or C-section) ☐Y ☐N ☐Unk **IF YES,** date of delivery:____/____/____
47. Did patient have: ☐Varicella ☐Burns ☐Penetrating trauma ☐Blunt trauma ☐Surgical wound (post operative)

48. Comments:

E. OFFICE USE ONLY

StateID:	Lab/Hospital ID (culture confirmed):	Hospital ID (where treated):	Transfer Hospital ID:
Accession #:	MEDSS Event ID:	Date Received at Site:	S.O. Initials:

Case first identified through audit? ☐Y ☐N ☐Unk CRF Status: ☐Complete ☐Incomplete ☐Edited and correct ☐Chart unavailable 3x

Is this case a recurrent disease with same pathogen? ☐Y ☐N ☐Unk IF YES, previous (first) State ID:

Questions or to report by phone, contact MDH at 651-201-5414 (toll free 1-877-676-5414) FAX: 651-201-5743