

ABCs *H. Influenzae* Neonatal Sepsis Expanded Surveillance (HiNSES) Form Instruction Sheet

For sites participating in the Hi Neonatal Sepsis Expanded Surveillance (HiNSES), this form should be filled out for all *H. influenzae* neonatal, pregnant, and post-partum cases in addition to the ABCs Case Report Form. Neonatal sepsis is defined as invasive *H. influenzae* disease onset at 0-30 days of age [(culture date-birth date) <31 days]. Case report forms for HiNSES cases should not be completed on infants born at home. Stillbirths, fetal deaths associated with positive placenta and/or amniotic fluid isolates, and live births <22 weeks gestation are included as HiNSES cases but not as core ABCs cases; therefore, for these cases, please mark Yes to #24c in the ABCs Case Report Form to ensure they are not counted as a core ABCs case. Please refer to the HiNSES protocol for clarification on the inclusion and exclusion criteria for HiNSES cases.

Form to be filled out for HiNSES cases:

SCENARIO	HiNSES Form	ABCs Case Report Form**
<i>H. influenzae</i> case 0-≤30 days of life	√	√
Maternal <i>H. influenzae</i> cases*	√	√

*See HiNSES protocol for definition of maternal *H. influenzae* cases

**Stillbirths, fetal deaths associated with positive placenta and/or amniotic fluid isolates, and live births <22 weeks gestation will not be counted as core ABCs cases. Please fill in the appropriate variable to note these cases in the core ABCs CRF.

GENERAL INSTRUCTIONS

The sources of information that should be used to complete this case report form are found in both the infant’s chart and mother’s delivery chart and include the following: 1) Neonatal Summary Sheet, 2) Neonatal & Maternal Discharge Summary, 3) Neonatal & Maternal Admitting History & Physical (H & P) form, 4) Physician Orders, 5) Physician & Nurse’s Progress Notes, 6) OB Admitting Form, 7) Prenatal Forms, 8) Labor Flow/Progress Record, 9) Labor & Delivery Summary, 10) Drug/Medicine Administration Records (MARs), and 11) Laboratory & Microbiology Reports. **For general reference and guide to neonatal and obstetric charts, please reference Table 1.**

It is only necessary to collect information that is readily available in the medical chart. *Very often charts will only tell you that something happened. Charts will not tell you that something did NOT happen.* For example, if a woman had a previous anaphylactic reaction, this will be noted in the chart. If you can’t find mention of it in the chart, then you would answer “No” to this question. Sometimes, we can tell the difference between “No” and “Not documented/Unknown”. For example, the question ‘Intrapartum temperature >100.4°F’ can truly be answered “Yes” or “No”. In the case where the mother’s temperature was not documented because the chart was incomplete, you would check “Unknown”. For yes/no/unknown questions, CHECK UNKNOWN when something is unknown rather than leaving it blank. In questions where *check all that apply* is indicated, please check items to indicate “Yes”; blank items will be counted as “No.”

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Conventions for filling out form:

Record all times as military time (i.e., 1:00pm = 1300 and 1:00am = 0100). Valid time values are 0000 (12:00 AM) to 2359 (11:59 pm). All dates should be recorded as Month/Day/4-Digit Year: 05/16/79 = 05/16/1979. Be careful around January and December; it’s easy to forget to change the year when a record spans this period.

Patient identifier information (NOT transmitted to CDC)

Information on Form	Definition	Special Instructions/Notes
Person filling out form	Person filling out form’s name	Last name, first name, middle initial
Infant’s Name	Infant’s name	Last name, first name, middle initial
Infant’s Chart No.	Infant’s chart number	
Mother’s Name	Mother’s name	Last name, first name, middle initial
Mother’s Chart No.	Mother’s chart number	
Mother’s Date of Birth	Mother’s date of birth	
Hospital Name	Name of hospital	
Estimated Due Date	Estimated date of delivery	
Mother’s Prenatal Care Provider: Name of provider	Name of mother’s prenatal care provider	Last name, first name,
Mother’s Prenatal Care Provider: Name of clinic	Name of clinic where mother’s prenatal care provider is located	
Mother’s Prenatal Care Provider: Clinic phone number	Phone number for mother’s prenatal care clinic	

Patient identifier information (transmitted to CDC)

Information on Form	Definition	Special Instructions/Notes
Culture date	Indicate the date of collection of the first positive culture, not the date when the culture was first noted to have growth. Indicate whether this is the culture date for the infant or the mother (pregnant and post-partum cases)	NOTE: The culture date should match the culture date on the ABCs CRF and the HiNSES CRF.

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Information on Form	Definition	Special Instructions/Notes
<p>Indicate the type of HiNSES case</p>	<p>Record whether the form is being filled out for a Neonatal (infant) case (with sterile isolate), maternal/pregnant/post-partum case (with sterile isolate from mother), or a fetal case (no sterile isolate for neonatal or maternal case, including cases for any gestational age).</p> <p>If the case is pregnant/post-partum, indicate the outcome of the pregnancy: live birth, stillbirth (fetal death at ≥ 20 weeks gestation), spontaneous abortion (fetal death < 20 weeks gestation), or induced abortion.</p> <p>A fetal case is any fetal demise at any gestational age where the isolate is obtained either from the infant (sterile isolate) or <i>Hi</i> isolated from placenta/amniotic fluid, indicate whether stillbirth (fetal death at ≥ 20 weeks gestation) or spontaneous abortion (fetal death < 20 weeks gestation).</p> <p>*Note: Fetal cases can include live births that are considered previability (born at < 22 weeks gestation) that subsequently die within 30 days of birth. These cases are not likely to have a sterile isolate from the infant, and, similarly to stillbirths, for these cases isolate of <i>Hi</i> from placenta/amniotic fluid will be included in HiNSES. If a sterile isolate is available from the mother, the case can be included as maternal case.</p> <p>In previability cases, please feel free to contact us to discuss.</p>	<p>- For Neonatal (infant) cases, complete questions 1-31.</p> <p><u>For pregnant or post-partum cases with a sterile isolate indicate outcome:</u></p> <p>- Delivered a live birth: complete questions 1-31.</p> <p>- Delivered a stillbirth: complete questions 1-3 of the infant section, then skip to maternal section and complete questions 12-31.</p> <p>- Had a spontaneous abortion: complete questions 1-2b of the infant section, then skip to maternal section and complete questions 12-18, and 28-31.</p> <p>-Had a home delivery: indicate home delivery and then end form.</p> <p>Had an induced abortion: indicate induced abortion and then end form.</p> <p>-Pregnancy outcome unknown (this may occur if the patient was lost-to-follow-up by provider or moved out of state before delivery): Please check only after all possible sources of pregnancy outcome (birth registry, health network, provider follow-up) have been review): indicate and then end form, no further questions need to be completed.</p> <p>A provider letter and form with has been provided to help gather pregnancy outcome data.</p> <p><u>For fetal cases (formerly “other maternal cases”)</u> indicate isolate and outcome:</p> <p>-Fetal deaths where <i>Hi</i> in sterile site in stillbirth*) complete questions 1-3 of the infant section, then skip to maternal section and complete questions 12-31.</p> <p>Fetal death associated with <i>Hi</i> in placental/amniotic fluid): indicate whether a Stillbirth (complete questions 1-3, and 12-31) or Spontaneous abortion (complete-questions 1-2b, 12-18, and 28-31.</p>

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Information on Form	Definition	Special Instructions/Notes
Were labor and delivery records available?	Indicate whether or not the labor and delivery medical records were available to the abstractor at the time of chart review.	Labor and delivery records should be reviewed, if available, for all infant cases and all pregnant and post-partum cases who delivered a live infant or stillbirth or had a spontaneous abortion. See instructions above for specific questions to be completed for each outcome.
State ID	ABCs case unique identifier.	<p>Each ABCs site has its own system of assigning a unique ID to each case. In general, the first 2 spaces designate the location and are followed by 5 numbers. This state ID is assigned by ABCs personnel.</p> <p>IMPORTANT: The state ID links all information pertaining to this particular case including the ABCs CRF and potentially the lab isolate form and HiNSES CRF.</p>

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Infant Information: Questions 1-11

Generally, if an infant was readmitted to the same hospital for an infection after the initial discharge, the baby will only 1 have chart. If the baby was discharged (went home) and then was readmitted for an infection to a different hospital, the baby will have 2 separate charts.

The same form is used for maternal (pregnant/postpartum) cases and infant cases; the infant information needed is different for each case. Please use the table below as a guide for the infant questions that should be answered.

Scenario	Infant questions to answer
Infant case	1-10, skip 10a-c, then complete 11 and maternal information (Q12-31)
Pregnant/postpartum case – live birth	1-11c, then complete maternal information (Q12-31)
Pregnant/postpartum case – stillbirth	1-3, then complete maternal information (Q12-31)
Pregnant/postpartum case – spontaneous abortion	1-2b, then complete maternal information (Q12-18, 28-31)
Pregnant/postpartum case-induced abortion	End form
Pregnant/postpartum outcome unknown	End form
Pregnant/postpartum outcome – home birth	End form
Fetal case – Hi in sterile site from stillbirth	1-3, then complete maternal information (Q12-31)
Fetal case – Fetal death associated with Hi in placental/amniotic fluid: stillbirth	1-3, then complete maternal information (Q12-31)
Fetal case – Fetal death associated with Hi in placental/amniotic fluid: Spontaneous abortion	1-2b, then complete maternal information (Q12-18, 28-31)

* A provider letter and form with has been provided to help gather pregnancy outcome data.

Form Question No.	Definition	Special Instructions/Note
1. Date of live birth/stillbirth/spontaneous abortion and time of live birth	Record date of live birth/stillbirth/spontaneous abortion. For live births, record time of birth	If both the infant’s date and time of birth are missing, mark the “Unknown” checkbox. If the infant’s date of birth is known but the time of birth is missing, indicate the date of birth and mark the “Unknown” checkbox. If the infant’s time of birth is known but the date of birth is missing, indicate the time of birth and mark the “Unknown” checkbox. The unknown box should only be checked if the date, time, or both variables are missing but have been looked for in the charts. NOTE: The date and time of birth should match the date and time of birth on the ABCs CRF for infant cases. Exception for infants of pregnant/post-partum HiNSES cases.

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Form Question No.	Definition	Special Instructions/Note
2. Gestational age of infant at live birth/stillbirth/spontaneous abortion in completed weeks	Record gestational age of infant at birth or spontaneous abortion. "Gestational age" refers to <u>completed weeks</u> .	<p>If gestation is estimated as 36 weeks and 6 days, the gestational age entered should be 36. Do not round up on the gestational age.</p> <p>If gestational age at birth can't be determined and is unknown, record gestational age as "99".</p> <p>If discrepant values for gestational age are found throughout the chart, the gestational age should be calculated based on the dates given for the last menstrual period (LMP). Gestational age is calculated from the first day of the mother's last menstrual period, not from the date of conception, to the date of birth.</p> <p>NOTE: The gestational age at birth should match the gestational age on the ABCs CRF for infant cases. Exception for infants of pregnant/post-partum HiNSES cases.</p>
2a. How was gestational age was determined?	Record whether gestational age was determined by dates, physical exam, or ultrasound.	If no indication of how dates were determined in chart, mark Unknown.
2b. Date of maternal last menstrual period (LMP)?	Record the date of the mother's last menstrual period as related to this infant case.	If the date of the mom's last menstrual period as related to this infant case can't be determined in the chart, check the "unknown" checkbox.
3. Birth weight	Indicate weight at birth in pounds (lbs) and ounces (oz) <u>OR</u> in grams (g).	<p>*** This question is only for infant HiNSES cases, live births, and stillbirths HiNSES cases ***</p> <p>The infant's birth weight should match the infant's birth weight on the ABCs CRF for infant cases. Exception for infants of pregnant/post-partum HiNSES cases.</p>

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Form Question No.	Definition	Special Instructions/Note
<p>4. Date and time of newborn discharge from the birth hospital</p>	<p>Record the date and time of discharge of the newborn from the birth hospital.</p>	<p>***This question is only for infant HiNSES cases and live births of pregnant/post-partum HiNSES cases.***</p> <p>If both the infant’s date and time of hospital discharge are missing, please mark the “Unknown” checkbox. If the infant’s date of hospital discharge is known but the time of hospital discharge is missing, indicate the date of hospital discharge and mark the “Unknown” checkbox. If the time of hospital discharge is known but the date of hospital discharge is missing, indicate the time of hospital discharge and mark the “Unknown” checkbox.</p> <p>The unknown box should only be checked if the date, time, or both variables are missing but have been looked for in the charts.</p> <p>We ultimately want to capture those infants who were discharged from the birth hospital too soon and were readmitted to the hospital with sepsis. If the infant is transferred from the birth hospital without being discharged home first, record the date of transfer as the date of discharge from the hospital of birth.</p> <p>NOTE: For infant HiNSES cases, the date and time of discharge from the hospital of birth should match the date and time of discharge from the hospital of birth on the ABCs CRF. Exception for infants of pregnant/post-partum HiNSES cases.</p>
<p>5. Was the infant transferred to another hospital following birth?</p>	<p>Record whether or not an infant was transferred to a hospital other than the birth hospital. Only answer “Yes” to this question for infants that were transferred to another hospital <i>without discharging to home first</i>.</p> <p>If infant was transferred to another hospital following birth, record the Hospital ID of non-birth hospital where infant was transferred, date of transfer, and date of discharge.</p>	<p>***This question is only for infant HiNSES cases, and live births of pregnant/post-partum HiNSES cases.***</p> <p>If the infant’s date of transfer to hospital OR date of discharge are missing, please mark the respective “Unknown” checkbox.</p> <p>The unknown box should only be checked if the dates are missing, but have been looked for in the charts.</p>

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Form Question No.	Definition	Special Instructions/Note
<p>6. Was the infant discharged to home and readmitted to the birth hospital?</p>	<p>Record whether or not an infant was readmitted to the birth hospital from home. Only answer “Yes” to this question for infants that were discharged home and then were readmitted from home to their birth hospital.</p> <p>If the infant was readmitted to the birth hospital (after first being discharged home), record the date of discharge.</p>	<p>***This question is only for infant HiNSES cases, and live births of pregnant/post-partum HiNSES cases.***</p> <p>If both the infant’s date and time of readmission to the birth hospital from home are missing, mark the “Unknown” checkbox. If the infant’s date of readmission is known but the time of readmission is missing, indicate the date of readmission and mark the “Unknown” checkbox. If the infant’s time of readmission is known but the date of readmission is missing, indicate the time of readmission and mark the “Unknown” checkbox.</p> <p>The date of discharge should be marked as “Unknown” if the date is missing but has been looked for in the charts.</p>
<p>7. Was the infant discharged to home and readmitted to a different hospital?</p>	<p>Record whether or not an infant was readmitted to a hospital, other than the birth hospital, from home. Only answer “Yes” to this question for those infants that were discharged home and then were readmitted from home to a different hospital from their birth hospital.</p> <p>If the infant was readmitted to a different hospital from home, record the hospital ID (which will be different than the birth hospital ID) as well as the date and time of readmission and date of discharge.</p>	<p>***This question is only for infant HiNSES cases, and live births of pregnant/post-partum HiNSES cases.***</p> <p>If an infant was transferred to a new hospital <i>without discharging to home first</i>, answer “No” to this question.</p> <p>If both the infant’s date and time of readmission to the different hospital from home are missing, mark the “Unknown” checkbox. If the infant’s date of readmission is known but the time of readmission is missing, indicate the date of readmission and mark the “Unknown” checkbox. If the infant’s time of readmission is known but the date of readmission is missing, indicate the time of readmission and mark the “Unknown” checkbox.</p> <p>The date of discharge should be marked as “Unknown” if the date is missing but has been looked for in the charts.</p>
<p>8. Outcome of infant</p>	<p>Record whether the infant survived, died, or the outcome was unknown. This pertains to the outcome of the hospitalization and not necessarily to outcomes ascribed to the particular neonatal infection. If infant died, record date of death.</p>	<p>***This question is only for infant HiNSES cases and live births of pregnant/post-partum HiNSES cases.***</p> <p>This is the outcome of the <i>infant</i>. Maternal outcome for pregnant and post-partum cases is captured in the ABCs CRF.</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p> <p>If infant died, record date of death. If date unknown, mark “Unknown”.</p>

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Form Question No.	Definition	Special Instructions/Note
8a. If survived, did infant have the following neurologic or medical sequelae evident on discharge? (<i>check all that apply</i>)	Record whether infant had seizure disorder, hearing impairment, or required oxygen on discharge. Check all that apply. If no sequelae were noted, check None.	<p>***This question is only for infant HiNSES cases, and live births of pregnant/post-partum HiNSES cases.***</p> <p>This is the outcome of the <i>infant</i>. Maternal outcome for pregnant and post-partum cases is captured in the ABCs CRF.</p>
9. Was the infant admitted to the NICU during hospitalization following birth?	Record whether or not an infant was admitted to the NICU during hospitalization following birth.	<p>*** This question is only for infant HiNSES cases, and live births of pregnant or post-partum HiNSES cases***</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>
9a. If infant was discharged home and readmitted, was infant admitted to NICU during rehospitalization?	Record whether or not an infant was admitted to the NICU during re-hospitalization.	<p>*** This question is only for infant HiNSES cases, and live births of pregnant or post-partum HiNSES cases***</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>
9b. If yes to either 9 or 9a, total number of days in NICU	Record the total number of days the infant spend in the NICU.	<p>*** This question is only for infant HiNSES cases, and live births of pregnant or post-partum HiNSES cases***</p> <p>The number of days do not need to be continuous (ie, if an infant was in the NICU for 2 days, moved to newborn nursery for 1 day, and returned to NICU for 2 more days, record 4 total days in the NICU). If an infant was in the NICU following birth, discharged home, and readmitted to the NICU, record the total number of days for both hospitalizations combined.</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>

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Form Question No.	Definition	Special Instructions/Note
10. From time of birth to date of discharge, did infant have a temperature $\geq 100.4^{\circ}\text{F}/38.0^{\circ}\text{C}$?	Record if the infant’s temperature was greater than 100.4°F or 38.0°C in the period from birth to date of discharge.	<p>*** This question is only for infant HiNSES cases, and live births of pregnant and post-partum HiNSES cases***</p> <p>If there is a complete medical record and there is no mention of fever, answer “No” to this question, not “Unknown” (fever is something important that would almost always be recorded). Only check “Unknown” if sections of the medical chart dealing with infant temperature are missing.</p> <p>In the medical charts, there is often a column and/or graph dedicated to vital stats (e.g., temperature/BP/pulse). Be careful when interpreting temperature on these graphs; sometimes pulse and temperature will be charted on the same graph.</p>
10a. Were any bacterial cultures performed from time of birth to date of discharge?	If the infant did have a fever from time of birth to date of discharge, record whether any bacterial cultures were performed.	<p>*** This question is only for live births of pregnant and post-partum HiNSES cases***</p> <p>This information should be present in the medical record. If there is no mention of culture, answer “No”. There is no “Unknown” option for this as culture should be reflected in the medical record.</p>
10b. If cultures performed from time of birth to date of discharge, list the culture date(s), culture source(s), and result(s)	Record the date and source of cultures performed and results of culture.	<p>*** This question is only for live births of pregnant and post-partum HiNSES cases***</p> <p>If the culture date is not listed in the medical record, leave blank and will be considered “Unknown.”</p> <p>Note the source of culture. Include all sterile site cultures performed. If non-sterile site cultures are performed and positive, please record in “Other” section.</p> <p>If culture positive, record the organism isolated. If negative, record culture negative. If cultures were performed but the results are not able to be found after searching the chart, record culture results unknown.</p> <p>For infants hospitalized for >7 days, list cultures only from time of birth through day 7 of life.</p>

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Form Question No.	Definition	Special Instructions/Note
10c. If any sterile site cultures were positive for <i>H. influenzae</i> , list ABCs StateID assigned to infant case	If a sterile site culture was performed and positive for <i>H. influenzae</i> and the infant was captured as an ABCs case, record the ABCs StateID assigned to the infant case.	<p>*** This question is only for live births of pregnant and post-partum HiNSES cases***</p> <p>This information is important as it will allow us to link maternal Hi cases with infant cases.</p>
11. Were <i>any</i> ICD-9 codes reported in the discharge diagnosis of the infant’s chart?	The ICD-9 codes are standardized, alphanumeric codes which often have decimal places (e.g., ###.## or 123.45) that classify diseases by etiology and anatomic localization.	<p>*** This question is only for infant cases and live births of pregnant and post-partum HiNSES cases***</p> <p>Please record whether there were any ICD-9 codes reported in the discharge diagnosis of the infant’s chart, regardless of disease classification or diagnosis – we would like to know if ANY ICD-9 codes were recorded for that infant. If there are none, check “No” and move to Question 11a. This question applies to the chart for the hospitalization and the rehospitalization, if applicable.</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>
11a. If ICD-9 codes are present, were any of the following ICD-9 codes reported in the discharge diagnosis of the infant’s chart?	<p>Record if any of these additional ICD-9 codes were in the discharge diagnosis of the chart for infants born to pregnant or post-partum <i>H. influenzae</i> cases.</p> <p>If other related ICD-9 codes are listed, please specify those under “Other ICD-9 codes”.</p>	<p>*** This question is only for infant cases and live births of pregnant and post-partum HiNSES cases***</p> <p>All items checked will indicate that “Yes” they were reported in the medical chart. All items not selected will be considered “No”. If none of the codes listed were found in the chart, please mark “None of the above codes reported”.</p>
11b. Were <i>any</i> ICD-10 codes reported in the discharge diagnosis of the infant’s chart?	<p>The ICD-10 codes are standardized, alphanumeric codes which often have decimal places (e.g., ###.## or 123.45) that classify diseases by etiology and anatomic localization.</p> <p>Starting in October 2015, hospitals will transition from use of ICD-9 codes to ICD-10 codes.</p>	<p>*** This question is only for infant cases and live births of pregnant and post-partum HiNSES cases***</p> <p>Please record whether there were any ICD-10 codes reported in the discharge diagnosis of the infant’s chart, regardless of disease classification or diagnosis – we would like to know if ANY ICD-10 codes were recorded for that infant. If any were reported, please detail those in Question 11c. If there are none, check “No” and move to Question 12.</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>

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Form Question No.	Definition	Special Instructions/Note
11c. If ICD-10 codes are present, were any of the following ICD-10 codes reported in the discharge diagnosis of the infant's chart?	<p>Record if any of these additional ICD-10 codes were in the discharge diagnosis of the chart for infants born to pregnant.</p> <p>If other related ICD-10 codes are listed, please specify those under "Other ICD-10 codes".</p>	<p>*** This question is only for infant cases and live births of pregnant and post-partum HiNSES cases***</p> <p>All items checked will indicate that "Yes" they were reported in the medical chart. All items not selected will be considered "No". If none of the codes listed were found in the chart, please mark "None of the above codes reported".</p>

Maternal Information: Questions 12-31

Maternal labor and delivery information might be separated or in several sections for the first stage of labor compared to the second stage of labor.

Form Question No.	Definition	Special Instructions/Note
12. Maternal admission date and time	Record the <i>earliest</i> labor/delivery admission date and time for the mother that can be found in the chart. The hospital admission record may show a Labor & Delivery admission time that is a bit later than other sources (mainly because the woman may be admitted on the floor and receiving care before she is actually in the computer's system).	If both the date and time of the maternal admission are missing, mark the "Unknown" checkbox. If the date of maternal admission is known but the time of maternal admission is missing, indicate the date of birth and mark the "Unknown" checkbox. If the time of maternal admission is known but the date of maternal admission is missing, indicate the time of maternal admission and mark the "Unknown" checkbox. If patient was not hospitalized, mark "Patient not hospitalized/Not applicable".
13. Maternal age at delivery	Record the maternal age at delivery in years (do not round up).	If age is not specifically listed in the chart, you will need to subtract the delivery date from the maternal date of birth.
14. Number of prior pregnancies	Record number of pregnancies, regardless of outcome (include abortions)	<p>The number of pregnancies may be found in the mother's admission note or prenatal notes. The nomenclature GTPAL or just GPA is often used. G=gravidity (number of pregnancies, regardless of outcome); T= number of term births; P= number of premature births; A= number of abortions (spontaneous or induced); L= number of living children. For example, a woman who has given birth at term once and has had one miscarriage at 12 weeks would be recorded as G2 T1 P0 A1 L1. Record the number noted for "G" for this question.</p> <p>"Unknown" should only be marked if the data are missing but have been looked for in the charts.</p>

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15. Any prior preterm births (<37 weeks gestational age)	Record whether the mother has had any previous premature births.	<p>The nomenclature GTPAL or just GPA is often used to note a woman’s pregnancy history. G=gravidity (number of pregnancies, regardless of outcome); T= number of term births; P= number of premature births; A= number of abortions (spontaneous or induced); L= number of living children. For example, a woman who has given birth at term once and has had one miscarriage at 12 weeks would be recorded as G2 T1 P0 A1 L1. Record the number noted for “P” for this question.</p> <p>If there is no prenatal information in the maternal labor and delivery chart to determine whether a mother had any prior preterm births, check “Unknown”.</p>
16. Did mother receive prenatal care?	<p>Prenatal, or antenatal, care refers to the medical and nursing care recommended to women before and during pregnancy.</p> <p>Specific prenatal care information and data on the expectant mother is usually forwarded to the hospital to be included in the maternal labor and delivery chart. Prenatal data can be found on ACOG forms, which are usually pink or yellow with “ACOG” printed in the upper-left or right corner. However, some prenatal providers may use another form and/or notation to record prenatal care.</p>	<p>If a mother received no prenatal care, there are usually multiple notations on the absence of prenatal care through all sections of the chart. If there is only partial prenatal information in the chart, do not leave question 15 blank.</p> <p>If there is no prenatal information in the maternal labor and delivery chart to determine whether a mother had any prenatal care, as well as no mention of prenatal care in the admission notes or H&P, check “Unknown”.</p>
17. Number of prenatal visits AND dates of the first and last prenatal visits.	If there are prenatal records in the labor and delivery chart, record the total number of prenatal visits as well as the date of the first and last prenatal visit.	<p>The date of last prenatal visits refers to the last recorded visit in the prenatal record forwarded to the hospital. This may not have been the woman’s last visit before birth; however, it will be important to calculate the gestational age at the time the prenatal information of the mother was forwarded to the hospital for labor & delivery.</p> <p>If the prenatal record was not in the chart, some information can be recovered from other areas of the chart. A prenatal visit will be recorded by a physician or other clinicians such as a nurse. A visit to a lab only does not count as a prenatal visit.</p> <p>If there is no prenatal information in the maternal labor and delivery chart, as well as no mention of prenatal care in the admission notes enter “99” for the number of prenatal visits.</p> <p>If both the mother’s first and last date of prenatal visits are missing, mark the “Unknown” checkbox. If</p>

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Form Question No.	Definition	Special Instructions/Note
		<p>the mother’s first date of prenatal visit is known but the last date of prenatal visit is missing, indicate the first date of prenatal visit and mark the “Unknown” checkbox. If the mother’s last date of prenatal visit is known but the first date of prenatal visit is missing, indicate the last date of prenatal visit and mark the “Unknown” checkbox.</p> <p>The unknown box should only be checked if the first date, second date, or both variables are missing but have been looked for in the charts.</p>
<p>18. Estimated gestational age at last documented prenatal visit</p>	<p>In the provider notes of the maternal prenatal record, turn to the last documented date of the prenatal visit. If gestational age at the last documented prenatal visit is available as weeks and days, record the exact age in weeks and days; do not round up. Use the number of days after the decimal place (e.g., 36.4 = 36 weeks and 4 days) to convert the gestational age to a decimal value. For example, 36.4 should be converted to 36.57 (36 weeks and 4/7(=.57) days).</p> <p>If gestational age is available as days only, convert the gestational age from days to weeks + days. For example, 207 days = 207/7 = 29 weeks, 4 days (because 7*.47=4). However, the correct gestational age to record would be 29.57 (because 4/7 days is 0.57).</p>	<p>Acceptable values for gestational days are: 0, 1=.14, 2=.29, 3=.43, 4=.57, 5=.71, and 6=.86.</p> <p>If discrepant values for gestational age are found throughout the chart, the gestational age should be calculated based on the dates given for the last menstrual period (LMP). Gestational age is calculated from the first day of the mother’s last menstrual period, not from the date of conception, to the date of the last documented prenatal visit.</p> <p>If there is no prenatal information in the maternal labor and delivery chart, as well as no mention of prenatal care in the admission notes, to note estimated gestational age at last prenatal visit, mark “Unknown”.</p>
<p>19. Date and time of membrane rupture</p>	<p>Record the date and time of membrane rupture. If the mother has ruptured membranes on admission, the date and time of the rupture of membranes (ROM) will be on the OB admission form. If membranes are intact on admission, the ROM date/time can be found on the L&D summary and/or the L&D/obstetric flow sheet. If membranes are ruptured at the time of C-section, record the time that the C-section began as ROM date and time.</p>	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>If both the date and time of the maternal ROM are missing, mark the “Unknown” checkbox. If the date of maternal ROM is known but the time of maternal ROM is missing, indicate the date of birth and mark the “Unknown” checkbox. If the time of maternal ROM is known but the date of maternal ROM is missing, indicate the time of maternal admission and mark the “Unknown” checkbox.</p>

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Form Question No.	Definition	Special Instructions/Note
20. Was duration of membrane rupture ≥ 18 hours?	To calculate ROM ≥ 18 hours, subtract the ROM date & time from the delivery date & time.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>Sometimes the precise time that membranes ruptured will not be known, but it will be evident that at least 18 hours elapsed between ROM and delivery (e.g., ROM occurred prior to admission and there were 20 hours between admission and delivery). In such cases, check “Yes” for ROM ≥ 18 hours, even though the exact date & time may be unknown.</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>
21. If membranes ruptured at <37 weeks, did membrane rupture before onset of labor?	Using gestational age at birth, record whether membranes ruptured before the onset of labor. If membrane rupture occurred earlier than 37 weeks gestation, check “Yes”.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>Though every pregnancy is different and no list can cover all situations, the onset of labor is usually defined by the following signs: dilation of cervix; contractions that are increasingly longer, stronger, and closer together; and loss of mucous plug and/or vaginal discharge (also known as when a woman’s “water breaks”).</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>
22. Type of rupture	Spontaneous and artificial rupture of membranes may be abbreviated as SROM and AROM, respectively.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>If membranes are ruptured at the time of C-section, list type of rupture as “artificial” (and record the time of membrane rupture from the operative report in Question 20 (date & time of membrane rupture)). If it is not possible to determine the type of rupture of the membranes, check “Unknown”.</p>

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Form Question No.	Definition	Special Instructions/Note
22a. If artificial rupture, reason for rupture	Record the reason for artificial rupture of membranes.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>The reason for artificial rupture of membranes may be found in the Labor Flow/Progress Record or the Labor & Delivery Summary.</p> <p>The checkboxes on the form are the key/trigger words to look for in the charts to help determine the reason for artificial rupture of the membranes. Please do not make a clinical judgment. If it is not possible to determine the reason for artificial rupture of the membranes, check “Unknown”.</p>
23. Type of delivery	<p>Record the type of delivery. More than one delivery option may be checked (e.g., a mother has a vaginal birth but forceps and/or vacuum is used to suction the baby out of the birth canal).</p> <p>Forceps and vacuum data may be listed under a “Complications” section of the medical chart. Additionally, a section called “Indications for C-section” may be included in the chart.</p>	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>The abbreviation “VBAC” stands for “Vaginal Birth After previous C-section”.</p> <p>As noted, every pregnancy is different and no list can cover all situations, however, several physiological signs are potential indicators labor is beginning. Some common signs that labor is imminent include the following: rupture of membranes, dilation of cervix, contractions that are regular at ~5 minutes apart, and sudden increase or decrease in fetal activity (note: this list is <i>not</i> exhaustive and should not be used as a checklist).</p> <p>NOTE: Both dilation of the cervix and contractions can start long before delivery and may not necessarily be synonymous with labor starting. Please use what is recorded in the medical chart to help guide abstraction.</p> <p>“Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>
23a. If delivery was by C-section, did labor begin before C-section?	Record whether labor began before C-section	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>If it is not possible to determine whether labor began before C-section, check “Unknown”.</p> <p>NOTE: Both dilation of the cervix and contractions can start long before delivery and may not necessarily be synonymous with labor starting. Please use what is recorded in the medical chart to help guide abstraction.</p>

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Form Question No.	Definition	Special Instructions/Note
23b. If delivery was by C-section, did membrane rupture happen before C-section?	Record whether membrane rupture occurred before C-section	<p>****This question does not apply to spontaneous abortion cases****</p> <p>If it is not possible to determine whether membrane rupture happened before C-section, check “Unknown”.</p> <p>If membrane rupture was artificial, as part of the C-section procedure, do not answer yes to this question.</p> <p>NOTE: Both dilation of the cervix and contractions can start long before delivery and may not necessarily be synonymous with labor starting. Please use what is recorded in the medical chart to help guide abstraction.</p>
23c. If delivery by C-section, scheduled or emergency?	Record whether delivery by C-section was scheduled or emergency.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>This information may be found in the Labor & Delivery Summary or the maternal or infant discharge summary. Scheduled C-sections may also be referred to as an <i>elective</i> C-section, they typically occur before labor has started. Emergency C-sections are unplanned and usually occur after labor has already started. If it is not possible to determine whether the primary C-section was scheduled or emergency, check “Unknown”.</p>
23d. If emergency, what was reason?	Record the reason for the emergency primary C-section.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>Emergency C-sections are unplanned and usually occur after labor has already started and a complication or medical condition occurs in which vaginal delivery or delay of delivery may result in a risk to the health of the mother or baby.</p> <p>The checkboxes on the form are the key/trigger words to look for in the charts to help determine why an emergency C-section was performed. Please do not make a clinical judgment. If another reason is noted in the chart, please note it in “Other (specify)”. If it is not possible to determine the reason for the emergency C-section, check “Unknown”.</p>

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Form Question No.	Definition	Special Instructions/Note
<p>24. Did mother have history of penicillin allergy?</p>	<p>Allergy to any drug belonging to the penicillin class of antibiotics counts as a penicillin allergy.</p> <p>If “Yes”, note if there was a previous maternal history of anaphylaxis noted.</p>	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>This class includes: penicillin G, penicillin V, amoxicillin, ampicillin, nafcillin, ticarcillin (combined with clavulanic acid = Timentin), Augmentin (amoxicillin and clavulanic acid), Zosyn, and many others. The abbreviation “NKDA” stands for “No known drug allergy”. Please check “No” to maternal history of penicillin allergy if this is noted in the chart.</p> <p>Be careful when recording history of anaphylaxis. Though a person can have a penicillin allergy, they may not have had an anaphylactic reaction. If penicillin allergy is “Yes”, but there is no further documentation of type of reaction, check “No” for history of anaphylaxis. If penicillin allergy is “Yes” and includes notation of anaphylaxis (most common), shock, required ICU/hospitalization, intubated, vascular collapse, severe allergy, immediate hypersensitivity to penicillin, angioedema, urticaria, respiratory distress, check “Yes” for history of anaphylaxis. If there is description of a milder penicillin allergy (e.g., rash, diarrhea, etc), check “No” to history of anaphylaxis.</p> <p>If a woman has an allergy to penicillin, the allergy will be noted in the chart. If a woman has had an anaphylactic reaction, this will also be noted in the chart. Therefore, the checkbox for these two questions should either be “Yes” (as noted in the chart) or “No” (no allergy and/or anaphylaxis noted in the chart). There should be no “Unknown”s.</p>
<p>25. Were antibiotics given to the mother intrapartum?</p>	<p>Intrapartum (IP) refers to the period from the onset of labor until the delivery of the infant. However, for the purpose of prophylaxis, IP is defined as the period from rupture of membranes (ROM) to delivery, or admission to the hospital for labor until delivery (whichever is longer). Thus, intrapartum antibiotics (IAP) refers to antibiotics given during labor and prior to time of birth (i.e. delivery).</p>	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>Once the infant is delivered, the intrapartum period is over.</p> <p>Record whether any antibiotics were given in this IP period. “Unknown” should only be marked if the data are missing but have been looked for in the charts.</p>

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Form Question No.	Definition	Special Instructions/Note
25a. Date and time antibiotics were first administered before delivery	Record the date and time antibiotics were administered, <i>not</i> the date and time antibiotics were ordered from the Physician’s Order Forms.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p><i>NOTE:</i> Just because an antibiotic was ordered, does not mean it was given/administered.</p> <p><i>NOTE:</i> Nurses’ notes can be confusing as often a time is written down for when a medication is scheduled, but then crossed out with initials to show that it was given at a different time.</p> <p>If you can’t find the time an antibiotic was given, be suspicious. You may be looking at a sheet that only shows when an antibiotic is scheduled or ordered. Antibiotics ordered will be written in the MD orders.</p> <p>If both the mother’s date and time of intrapartum antibiotic prophylaxis (IAP) administration are missing, mark the “Unknown” checkbox. If the mother’s date of IAP administration is known but the time of IAP administration is missing, indicate the date of IAP administration and mark the “Unknown” checkbox. If the mother’s time of IAP administration is known but the date of IAP administration is missing, indicate the time of IAP administration and mark the “Unknown” checkbox.</p>

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Form Question No.	Definition	Special Instructions/Note
25b. Antibiotic’s name, delivery, dose, and date of administration	List the name of each antibiotic given, mode of delivery, number of doses, start date and if antibiotics were terminated before delivery, stop date (leave stop date blank if it does not apply).	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>Be careful to verify that ordered antibiotics were actually administered. Common antibiotics that you may see include: Penicillin, Ampicillin, Gentamicin, Clindamycin, Erythromycin, Vancomycin, and Cefazolin. If an antibiotic name is not recorded, but it is evident in the chart an antibiotic was administered, write “ND” or “Not Documented”. Do not leave blank unless no antibiotics were given.</p> <p>IV refers to “intravenous” administration of antibiotics. IM refers to “intramuscular” administration of antibiotics. PO refers to “oral” administration of antibiotics. If route of administration is not clear from looking in the charts, please leave blank and it will be considered “Unknown”.</p> <p>If number of doses given before delivery and start and stop date for antibiotic is not clear from looking in the charts, please leave blank and it will be considered “Unknown”.</p> <p>In the case of a C-section delivery, only antibiotics administered <i>before</i> clamping of the umbilical cord should be noted. If antibiotics are administered after clamping of the cord, they are considered postpartum.</p> <p>In the case of preterm rupture of the membranes (at <37 weeks), sometimes women receive multiple antibiotics over a long time period before delivering. There is a space to record 6 antibiotics. If a woman has received more than 6 antibiotics, list all IV antibiotics first and make a note in the comments field at the end of the form about the other antibiotics administered.</p>
26. Interval between receipt of first antibiotic and delivery	Subtract the date and time antibiotics were first administered from the date and time of delivery to determine the time interval between receipt of first antibiotics and delivery.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>If either the date and time of first antibiotic administration or the date and time of delivery are Unknown, enter “999” for hours, “99” for minutes, and “99” for days.</p> <p>The day variable should only be completed if the number of hours between receipt of first antibiotic and delivery is greater than 24 hours.</p>

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Form Question No.	Definition	Special Instructions/Note
27. What was reason for administration of intrapartum antibiotics?	Doctor’s progress notes will often mention why intrapartum antibiotics (IAPs) were administered. Many hospitals have standing orders for GBS prophylaxis, C-section prophylaxis, suspected amnionitis or chorioamnionitis, prolonged latency, intrapartum fever, and mitral valve prophylaxis. There may have been more than one reason for antibiotic prophylaxis in which case, check all that apply.	<p>****This question does not apply to spontaneous abortion cases ****</p> <p>The checkboxes on the form are the key/trigger words to look for in the charts to help determine why IAPs were given. Please do not make a clinical judgment. If it is not possible to determine the reason for administration of antibiotics, check “Unknown”.</p> <p>NOTE: Suspected amnionitis and chorioamnionitis are equivalent.</p> <p>All items checked will be considered, “Yes” and blanks will be considered “No”.</p>
28. Did the mother have chorioamnionitis or suspected chorioamnionitis during the intrapartum period or in the week prior to spontaneous abortion?	Record whether the medical record noted the mother to have chorioamnionitis or suspected chorioamnionitis during the intrapartum period or in the week prior to spontaneous abortion, independent of receipt of intrapartum antibiotics.	Please do not make a clinical judgment. If it is not possible to determine whether the mother had chorioamnionitis or suspected chorioamnionitis during the intrapartum period or in the week prior to spontaneous abortion, check “Unknown”.
29. During intrapartum period or in the week prior to spontaneous abortion did mother have any of the following symptoms or diagnoses? uterine tenderness, foul-smelling amniotic fluid, maternal tachycardia (>100 beats/min), fetal tachycardia (>160 beats/min), maternal WBC >20 or 20,000; urinary tract infection; intrapartum fever ≥100.4°F or 38.0°C	Record whether the medical record noted the mother to have any of the listed symptoms during the intrapartum period or in the week prior to spontaneous abortion, independent of receipt of intrapartum antibiotics. The mother may have more than one symptom - mark all that apply.	<p>The checkboxes on the form are the key/trigger words to look for in the charts to help determine whether the mother had any signs of infection during the intrapartum period. Please do not make a clinical judgment. If it is not possible to determine whether the mother had uterine tenderness, foul smelling amniotic fluid, intrapartum fever or urinary tract infection, check “Unknown”.</p> <p>All items checked will be considered, “Yes” and blanks will be considered “No”.</p> <p>If all responses are “No”, please select the “None option”</p>

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Form Question No.	Definition	Special Instructions/Note
30. Maternal Intrapartum/end of pregnancy fever	Record if the mother’s intrapartum (IP)/end of pregnancy temperature was greater than 100.4°F or 38.0°C. If a mother had an IP fever, record the date and time the fever was first recorded greater than 100.4°F or 38.0°C.	<p>This question ONLY refers to the mother’s temperature <u>during labor/end of pregnancy</u> (not after delivery). Do not look in any postpartum assessment sheets. If there is a complete medical record and there is no mention of IP fever, answer “No” to this question, not “Unknown” (fever is something important that would almost always be recorded). Only check “Unknown” if sections of the medical chart dealing with maternal temperature are missing.</p> <p>In the medical charts, there is often a column and/or graph dedicated to vital stats (e.g., temperature/BP/pulse). Be careful when interpreting temperature on these graphs; sometimes pulse and temperature will be charted on the same graph.</p> <p>If both the mother’s date and time of IP fever are missing, mark the “Unknown” checkbox. If the mother’s date of IP fever is known but the time of IP fever is missing, indicate the date of IP fever and mark the “Unknown” checkbox. If the mother’s time of IP fever is known but the date of IP fever is missing, indicate the time of IP fever and mark the “Unknown” checkbox.</p> <p>The unknown box should only be checked if the date, time, or both variables are missing but have been looked for in the charts.</p>
30a. Were any bacterial cultures performed on mother during labor/end of pregnancy?	Record whether any bacterial cultures were performed during labor/end of pregnancy.	<p>If there is no mention of culture after noting IP fever, answer “No” to this question, not “Unknown”.</p> <p>There is no “Unknown” option for this as culture should be reflected in the medical record.</p>
30b. If cultures performed during labor/end of pregnancy and positive, list the culture date(s), culture source(s), and result(s)	Record the date, source of cultures performed and results of culture.	<p>If the culture date is missing in the charts, leave this date blank and it will be considered “Unknown”.</p> <p>The list of culture sources include sterile and non-sterile sites. If other sterile or non-sterile sites not included on this list are performed and positive, please record in the other section.</p> <p>If culture positive, record the organism isolated. If negative, record culture negative. If cultures were performed but the results are not able to be found after searching the chart record culture results “Unknown”.</p>

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Form Question No.	Definition	Special Instructions/Note
30c. If any sterile site cultures collected during labor/end of pregnancy were positive for <i>H. influenzae</i> , list ABCs StateID assigned to maternal case	If a sterile site culture was performed and positive for <i>H. influenzae</i> and the mother was captured as an ABCs case, record the ABCs StateID assigned to the maternal case.	This information is important, as it will allow us to link maternal Hi cases with infant cases.
31. Maternal postpartum/post pregnancy loss fever	Record if the mother’s postpartum (PP)/post pregnancy loss temperature was greater than 100.4°F or 38.0°C. If a mother had a PP fever, record the date and time the fever was first recorded greater than 100.4°F or 38.0°C.	<p>This question ONLY refers to the mother’s temperature <u>in the postpartum period</u> (after delivery or pregnancy loss). If there is a complete medical record and there is no mention of PP fever, answer “No” to this question, not “Unknown” (fever is something important that would almost always be recorded). Only check “Unknown” if sections of the medical chart dealing with maternal temperature are missing.</p> <p>In the medical charts, there is often a column and/or graph dedicated to vital stats (e.g., temperature/BP/pulse). Be careful when interpreting temperature on these graphs; sometimes pulse and temperature will be charted on the same graph.</p> <p>If both the mother’s date and time of PP fever are missing, mark the “Unknown” checkbox. If the mother’s date of PP fever is known but the time of PP fever is missing, indicate the date of PP fever and mark the “Unknown” checkbox. If the mother’s time of PP fever is known but the date of PP fever is missing, indicate the time of PP fever and mark the “Unknown” checkbox.</p>
31a. Were any bacterial cultures performed on mother during the postpartum period/post pregnancy loss?	Record whether any bacterial cultures were performed.	<p>If there is no mention of culture after noting PP fever, answer “No” to this question, not “Unknown”.</p> <p>There is no “Unknown” option for this as culture should be reflected in the medical record.</p>
31b. If performed during the postpartum period/post pregnancy loss and positive, list the culture date(s), culture source(s), and result(s)	Record the date, source of cultures performed and results.	<p>If the culture date is missing in the charts, leave this date blank and it will be considered “Unknown”.</p> <p>The list of culture sources include sterile and non-sterile sites. If other sterile or non-sterile sites not included on this list are performed and positive, please record in the other section.</p> <p>If positive, record the organism isolated. If negative, record culture negative. If cultures were performed but the results are not able to be found after searching the chart record culture results “Unknown”.</p>

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Form Question No.	Definition	Special Instructions/Note
31c. If any sterile site cultures collected postpartum/post pregnancy loss were positive for <i>H. influenzae</i> , list ABCs StateID assigned to maternal case	If a sterile site culture was performed and positive for <i>H. influenzae</i> and the mother was captured as an ABCs case, record the ABCs StateID assigned to the maternal case.	This information is important, as it will allow us to link maternal Hi cases with infant cases.
31d. Were any ICD-9 or ICD-10 codes reported in the discharge diagnosis of the mother’s chart?	The ICD-9 codes are standardized, alphanumeric codes which often have decimal places (e.g., ###.## or 123.45) that classify diseases by etiology and anatomic localization.	Please record whether there were any ICD-9 or ICD-10 codes reported in the discharge diagnosis of the mother’s chart, regardless of disease classification or diagnosis – we would like to know if ANY ICD-9 or ICD-10 codes were recorded for that mother. If there are none, check “No”. “Unknown” should only be marked if the data are missing but have been looked for in the charts.
31e. Which of the following ICD-9 or ICD-10 codes were reported in the discharge diagnosis of the mother’s chart?	Record if any of these ICD-9 or ICD-10 codes were in the discharge diagnosis of the chart for mothers of HiNSES infant cases. .	All items checked will indicate that “Yes” they were reported in the medical chart. All items not selected will be considered “No”. If none of the codes listed were found in the chart, please mark “None of the above codes reported”. If other related ICD-9 or ICD-10 codes are listed, please check “Other ICD-9 codes” and/or “Other ICD-10 codes” respectively, and specify on the line provided on the form.

To be filled out by ABCs personnel only

Form Question No.	Definition	Special Instructions/Notes
Comments	Use this space to add other information that might not have fit the choices provided or to enhance existing information.	Do NOT include any personal identifying information in the comments section. All comments are transmitted to CDC.
HiNSES form tacking status	Record the status of the HiNSES form.	Only complete forms will be sent to CDC. Other tracking status information is for sites to manage information.

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Table 1: Reference Guide to Neonatal and Obstetric Charts*

Chart Component	Variables Likely Found
Neonatal Summary Sheet	Date & time of birth; hospital of birth; location of birth; date & time of discharge from hospital; transfer of infant to another hospital following birth; readmission to hospital for sepsis; birth weight; gestational age
Neonatal Discharge Summary	Outcome of hospitalization; location of birth; gestational age; clinical syndromes; discharge diagnosis
Neonatal Admitting H&P/Admitting History & Physical (MD)	Date & time of discharge from hospital; gestational age; date of birth (sometimes time)
Maternal Admitting H&P/Admitting History & Physical (MD)	Date of birth; age; penicillin allergy; history of anaphylaxis; blood type
Maternal Discharge Summary	Receipt of prenatal care; prenatal tests (results only); ROM date & time; delivery method; IP fever; IP antibiotics (no times or dates); discharge diagnosis; breast milk
Physician Orders	IP antibiotic orders date & time; tests on admission
Progress Notes (MD)	Useful to scan for a general idea of the chart, includes test results, reason antibiotics were ordered/administered; other relevant history
Nursing Progress Notes	Same as MD progress notes, but more detailed; includes lactation consult & breast milk information
OB Admitting Form	Receipt of prenatal care; admission date & time; prior GBS baby; prior pregnancy with GBS colonization; GBS bacteriuria; ROM date & time; prenatal test results; tests requested on admission
Prenatal Forms	Mother's date of birth; number of prenatal visits; dates of first & last prenatal visits; gestational age at last prenatal visit; GBS bacteriuria, prior GBS baby; prior pregnancy with GBS colonization; prenatal tests results, dates, & test types; susceptibility test results
Labor Flow/Progress Record	IP fever date & time; IAP antibiotics administered; date, time & number of antibiotic doses
Labor & Delivery Summary	Admission date & time; ROM date & time; delivery date & time; delivery method; IV medications including antibiotics; could include IP fever (no time); positive prenatal test results; gestational age; birth weight
Medicine Administration Record (MAR)	IAP antibiotics administered; date, time & number of doses
Laboratory & Microbiology Reports	Maternal blood type; organism isolated; collection date; culture site; resistance pattern (i.e., SIR/MIC data)

*Locations, names of forms, and test vary by hospital