**2020 Active Bacterial Core Surveillance (ABCs) Case Report**

**A Core Component Of The Emerging Infections Program**

- **SHADOED AREAS FOR OFFICE USE ONLY**

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**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/LAB I.D. WHERE PATIENT TREATED:**

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**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

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**10a. ETHNIC ORIGIN:**

1. Hispanic or Latino

2. Not Hispanic or Latino

3. Unknown

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**10b. RACE:**

- American Indian/Alaska Native
- Native Hawaiian or Other Pacific Islander
- White
- Black
- Asian
- Unknown

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**11a. COLLECTION DATE**

Mo. Day Year

**13a. SOURCE**

<table>
<thead>
<tr>
<th>Test 1</th>
<th>Test 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood (1)</td>
<td>Blood (1)</td>
</tr>
<tr>
<td>Bone (2)</td>
<td>Bone (2)</td>
</tr>
<tr>
<td>Brain (3)</td>
<td>Brain (3)</td>
</tr>
<tr>
<td>CSF (4)</td>
<td>CSF (4)</td>
</tr>
<tr>
<td>Heart (5)</td>
<td>Heart (5)</td>
</tr>
<tr>
<td>Joint (6)</td>
<td>Joint (6)</td>
</tr>
<tr>
<td>Kidney (7)</td>
<td>Kidney (7)</td>
</tr>
<tr>
<td>Liver (10)</td>
<td>Liver (10)</td>
</tr>
<tr>
<td>Lymph node (11)</td>
<td>Lymph node (11)</td>
</tr>
<tr>
<td>Muscle/Fascia/Tendon* (12)</td>
<td>Muscle/Fascia/Tendon* (12)</td>
</tr>
<tr>
<td>(specify)</td>
<td>(specify)</td>
</tr>
</tbody>
</table>

---

**11b. COLLECTION DATE**

Mo. Day Year

**13b. SOURCE**

<table>
<thead>
<tr>
<th>Test 1</th>
<th>Test 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood (1)</td>
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<td>Bone (2)</td>
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<tr>
<td>CSF (4)</td>
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<td>Liver (10)</td>
<td>Liver (10)</td>
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<tr>
<td>Lymph node (11)</td>
<td>Lymph node (11)</td>
</tr>
<tr>
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<td>Muscle/Fascia/Tendon* (12)</td>
</tr>
<tr>
<td>(specify)</td>
<td>(specify)</td>
</tr>
</tbody>
</table>

---

**14a. TEST METHOD**

- **Positive**
- **Negative**

- Culture
- PCR
- Biofire M/E Panel
- Biofire Blood ID (BCID)
- Verigen BCT
- Bruker MALDI
- Antigen Thermo Fisher
- Antigen Aenea BinarNow
- Other

---

**14b. TEST METHOD**

- **Positive**
- **Negative**

- Culture
- PCR
- Biofire M/E Panel
- Biofire Blood ID (BCID)
- Verigen BCT
- Bruker MALDI
- Antigen Thermo Fisher
- Antigen Aenea BinarNow
- Other

---

**15. WAS PATIENT HOSPITALIZED?**

<table>
<thead>
<tr>
<th>If YES, date of admission:</th>
<th>Date of discharge:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo. Day Year</td>
<td>Mo. Day Year</td>
</tr>
</tbody>
</table>

---

**16. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?**

<table>
<thead>
<tr>
<th>If YES</th>
<th>2. No</th>
<th>9. Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo. Day Year</td>
<td>Mo. Day Year</td>
<td></td>
</tr>
</tbody>
</table>

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**17a. Where was the patient a resident at time of initial culture?**

1. Private residence
2. Homeless
3. Non-medical ward

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

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**18a. Was patient transferred from another hospital?**

<table>
<thead>
<tr>
<th>If YES</th>
<th>2. No</th>
<th>9. Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo. Day Year</td>
<td>Mo. Day Year</td>
<td></td>
</tr>
</tbody>
</table>

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**18b. If YES, hospital name:**

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**19a. WEIGHT:**

- **_ lbs:**
- **_ oz:**
- **_ kg:**
- **Unknown**

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**19b. HEIGHT:**

- **_ ft:**
- **_ in:**
- **_ cm:**
- **Unknown**

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**19c. BMI:**

- **_**
- **Unknown**

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**20. TYPE OF INSURANCE:**

- **Private**
- **Military**
- **Other (specify):**

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**21a. OUTCOME:**

<table>
<thead>
<tr>
<th>If survived</th>
<th>2. Died</th>
<th>9. Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo. Day Year</td>
<td>Mo. Day Year</td>
<td></td>
</tr>
</tbody>
</table>

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**21b. If survived, patient discharged to:**

- **Home**
- **LTC/SNF**
- **LTACH**
- **Left AMA**
- **Unknown**

---

**22. If patient died, was the culture obtained on autopsy?**

<table>
<thead>
<tr>
<th>If discharged to LTC/SNF or LTACH, list facility</th>
<th>Other, specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo. Day Year</td>
<td>Mo. Day Year</td>
</tr>
</tbody>
</table>

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**23a. At time of first positive culture, patient was:**

1. Pregnant
2. Postpartum
3. Other
4. Unknown

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**23b. If pregnant or postpartum, what was the outcome of fetus?**

1. Survived, no apparent illness
2. Survivor, stillbirth
3. Induced abortion
4. Stillborn

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**23c. Mark if this is a VNSSES fetal death with placenta and/or amniotic fluid isolate, a stillbirth, or neonate <22 wks gestation.**

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**23d. Mark if this is a GBSD blood spot study case that lives outside ABCs catchment area.**

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**24. If patient <1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only.**

| Gestational age
| Birth weight |
|---------------|-------------|

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**25. TYPES OF INFECTION CAUSED BY ORGANISM:**

- **Bacteremia**
- **Peritonitis**
- **Endometritis**
- **without Focus**
- **Pericarditis**
- **STSS**
- **Meningitis**
- **Septic abortion**
- **Necrotizing fasciitis**
- **Otis media**
- **Septic arthritis**
- **Cellulitis**
- **Septic shock**
- **Pneumonia**
- **Chorioamnionitis**
- **Hemolytic uremic syndrome (HUS)**
- **Puerperal sepis**
- **Epiglottitis**
- **Osteomyelitis**
- **Erythema**
- **Abscess (not skin)**
- **Endocarditis**
- **Unknown**
- **Other (specify):**

---

<table>
<thead>
<tr>
<th>History checked</th>
<th>IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –</th>
</tr>
</thead>
</table>

Public reporting burden to collect this information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering/maintaining the data needed, and completing/reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden to CDC, CDC/ATSDR, Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30324; ATTN: PRA0920-0978. Do not send the completed form to this address.
26a. UNDERLYING CAUSES OR PRIOR ILLNESSES:  
1. AIDS or CD4 count <200 1. Connective Tissue Disease (Lupus, etc.) CSF 1. Immunosuppressive Therapy (Steroids, etc) 1. Peripheral Neuropathy  
1. Asthma 1. Leukemia 1. Eculizumab (Soliris) - N.men. only 1. Peripheral Vascular Disease  
1. Atherosclerotic CVD (ASCVD)/CAD 1. Deaf/Profound Hearing Loss 1. Ravulizumab (Ulimontics) - N.men. only 1. Plegias/Paralysis  
1. Bone Marrow Transplant (BMT) 1. Dementia 1. Multiple Myeloma 1. Premature Birth (specify gestational age at birth)  
1. Chronic Skin Breakdown 1. Immunoglobulin Deficiency 1. Parkinson’s Disease 1. Spleenecy/Asplenia  
1. Cochlear Implant 1. Unknown 1. Paralysis or spasticity 1. Other prior illness (specify):  

SUBSTANCE USE, CURRENT  
1. Marijuana/cannabinoi (other than smoking) 1. Unknown 1. Unknown 1. Unknown  
1. Opiod, DEA schedule I (e.g., heroin) 1. Unknown 1. Unknown 1. Unknown  
1. Opiod, DEA schedule II - IV (e.g., methadone, oxycodone) 1. Unknown 1. Unknown 1. Unknown  
1. Opiod, NOS 1. Unknown 1. Unknown 1. Unknown  
* Includes hallucinogens (LSD, mushrooms, etc.), club drugs (MDMA, GHB, etc.), dissociative drugs (ketamine, etc.), inhalants  

GROUP A STREPTOCOCCUS  
27a. Did the patient have surgery or any skin incision? If YES, date of surgery or skin incision:  
1. Yes 2. No 9. Unknown  

HAEMOPHILUS INFLUENZAE  
28b. If <15 years of age and serotype ‘b’ or ‘unknown’ did patient receive Haemophilus influenza b vaccine?  
1. Yes 2. No 9. Unknown  
1. If YES, please complete the list below.  

NEISSERIA MENINGITIS  
29a. What was the serogroup?  
9. Not Tested or Unknown  
29b. Is patient currently attending college?  
1. Yes 2. No 9. Unknown  

STREPTOCOCCUS PNEUMONIAE  
30. Did patient receive pneumococcal vaccine?  
1. Yes 2. No 9. Unknown  
1. If YES, please note which pneumococcal vaccine was received: (Check all that apply)  

29d. If survived, did patient have any of the following sequelae evident upon discharge? (check all that apply) 1. None 1. Unknown  

31. COMMENTS:  

33. Does this case have recurrent disease with the same pathogen? 1. Yes 2. No 9. Unknown  
32. If YES, previous (1st) state I.D.:  

Submitted By: ____________________________ Phone No.: ( ) ____________ Date:__/__/____  
Physician’s Name: ____________________________ Phone No.: ( ) ____________