

NEONATAL GROUP B STREPTOCOCCAL DISEASE PREVENTION TRACKING FORM

Infant's Name: _____
(Last, First, M.I.)

Infant's Chart No.: _____

Mother's Name: _____
(Last, First, M.I.)

Mother's Chart No.: _____

Hospital Name: _____

Culture date: _____

* Patient identifier information is NOT transmitted to CDC *



ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)
NEONATAL GROUP B STREPTOCOCCAL DISEASE PREVENTION TRACKING FORM



STATEID _____

HOSPITAL ID (of birth; if home birth leave blank) _____

Infant Information

Were labor & delivery records available? Yes (1) No (0)

1. Date of Birth: ____/____/____ month / day / year (4 digits)		2. Did this birth occur outside of the hospital? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)	
Time of birth: _____ <input type="checkbox"/> Unknown (1) (times in military format)		IF YES, please check one: <input type="checkbox"/> Home Birth (1) <input type="checkbox"/> Birthing Center (2) <input type="checkbox"/> En route to hospital (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	
3. Gestational age in completed weeks: ____ (do not round up)		4. Birthweight: ____ lbs ____ oz OR _____ grams	
5. Date & time of newborn discharge after birth: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) month / day / year (4 digits) time			
6. Outcome: <input type="checkbox"/> Survived (1) <input type="checkbox"/> Died (2) <input type="checkbox"/> Unknown (9)			
7. Readmitted to the same hospital: <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) IF YES, date & time of readmission: ____/____/____ ____:____:____ month / day / year (4 digits) time			
8. Admitted from home to different hospital: <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) IF YES, hospital id: _____ AND date & time admission: ____/____/____ ____:____:____ month / day / year (4 digits) time			
9. Infant discharge diagnosis: ICD9-1 _____ ICD9-2 _____ ICD9-3 _____			
10. Did the baby receive breast milk from the mother? (for late-onset cases only) <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES, did the baby receive breast milk before onset of GBS infection (eg, date of first positive neonatal culture): <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)			

Maternal Information

11. Maternal admission date & time: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) month / day / year (4 digits) time	
Maternal age at delivery (years): ____ years	Maternal blood type: <input type="checkbox"/> A (1) <input type="checkbox"/> B (2) <input type="checkbox"/> AB (3) <input type="checkbox"/> O (4)
12. Did mother have a prior history of penicillin allergy? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) IF YES, was a previous maternal history of anaphylaxis noted? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	
13. Date & time membrane rupture: ____/____/____ ____:____:____ <input type="checkbox"/> Unknown (1) month / day / year (4 digits) time	
14. Was duration of membrane rupture ≥18 hours? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)	
15. If membranes ruptured at <37 weeks, did membranes rupture before onset of labor? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)	
16. Type of rupture: <input type="checkbox"/> Spontaneous (1) <input type="checkbox"/> Artificial (2)	

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and 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 of information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address.

Maternal Information (continued)

17. Type of delivery: (Check all that apply)

- Vaginal (1)
 Vaginal after previous C-section (1)
 Primary C-section (1)
 Repeat C-section (1)
 Forceps (1)
 Vacuum (1)
 Unknown (1)

If delivery was by C-section: Did labor or contractions begin before C-section? Yes (1) No (0) Unknown (9)
Did membrane rupture happen before C-section? Yes (1) No (0) Unknown (9)

18. Intrapartum fever (T ≥ 100.4 F or 38.0 C): Yes (1) No (0) Unknown (9)

IF YES, 1st recorded T ≥ 100.4 F or 38.0 C at: ___ / ___ / ___ : ___ : ___
month day year (4 digits) time

19. Did mother receive prenatal care? Yes (1) No (0) Unknown (9)

20. Was prenatal record (even partial information) in labor and delivery chart? Yes (1) No (0) Unknown (9)

IF YES: No. of visits: ___ First visit: ___ / ___ / ___ Last visit: ___ / ___ / ___
month day year (4 digits) month day year (4 digits)

21. Estimated gestational age (EGA) at last documented prenatal visit: ___ . ___ (weeks)

22. GBS bacteriuria during this pregnancy? Yes (1) No (0)

IF YES, what order of magnitude was the colony count?

- 0 (1)
 <10,000 (2)
 10k-<25,000 (3)
 25k-<50,000 (4)
 50k-<75,000 (5)
 75k-<100,000 (6)
 ≥100,000 (7)
 Unknown (9)

23. Previous infant with invasive GBS disease? Yes (1) No (0)

24. Previous pregnancy with GBS colonization? Yes (1) No (0)

25a. Was maternal group B strep colonization screened for BEFORE admission (in prenatal care)?

- Yes (1) No (0) Unknown (9)

IF YES, list dates, test type, and test results below:

Test date (list most recent first):	Test type:	Positive culture (Do not include urine here!)
1. ___ / ___ / _____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> Rapid pcr (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)
2. ___ / ___ / _____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> Rapid pcr (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)

25b. If the *most recent* test was GBS positive, was antimicrobial susceptibility performed? Yes (1) No (0) Unknown (9)

IF YES, Was the isolate resistant to clindamycin? Yes (1) No (0) Unknown (9)

Was the isolate resistant to erythromycin? Yes (1) No (0) Unknown (9)

26a. Was maternal group B strep colonization screened for AFTER admission (before delivery)? Yes (1) No (0) Unknown (9)

IF YES, list date of most recent test, test type and test results below:

Test date (list most recent first):	Test type:	Positive culture (Do not include urine here!)
___ / ___ / _____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> Rapid pcr (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)

