Patient's Name: _____ Phone No.:( ) _____
(Last, First, MI.)

Address: _____ Patient Chart No.: _____
(Number, Street, Apt. No.)

_____ _____ Hospital: _____
(City, State) (Zip Code)

– Patient Identifier information is not transmitted to CDC –

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

2025 ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM

– DARK 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. CRF Status: 1 ☐ Complete 2 ☐ Incomplete 3 ☐ Edited & Correct 4 ☐ Chart unavailable after 3 requests 7 ☐ QA Review Change

11. RACE and/or ETHNICITY: *(Check all that apply)* 1 ☐ Unknown
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Hispanic or Latino
1 ☐ Middle Eastern or North African
1 ☐ Native Hawaiian or Pacific Islander
1 ☐ White

6. COUNTY *(Patient Residence)*: _____
or
6a. PLANNING REGION: _____

7a. HOSPITAL/LAB I.D. WHERE PATIENT TREATED:: ☐☐☐☐☐

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

9a. AGE: ☐☐☐

9b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

10.SEX: 1 ☐ Male 2 ☐ Female

Lab Repeating Group Section T1-T10

	T1 Test Type	T2 Date of Specimen Collection (Mo. Day Year)	T3 Test Method (non-culture)	T3a Hospital/Lab I.D. where test identified	T4 Site from which organism isolated	T5 Bacterial Species Isolated*	T6 Test Result
1		☐☐ ☐☐ ☐☐☐☐		☐☐☐☐☐			☐ 1=Positive ☐ 0=Negative
2		☐☐ ☐☐ ☐☐☐☐		☐☐☐☐☐			☐ 1=Positive ☐ 0=Negative
3		☐☐ ☐☐ ☐☐☐☐		☐☐☐☐☐			☐ 1=Positive ☐ 0=Negative
4		☐☐ ☐☐ ☐☐☐☐		☐☐☐☐☐			☐ 1=Positive ☐ 0=Negative

	T7 Isolate/Specimen Available?	T8 If isolate/specimen N/A, why not?	T9 Shipped to CDC?	T10 If shipped, accession#
1	☐ 1=Yes ☐ 2=No		☐ 1=Yes ☐ 0=No	
2	☐ 1=Yes ☐ 2=No		☐ 1=Yes ☐ 0=No	
3	☐ 1=Yes ☐ 2=No		☐ 1=Yes ☐ 0=No	
4	☐ 1=Yes ☐ 2=No		☐ 1=Yes ☐ 0=No	

#T1 - Test Type
1=PCR
2=Culture
7=Other
9=Unknown

T3 - Test Method (if non-culture)
1=Biofire Filmarray Meningitis/Encephalitis Panel
2=Other
3=Biofire Filmarray Blood Culture ID (BCID) Panel
4=Verigene Gram + Blood Culture (BCT) Test
5=Bruker MALDI Biotyper CA System
9=Unknown

T5 - Bacterial Species Isolated
1=*Neisseria meningitidis*
2=*Haemophilus influenzae*
3=Group B *Streptococcus*
5=Group A *Streptococcus*
6=*Streptococcus pneumoniae*
* For other bacterial pathogens (i.e. non-ABCs), write in pathogen name

T4 - Site
1=Blood
2=Bone
3=Brain
4=CSF
5=Heart
6=Joint
7=Kidney
8=Other Sterile Site
9=Unknown
10=Liver
11=Lymph Node
12=Muscle/Fascia/Tendon
13=Ovary
14=Pancreas
15=Pericardial Fluid
16=Peritoneal Fluid
17=Pleural Fluid
18=Spleen
19=Vascular Tissue
20=Vitreous Fluid

Non Sterile Sites
27=Wound

T8 - No Isolate, why not
1=N/A at Hospital Lab
2=N/A at State Lab
3=Hospital Refuses
4=Isolate Discrepancy (2x)
5=No DNA (non-viable)
6=Isolate Not Needed

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

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

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

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

18a. 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 ☐ Correctional or detention facility
6 ☐ College dormitory
7 ☐ Non-medical ward
8 ☐ Other (specify): _____
9 ☐ Unknown

18b. If resident of a facility, what was the name of the facility? _____

Facility ID: _____

19a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

19b. If YES, hospital I.D.: ☐☐☐☐☐

20a. WEIGHT:_____ lbs _____oz OR _____ kg OR ☐ Unknown

20b. HEIGHT:_____ ft _____in OR _____ cm OR ☐ Unknown

20c. BMI: ___ ___ . ___ OR ☐ Unknown

21. TYPE OF INSURANCE: *(Check all that apply)*
1 ☐ Private
1 ☐ Medicare
1 ☐ Medicaid/state assistance program
1 ☐ Military
1 ☐ Indian Health Service (IHS)
1 ☐ Correctional or detention facility
1 ☐ Other (specify)_____
1 ☐ Uninsured
1 ☐ Unknown

22. OUTCOME: 1 ☐ Survived 2 ☐ Died 9 ☐ Unknown

22a. 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 ID: _____ 4 ☐ Other, Specify: _____

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

24a. At time of first positive culture, patient was:
1 ☐ Pregnant 2 ☐ Postpartum
3 ☐ Neither 9 ☐ Unknown

24b. 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

25. 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)*

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

26. TYPES OF INFECTION CAUSED BY ORGANISM: *(Check all that apply)*

1 ☐ Abscess (not skin) 1 ☐ Bacteremia without Focus 1 ☐ Cellulitis 1 ☐ Chorioamnionitis 1 ☐ Endocarditis 1 ☐ Epiglottitis 1 ☐ Endometritis 1 ☐ Empyema 1 ☐ Hemolytic uremic syndrome (HUS) 1 ☐ Meningitis 1 ☐ Necrotizing fasciitis 1 ☐ Osteomyelitis 1 ☐ Otitis media 1 ☐ Peritonitis 1 ☐ Pericarditis 1 ☐ Pneumonia 1 ☐ Puerperal sepsis 1 ☐ Septic abortion 1 ☐ Septic arthritis 1 ☐ Septic shock 1 ☐ STSS 1 ☐ Other (*specify*): _____ 1 ☐ Unknown

27. UNDERLYING CAUSES OR PRIOR ILLNESSES: (*Check all that apply* OR *if* NONE *or* CHART UNAVAILABLE, *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.)
1 ☐ 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 ☐ Any complement inhibitor - N.men. only (*specify*): _____
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

SUBSTANCE USE, CURRENT

27b. SMOKING: *(Check all that apply)* 1 ☐ None documented 1 ☐ Unknown 1 ☐ Tobacco 1 ☐ Marijuana 1 ☐ E-Nicotine delivery system

27c. ALCOHOL ABUSE: 1 ☐ Yes 0 ☐ None documented 9 ☐ Unknown

27d. OTHER SUBSTANCES: *(check all that apply)* 1 ☐ None documented 1 ☐ Unknown

	Documented Use Disorder (DUD)/Abuse	Mode of delivery: *(check all that apply)*
1 ☐ Marijuana/cannabinoid (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

– IMPORTANT – PLEASE COMPLETE FOR THE RELEVANT ORGANISM –

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 influenzae* b vaccine? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown **If YES, please complete the list below.**

DOSE	DATE GIVEN (Mo. Day Year)	VACCINE NAME/MANUFACTURER	DOSE	DATE GIVEN (Mo. Day Year)	VACCINE NAME/MANUFACTURER
1			3		
2			4		

NEISSERIA MENINGITIDIS

29. What was the serogroup? 1 ☐ A 2 ☐ B 3 ☐ C 4 ☐ Y 5 ☐ W135 6 ☐ Not Groupable 8 ☐ Other: _____ 9 ☐ Unknown

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

31. 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	DOSE	TYPE	DATE GIVEN (Mo. Day Year)	VACCINE NAME/ MANUFACTURER
1				4			
2				5			
3				6			

32. 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*): _____

GROUP A STREPTOCOCCUS

(33-35 refer to the 14 days prior to first positive culture)

33. 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

34. 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

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

Submitted By: _____
Phone No.:( ) _____
Date: ____/____/____
Physician's Name: _____
Phone No.:( ) _____

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

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

39. Initials of S.O. _____

36. COMMENTS: _____