

NEONATAL INFECTION EXPANDED TRACKING FORM

*Infant's Name: _____ (Last, First, M.I.) *Infant's Chart No.: _____
 *Mother's Name: _____ (Last, First, M.I.) *Mother's Chart No.: _____
 *Mother's Date of Birth: ___/___/___ *Hospital Name: _____
month day year (4 digits)

ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)
 NEONATAL INFECTION EXPANDED TRACKING FORM



Form Approved
 0920-0978

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

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

Date & time of positive culture: ___/___/___ (times in military format)
month day year (4 digits)

1. Date of Birth: ___/___/___ <small>month day year (4 digits)</small> Time of birth: _____ <input type="checkbox"/> Unknown (1) <small>time</small>	2. Did this birth occur outside of the hospital? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) 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)
---	--

3a. Gestational age of infant at birth in completed weeks: ___ (do not round up)	3b. Date of maternal last menstrual period (LMP): ___/___/___ <small>month day year (4 digits)</small> <input type="checkbox"/> Unknown (1)	3c. Gestational age determined by: <input type="checkbox"/> Dates (1) <input type="checkbox"/> Physical Exam (2) <input type="checkbox"/> Ultrasound (3) <input type="checkbox"/> Assisted Reproductive Technology (4) <input type="checkbox"/> Unknown (9)
--	--	---

4. Birth weight: ___ lbs ___ oz OR _____ grams	5. Date & time of newborn discharge from hospital of birth: ___/___/___ _____ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>
--	---

6. Was patient admitted to the ICU during hospitalization? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)	IF YES, Date & time of admission: ___/___/___ _____ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small> Date & time of discharge: ___/___/___ _____ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>
---	---

Questions 7-10b should only be completed for early- and late-onset GBS cases

7. Was the infant discharged to home and readmitted to the birth hospital? IF YES, date & time of readmission: ___/___/___ _____ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
---	--

8. Was the infant admitted to a different hospital from home? IF YES, hospital ID: _____ AND date & time of admission: ___/___/___ _____ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
--	--

9a. Were any ICD-10 codes reported in the discharge diagnosis of the infant's chart? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)
9b. IF YES, were any of the following ICD-10 codes reported in the discharge diagnosis of the chart? (Check all that apply)
<input type="checkbox"/> A40.1: Sepsis due to streptococcus, group B (1) <input type="checkbox"/> P36.1: Sepsis of newborn to other unspecified streptococci (1) <input type="checkbox"/> A40.8: Other Streptococcal sepsis (1) <input type="checkbox"/> P36.9: Bacterial sepsis of newborn, unspecified (1) <input type="checkbox"/> A40.9: Streptococcus sepsis, unspecified (1) <input type="checkbox"/> B95.1: Streptococcus, group b as the cause of disease classified elsewhere (1) <input type="checkbox"/> A49.1: Streptococcal infection, unspecified site (1) <input type="checkbox"/> B95.5: Unspecified streptococcus as the cause of disease classified elsewhere (1) <input type="checkbox"/> P36: Bacterial sepsis of newborn (1) <input type="checkbox"/> G00.2: Streptococcal meningitis (1) <input type="checkbox"/> P36.0: Sepsis of newborn due to streptococcus, group B (1)

10. Did the baby receive breast milk from the mother? (for late-onset GBS 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 <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)

10a. Did the infant receive antibiotics anytime during the birth hospitalization? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)
10b. IF YES, was it a beta-lactam? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)

Public reporting burden of this collection of information is estimated to average 20 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 information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30329, ATTN: PRA(0920-0978). **Do not send the completed form to this address.**

Maternal Information

11. Maternal admission date & time: ___/___/___ ___:___:___ <small>month day year (4 digits) time</small> <input type="checkbox"/> Unknown (1)																																		
12. Maternal age at delivery (years): ___ years	12a. Number of prior pregnancies ___ <input type="checkbox"/> Unknown (9)																																	
13. Maternal blood type: <input type="checkbox"/> Unknown (9) <input type="checkbox"/> A (1) <input type="checkbox"/> B (2) <input type="checkbox"/> AB (3) <input type="checkbox"/> O (4)	14. 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)																																	
14a. MATERNAL UNDERLYING OR PRIOR ILLNESSES: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown <table style="width:100%; border:none;"> <tr> <td style="width:33%; border:none;">1 <input type="checkbox"/> AIDS or CD4 count <200</td> <td style="width:33%; border:none;">1 <input type="checkbox"/> Complement Deficiency</td> <td style="width:33%; border:none;">1 <input type="checkbox"/> Immunoglobulin Deficiency</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> Asthma</td> <td style="border:none;">1 <input type="checkbox"/> Connective Tissue Disease (Lupus, etc.)</td> <td style="border:none;">1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, etc.)</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> Atherosclerotic CVD (ASCVD)/CAD</td> <td style="border:none;">1 <input type="checkbox"/> CSF Leak</td> <td style="border:none;">1 <input type="checkbox"/> Leukemia</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> Bone Marrow Transplant (BMT)</td> <td style="border:none;">1 <input type="checkbox"/> Dementia</td> <td style="border:none;">1 <input type="checkbox"/> Multiple Myeloma</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> CVA/Stroke/TIA</td> <td style="border:none;">1 <input type="checkbox"/> Diabetes Mellitus, HbA1C _____(%), Date ___/___/___</td> <td style="border:none;">1 <input type="checkbox"/> Multiple Sclerosis</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> Chronic Hepatitis C</td> <td style="border:none;">1 <input type="checkbox"/> Emphysema/COPD</td> <td style="border:none;">1 <input type="checkbox"/> Myocardial Infarction</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> Chronic Kidney Disease</td> <td style="border:none;">1 <input type="checkbox"/> Heart Failure/CHF</td> <td style="border:none;">1 <input type="checkbox"/> Nephrotic Syndrome</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> Chronic Liver Disease/cirrhosis</td> <td style="border:none;">1 <input type="checkbox"/> HIV Infection</td> <td style="border:none;">1 <input type="checkbox"/> Neuromuscular Disorder</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> Current Chronic Dialysis</td> <td style="border:none;">1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma</td> <td style="border:none;">1 <input type="checkbox"/> Obesity</td> </tr> <tr> <td style="border:none;">1 <input type="checkbox"/> Chronic Skin Breakdown</td> <td style="border:none;"></td> <td style="border:none;">1 <input type="checkbox"/> Parkinson's Disease</td> </tr> <tr> <td style="border:none;"></td> <td style="border:none;"></td> <td style="border:none;">1 <input type="checkbox"/> Peptic Ulcer Disease</td> </tr> </table>		1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> Complement Deficiency	1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Connective Tissue Disease (Lupus, etc.)	1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, etc.)	1 <input type="checkbox"/> Atherosclerotic CVD (ASCVD)/CAD	1 <input type="checkbox"/> CSF Leak	1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> Bone Marrow Transplant (BMT)	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> CVA/Stroke/TIA	1 <input type="checkbox"/> Diabetes Mellitus, HbA1C _____(%), Date ___/___/___	1 <input type="checkbox"/> Multiple Sclerosis	1 <input type="checkbox"/> Chronic Hepatitis C	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Myocardial Infarction	1 <input type="checkbox"/> Chronic Kidney Disease	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Chronic Liver Disease/cirrhosis	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> Neuromuscular Disorder	1 <input type="checkbox"/> Current Chronic Dialysis	1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Chronic Skin Breakdown		1 <input type="checkbox"/> Parkinson's Disease			1 <input type="checkbox"/> Peptic Ulcer Disease
1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> Complement Deficiency	1 <input type="checkbox"/> Immunoglobulin Deficiency																																
1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Connective Tissue Disease (Lupus, etc.)	1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, etc.)																																
1 <input type="checkbox"/> Atherosclerotic CVD (ASCVD)/CAD	1 <input type="checkbox"/> CSF Leak	1 <input type="checkbox"/> Leukemia																																
1 <input type="checkbox"/> Bone Marrow Transplant (BMT)	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> Multiple Myeloma																																
1 <input type="checkbox"/> CVA/Stroke/TIA	1 <input type="checkbox"/> Diabetes Mellitus, HbA1C _____(%), Date ___/___/___	1 <input type="checkbox"/> Multiple Sclerosis																																
1 <input type="checkbox"/> Chronic Hepatitis C	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Myocardial Infarction																																
1 <input type="checkbox"/> Chronic Kidney Disease	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Nephrotic Syndrome																																
1 <input type="checkbox"/> Chronic Liver Disease/cirrhosis	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> Neuromuscular Disorder																																
1 <input type="checkbox"/> Current Chronic Dialysis	1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma	1 <input type="checkbox"/> Obesity																																
1 <input type="checkbox"/> Chronic Skin Breakdown		1 <input type="checkbox"/> Parkinson's Disease																																
		1 <input type="checkbox"/> Peptic Ulcer Disease																																
15. Date & time of membrane rupture: ___/___/___ ___:___:___ <small>month day year (4 digits) time</small> <input type="checkbox"/> Unknown (1)																																		
16. Was duration of membrane rupture \geq 18 hours? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)																																		
17. 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)																																		
18. Type of rupture: <input type="checkbox"/> Spontaneous (1) <input type="checkbox"/> Artificial (2) <input type="checkbox"/> Unknown (9)																																		
19. Type of delivery: (Check all that apply) <input type="checkbox"/> Vaginal (1) <input type="checkbox"/> Vaginal after previous C-section (1) <input type="checkbox"/> Primary C-section (1) <input type="checkbox"/> Repeat C-section (1) <input type="checkbox"/> Forceps (1) <input type="checkbox"/> Vacuum (1) <input type="checkbox"/> Unknown (1) If delivery was by C-section: Did labor begin before C-section? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) Did membrane rupture happen before C-section? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9)																																		
20. Intrapartum fever (T \geq 100.4 F or 38.0 C): <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES, 1st recorded T \geq 100.4 F or 38.0 C at: ___/___/___ ___:___:___ <input type="checkbox"/> Unknown (1) <small>month day year (4 digits) time</small>																																		
21. Were antibiotics given to the mother intrapartum? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Unknown (9) IF YES, answer 21a-b and Questions 22-23 a) Date & time antibiotics 1 st administered: (before delivery) ___/___/___ ___:___:___ <input type="checkbox"/> Unknown (9) <small>month day year (4 digits) time</small> b) Antibiotic 1: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: ___/___/___ Stop date (if applicable): ___/___/___ Antibiotic 2: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: ___/___/___ Stop date (if applicable): ___/___/___ Antibiotic 3: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: ___/___/___ Stop date (if applicable): ___/___/___ Antibiotic 4: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: ___/___/___ Stop date (if applicable): ___/___/___ Antibiotic 5: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: ___/___/___ Stop date (if applicable): ___/___/___ Antibiotic 6: _____ <input type="checkbox"/> IV (1) <input type="checkbox"/> IM (2) <input type="checkbox"/> PO (3) # doses given before delivery: _____ Start date: ___/___/___ Stop date (if applicable): ___/___/___																																		

22. Interval between receipt of 1st antibiotic and delivery: ____ (hours) ____ (minutes) ____ (days)*
 *Day variable should only be completed if the number of hours >24

23. What was the reason for administration of intrapartum antibiotics? (Check all that apply)

<input type="checkbox"/> GBS prophylaxis (1)	<input type="checkbox"/> Prolonged latency (1)	<input type="checkbox"/> Mitral valve prolapse prophylaxis (1)
<input type="checkbox"/> Suspected amnionitis/ chorioamnionitis (1)	<input type="checkbox"/> C-section prophylaxis (1)	<input type="checkbox"/> Other (1)
		<input type="checkbox"/> Unknown (1)

24. Did mother have chorioamnionitis or suspected chorioamnionitis? Yes (1) No (0) Unknown (9)

*****Questions 25–33 should only be completed for early- and late-onset GBS cases*****

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

26. Please record the following: the total number of prenatal visits AND the first and last visit dates to the prenatal as recorded in the labor and delivery chart
 No. of visits: ____ First visit: ____/____/____ Last visit: ____/____/____ Unknown (1)
month day year (4 digits) month day year (4 digits)

27. Estimated gestational age (EGA) at last documented prenatal visit: ____ . ____ (weeks)

28. GBS bacteriuria during this pregnancy? Yes (1) No (0) Unknown (9)
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)

29. Previous infant with invasive GBS disease? Yes (1) No (0) Unknown (9)

30. Previous pregnancy with GBS colonization? Yes (1) No (0) Unknown (9)

31a. 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:

<u>Test date</u> (list most recent first):	<u>Test type:</u>	<u>Test Result</u> (Do not include urine here!)
1. ____/____/____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9)
2. ____/____/____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9)

31b. If the *most recent* test was GBS positive was antimicrobial susceptibility performed BEFORE admission (in prenatal care)?
 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)

32a. 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:

<u>Test date</u> (list most recent first):	<u>Test type:</u>	<u>Test Result</u> (Do not include urine here!)
____/____/____	<input type="checkbox"/> Culture (1) <input type="checkbox"/> PCR (2) <input type="checkbox"/> Rapid antigen (3) <input type="checkbox"/> Other (4) <input type="checkbox"/> Unknown (9)	<input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) <input type="checkbox"/> Unknown (9)

32b. If the *most recent* test was GBS positive, was antimicrobial susceptibility performed AFTER admission?

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)

33. Were GBS test results available to care givers at the time of delivery? Yes (1) No (0) Unknown (9)

34. COMMENTS: _____

35. Neonatal Infection Expanded Form Tracking Status:

Complete (1) Incomplete (2) Edited & corrected (3) Chart unavailable after 3 requests (4)