

**NEONATAL SEPSIS SURVEILLANCE FORM**

Infant's Name: \_\_\_\_\_ Infant's Chart No.: \_\_\_\_\_  
(Last, First, M.I.)

Mother's Name: \_\_\_\_\_ Mother's Chart No.: \_\_\_\_\_  
(Last, First, M.I.)

Hospital Name: \_\_\_\_\_ Mother's Date of Birth: : \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month day year (4 digits)

Mother's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

-Patient Identifier Information is NOT transmitted to CDC-

**ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)  
NEONATAL SEPSIS SURVEILLANCE FORM**



**CORE INFORMATION**

HOSPITAL/LAB ID (Where culture identified) \_\_\_\_\_ (ID)

State ID \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Planning Region: \_\_\_\_\_  
(Patient Residence) (Patient Residence) (Patient Residence)

|            |   |                                  |
|------------|---|----------------------------------|
| <b>1.</b>  | Date & time of birth: ____ / ____ / ____<br><small>Month day year (4 digits) time</small> (list times in military format, e.g. midnight = 0000)   | <input type="checkbox"/> Unknown |
| <b>2.</b>  | <b>A.</b> Hospital of birth: _____ (ID)<br><b>B.</b> Date and time of discharge from hospital of birth: ____ / ____ / ____<br><small>Month day year (4 digits) time</small> (in military format)  |                                  |
| <b>3.</b>  | Was the infant transferred to another hospital following birth? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> Unknown (9)<br><b>IF YES</b> <b>A.</b> Hospital where infant was transferred: _____ (ID)<br><b>B.</b> Date of transfer: ____ / ____ / ____<br><small>Month day year (4 digits)</small> <b>C.</b> Date of discharge: ____ / ____ / ____<br><small>Month day year (4 digits)</small>  |                                  |
| <b>4.</b>  | Was the infant discharged to home and readmitted for sepsis? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> Unknown (9)<br><b>IF YES</b> <b>A.</b> Hospital where treated for sepsis: _____ (ID)<br><b>B.</b> Date of readmission: ____ / ____ / ____<br><small>Month day year (4 digits)</small> <b>C.</b> Date of discharge: ____ / ____ / ____<br><small>Month day year (4 digits)</small>  |                                  |
| <b>5A.</b> | Outcome of hospitalization: <input type="checkbox"/> Survived (1) <input type="checkbox"/> Died (3) <input type="checkbox"/> Unknown (9)  |                                  |
| <b>5B.</b> | If survived, did patient have the following neurologic or medical sequelae evident on discharge? ( <i>check all that apply</i> )<br><input type="checkbox"/> Seizure disorder (1) <input type="checkbox"/> Hearing impairment (1) <input type="checkbox"/> Requiring oxygen (1) <input type="checkbox"/> None (1)   |                                  |
| <b>6.</b>  | Sex: <input type="checkbox"/> Male (1) <input type="checkbox"/> Female (2) <input type="checkbox"/> Unknown (9)   |                                  |
| <b>7.</b>  | Race and/or Ethnicity: ( <i>check all that apply</i> ) <input type="checkbox"/> American Indian or Alaska Native (1) <input type="checkbox"/> Middle Eastern or North African (1)<br><input type="checkbox"/> Asian (1) <input type="checkbox"/> Native Hawaiian or Pacific Islander (1)<br><input type="checkbox"/> Black or African American (1) <input type="checkbox"/> White (1)<br><input type="checkbox"/> Hispanic or Latino (1) <input type="checkbox"/> Unknown (1)                                 |                                  |
| <b>8.</b>  | Birth weight: ____ lb ____ oz (Or _____ grams)  |                                  |
| <b>9A.</b> | Gestational age: ____ (99=Unknown) <b>B.</b> Determined by: <input type="checkbox"/> Dates (1) <input type="checkbox"/> Physical exam (2) <input type="checkbox"/> Ultrasound (3)<br><small>(Weeks)</small> <input type="checkbox"/> Assisted Reproductive Technology (4) <input type="checkbox"/> Unknown (9)  |                                  |
| <b>10.</b> | Clinical Syndromes ( <i>check all that apply</i> ):<br><input type="checkbox"/> Septicemia/symptomatic bacteremia (without meningitis or pneumonia) (1)<br><input type="checkbox"/> Pneumonia (1)<br><input type="checkbox"/> Meningitis (1)<br><input type="checkbox"/> Cellulitis (1)<br><input type="checkbox"/> Asymptomatic bacteremia (i.e., cultures obtained despite absence of symptoms) (1)<br><input type="checkbox"/> Unknown (1)<br><input type="checkbox"/> Other (1) ( <i>specify</i> ): _____ |                                  |

11A. Did the infant receive antibiotics during the first illness episode?  Yes (1)  No (2)  Unknown (9)

IF YES

|   | B1. Antibiotic Name | B2. # of doses | B3. Start Date                              | B4. Stop Date                               |
|---|---------------------|----------------|---|---|
| 1 | _____               | _____          | ____/____/____<br>Month day year (4 digits) | ____/____/____<br>Month day year (4 digits) |
| 2 | _____               | _____          | ____/____/____<br>Month day year (4 digits) | ____/____/____<br>Month day year (4 digits) |
| 3 | _____               | _____          | ____/____/____<br>Month day year (4 digits) | ____/____/____<br>Month day year (4 digits) |

12. Organism isolated – organism #1 (Please do **not** report any contaminants. Refer to contaminant list in instruction sheet):

- |   |  |
|---|--|
| <input type="checkbox"/> Bacteroides fragilis (2)                 | <input type="checkbox"/> Pseudomonas aeruginosa (16)               |
| <input type="checkbox"/> Other Bacteroides (36): (species) _____  | <input type="checkbox"/> Other Pseudomonas(41): (species) _____    |
| <input type="checkbox"/> Campylobacter (33): (species) _____      | <input type="checkbox"/> Salmonella (18): (species) _____          |
| <input type="checkbox"/> Other Citrobacter (37): (species) _____  | <input type="checkbox"/> Serratia marcescens (19)                  |
| <input type="checkbox"/> Enterobacter cloacae (6)                 | <input type="checkbox"/> Shigella (34): (species) _____            |
| <input type="checkbox"/> Other Enterobacter (38): (species) _____ | <input type="checkbox"/> Staphylococcus aureus (20)                |
| <input type="checkbox"/> Enterococcus (7)                         | <input type="checkbox"/> Streptococcus Group A (31)                |
| <input type="checkbox"/> Other Enterococcus (43): (species) _____ | <input type="checkbox"/> Streptococcus Group B (29)                |
| <input type="checkbox"/> Eschericia coli (8)                      | <input type="checkbox"/> Streptococcus Group D (21)                |
| <input type="checkbox"/> Haemophilus influenzae (28)              | <input type="checkbox"/> Streptococcus Group G (22)                |
| <input type="checkbox"/> Klebsiella oxytoca (10)                  | <input type="checkbox"/> Streptococcus pneumoniae (32)             |
| <input type="checkbox"/> Klebsiella pneumoniae (11)               | <input type="checkbox"/> Streptococcus viridans (23)               |
| <input type="checkbox"/> Other Klebsiella (39): (species) _____   | <input type="checkbox"/> Other Streptococcus (42): (species) _____ |
| <input type="checkbox"/> Listeria monocytogenes (30)              | <input type="checkbox"/> Vibrio (35): (species) _____              |
| <input type="checkbox"/> Neisseria meningitidis (27)              | <input type="checkbox"/> Yersinia enterocolitica (25)              |
| <input type="checkbox"/> Peptostreptococcus (12)                  | <input type="checkbox"/> Other (26): ( <i>specify</i> ) _____ *    |
| <input type="checkbox"/> Proteus mirabilis (14)                   |  |
| <input type="checkbox"/> Other Proteus (40): (species) _____      |  |

\* ONLY choose this if the organism does not fall into any of the above specified categories

Culture site, organism #1 (*check all that apply*)  Blood (1)  CSF (1)

Collection date of first positive culture, organism #1: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month day year (4 digits) Lab Accession No. \_\_\_\_\_

13. Organism isolated – organism #2 (Please do **not** report any contaminant unless a case is co-infected with a neonatal pathogen.

Refer to contaminant list in the instruction sheet.)

- |   |  |
|---|--|
| <input type="checkbox"/> Bacteroides fragilis (2)                 | <input type="checkbox"/> Pseudomonas aeruginosa (16)               |
| <input type="checkbox"/> Other Bacteroides (36): (species) _____  | <input type="checkbox"/> Other Pseudomonas(41): (species) _____    |
| <input type="checkbox"/> Campylobacter (33): (species) _____      | <input type="checkbox"/> Salmonella (18): (species) _____          |
| <input type="checkbox"/> Other Citrobacter (37): (species) _____  | <input type="checkbox"/> Serratia marcescens (19)                  |
| <input type="checkbox"/> Enterobacter cloacae (6)                 | <input type="checkbox"/> Shigella (34): (species) _____            |
| <input type="checkbox"/> Other Enterobacter (38): (species) _____ | <input type="checkbox"/> Staphylococcus aureus (20)                |
| <input type="checkbox"/> Enterococcus (7)                         | <input type="checkbox"/> Streptococcus Group A (31)                |
| <input type="checkbox"/> Other Enterococcus (43): (species) _____ | <input type="checkbox"/> Streptococcus Group B (29)                |
| <input type="checkbox"/> Eschericia coli (8)                      | <input type="checkbox"/> Streptococcus Group D (21)                |
| <input type="checkbox"/> Haemophilus influenzae (28)              | <input type="checkbox"/> Streptococcus Group G (22)                |
| <input type="checkbox"/> Klebsiella oxytoca (10)                  | <input type="checkbox"/> Streptococcus pneumoniae (32)             |
| <input type="checkbox"/> Klebsiella pneumoniae (11)               | <input type="checkbox"/> Streptococcus viridans (23)               |
| <input type="checkbox"/> Other Klebsiella (39): (species) _____   | <input type="checkbox"/> Other Streptococcus (42): (species) _____ |
| <input type="checkbox"/> Listeria monocytogenes (30)              | <input type="checkbox"/> Vibrio (35): (species) _____              |
| <input type="checkbox"/> Neisseria meningitidis (27)              | <input type="checkbox"/> Yersinia enterocolitica (25)              |
| <input type="checkbox"/> Peptostreptococcus (12)                  | <input type="checkbox"/> Other (26): ( <i>specify</i> ) _____ *    |
| <input type="checkbox"/> Proteus mirabilis (14)                   |  |
| <input type="checkbox"/> Other Proteus (40): (species) _____      |  |

\* ONLY choose this if the organism does not fall into any of the above specified categories

Culture site, organism #2 (*check all that apply*)  Blood (1)  CSF (1)

Collection date of first positive culture, organism #2: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month day year (4 digits) Lab Accession No. \_\_\_\_\_

14. Organism isolated – organism #3 (Please do **not** report any contaminant unless a case is co-infected with a neonatal pathogen. Refer to contaminant list in the instruction sheet.)

- |   |  |
|---|--|
| <input type="checkbox"/> Bacteroides fragilis (2)                 | <input type="checkbox"/> Pseudomonas aeruginosa (16)               |
| <input type="checkbox"/> Other Bacteroides (36): (species) _____  | <input type="checkbox"/> Other Pseudomonas(41): (species) _____    |
| <input type="checkbox"/> Campylobacter (33): (species) _____      | <input type="checkbox"/> Salmonella (18): (species) _____          |
| <input type="checkbox"/> Other Citrobacter (37): (species) _____  | <input type="checkbox"/> Serratia marcescens (19)                  |
| <input type="checkbox"/> Enterobacter cloacae (6)                 | <input type="checkbox"/> Shigella (34): (species) _____            |
| <input type="checkbox"/> Other Enterobacter (38): (species) _____ | <input type="checkbox"/> Staphylococcus aureus (20)                |
| <input type="checkbox"/> Enterococcus (7)                         | <input type="checkbox"/> Streptococcus Group A (31)                |
| <input type="checkbox"/> Other Enterococcus (43): (species) _____ | <input type="checkbox"/> Streptococcus Group B (29)                |
| <input type="checkbox"/> Eschericia coli (8)                      | <input type="checkbox"/> Streptococcus Group D (21)                |
| <input type="checkbox"/> Haemophilus influenzae (28)              | <input type="checkbox"/> Streptococcus Group G (22)                |
| <input type="checkbox"/> Klebsiella oxytoca (10)                  | <input type="checkbox"/> Streptococcus pneumoniae (32)             |
| <input type="checkbox"/> Klebsiella pneumoniae (11)               | <input type="checkbox"/> Streptococcus viridans (23)               |
| <input type="checkbox"/> Other Klebsiella (39): (species) _____   | <input type="checkbox"/> Other Streptococcus (42): (species) _____ |
| <input type="checkbox"/> Listeria monocytogenes (30)              | <input type="checkbox"/> Vibrio (35): (species) _____              |
| <input type="checkbox"/> Neisseria meningitidis (27)              | <input type="checkbox"/> Yersinia enterocolitica (25)              |
| <input type="checkbox"/> Peptostreptococcus (12)                  | <input type="checkbox"/> Other (26): ( <i>specify</i> ) _____ *    |
| <input type="checkbox"/> Proteus mirabilis (14)                   |  |
| <input type="checkbox"/> Other Proteus (40): (species) _____      |  |

\* ONLY choose this if the organism does not fall into any of the above specified categories

Culture site, organism #3 (*check all that apply*)  Blood (1)  CSF (1)

Collection date of first positive culture, organism #3: \_\_\_/\_\_\_/\_\_\_ Lab Accession No. \_\_\_\_\_  
Month day year (4 digits)

15. Was any additional blood culture performed?  Yes (1)  No (2)

| IF YES | Test date   | Test result   | IF POSITIVE, organism isolated |
|--------|---|---|--------------------------------|
|        | ___/___/___<br><small>Month day year (4 digits)</small> | <input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) | _____                          |
|        | ___/___/___<br><small>Month day year (4 digits)</small> | <input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) | _____                          |
|        | ___/___/___<br><small>Month day year (4 digits)</small> | <input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative (0) | _____                          |

16. Does this patient have a CORE ABCs pathogen?  Yes (1)  No (2)  Unknown (9)

### SURVEILLANCE OFFICE USE ONLY

17. How was neonatal sepsis case identified? (*check all that apply*)

- State reportable disease system (1)
- Lab surveillance (1)
- Active contact with clinical personnel (1)
- Other (1) (*specify*) \_\_\_\_\_

18. Neonatal sepsis case report form status:  
 Complete (1)  Incomplete (2)  Edited & Correct (3)  Chart unavailable after 3 requests (4)

19. Date of report: \_\_\_/\_\_\_/\_\_\_  
Month day year (4 digits)

\* Do NOT include any personal identifying information in the comments section. All comments are transmitted to CDC.

20. Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_