Program Element 25: Enhanced Communicable Disease Epidemiology Activities

OHA Program Responsible for Program Element:
Public Health Division/Center for Public Health Practice/Acute and Communicable Disease Prevention Section

1. **Description.** Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below, to deliver activities and outcomes related to projects funded through cooperative agreements between the Oregon Health Authority (OHA) Acute and Communicable Disease Prevention section (ACDP) and the federal Centers for Disease Control and Prevention (CDC). Overarching goals include establishing and conducting enhanced surveillance; supporting special studies for expanded surveillance, disease prevention interventions, or policy development; and generally supporting Oregon’s flexible response to emerging pathogens. Projects include:

   a. **Enhanced Pertussis Surveillance.** Establish and conduct among residents of Multnomah, Washington and Clackamas Counties enhanced surveillance for pertussis and enhanced investigation of pertussis cases reported to these specified Local Public Health Authorities (LPHAs) by medical laboratories and providers.
      - Expand pertussis surveillance activities in the Portland Metropolitan Area;
      - Determine the epidemiology of pertussis in the Portland Metropolitan Area;
      - Correlate laboratory data with clinical and demographic data, including age, vaccination status, and duration of cough illness, etc.;
      - Encourage physicians, physician assistants, nurse practitioners to test for pertussis including with culture, on patients with appropriate clinical symptoms;
      - Conduct special studies of pertussis and its control; and
      - Support OHA ACDP or Immunizations programs in the investigation and control of unusual pertussis activity or outbreaks in Oregon outside the Portland Metropolitan Area.

   b. **Healthcare Acquired Infections and Antibiotic Resistance (HAI/AR) Surveillance and Special Studies.** Conduct activities for enhanced surveillance and special studies to include chart reviews and abstractions; review of long-term care facility (LTCF) and hospital infection prevention surveys; use of existing surveillance systems; descriptive analysis of surveillance and survey data; and literature reviews related to the epidemiology and microbiology of Healthcare Acquired Infections (HAIs) and other emerging infections.

   c. **Active Bacterial Core Surveillance (ABCs).** Support enhanced surveillance to monitor the burden of disease caused by invasive infection with ABCs pathogens: group A streptococcus, group B streptococcus, *Streptococcus pneumoniae, Haemophilus influenzae*, and *Neisseria meningitidis*; and track antimicrobial resistance among these pathogens. Activities include chart reviews and abstractions; use of existing surveillance systems; descriptive analysis of surveillance and survey data; coordination of vaccine effectiveness studies; and literature reviews related to the epidemiology and microbiology of ABCs pathogens.

   d. **Influenza.** Support population-based surveillance to provide near real-time weekly rates of Laboratory-Confirmed Influenza-Associated Hospitalizations during each influenza season. Activities include completing standardized case-report forms for hospitalized influenza cases reported in Oregon; and entering the data into a CDC Access® database in preparation for electronic submission to CDC.

   e. **RSV.** Support population-based surveillance of Laboratory-Confirmed RSV-associated hospitalizations during each RSV season and evaluate testing practices on an annual basis. Activities include reporting basic demographic data on all hospitalizations and completing

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standardized case report forms on deaths from RSV and case-patients who are admitted to the intensive care unit.

f. **HPV-IMPACT.** Support the evaluation of human papillomavirus (HPV) vaccination programs and vaccine effectiveness through population-based surveillance. Activities include chart reviews and abstractions, and entry of data into Orpheus.

g. **Outbreak investigations.** Investigate clusters and outbreaks of emerging infectious diseases and other diseases of public health importance. Plan and conduct epidemiologic investigations, including design of questionnaires, interviews of patients, and review of medical records in collaboration with state and local health officials. Analyze data and summarize findings; make recommendations for prevention and control of outbreaks.

h. **Data quality review.** Enter data for above activities as required by project protocols. Assure information quality for ACDP Emerging Infection Program Activities (EIPAs) and special studies through chart abstraction quality assurance reviews; data cleaning, and preparation of summaries detailing areas for further training to improve accuracy of chart abstractions.

i. **Other Activities.** Assist with data collection, entry, cleaning, and analysis as needed for other ACDP Activities to address emerging data needs.

j. **Pilot to Assess Vaccine Effectiveness (PAVE) against Laboratory-confirmed Influenza Hospitalizations among Pregnant Women.** PAVE study is a case control study designed to evaluate the effectiveness in influenza vaccine in pregnant women.

k. **Group B streptococcus (GBS) Dried Blood Spot (DBS) study.** The purpose of this study is to obtain GBS from routine neonatal screening from infants with invasive GBS to determine serological correlates of protection against invasive GBS disease.

l. **Group A streptococcus (GAS) high risk investigation (HRI).** The purpose of the GAS HRI is to conduct in-depth interviews with persons hospitalized with invasive GAS to assess risk factors and develop better prevention and control measures.

m. **Gonococcal Isolate Surveillance Project (GISP) – Testing of gonococcus (GC) culture:** The purpose of these funds is to expand testing of persons seen at the Multnomah County Health Department Sexually Transmitted Disease Clinic (MCHD-STD) suspected to have GC infection, to:

- Collect urethral samples for culture from men; identify and subculture isolates, ship isolates to reference laboratory for susceptibility testing, and transmit demographic and clinical data to CDC; and identify trends in GC resistance in the Portland Metropolitan Area; and develop and disseminate practice recommendations to health care professionals.

This Program Element addresses multiple activities funded by CDC and overseen by ACDP and is designed to provide additional support required to meet the needs of OHA’s Communicable Disease Control foundational program; and OHA’s foundational capabilities of Assessment and Epidemiology, Policy and Planning; and Emergency Preparedness and Response. The additional staffing provided allows ACDP to maintain core surveillance for bacterial pathogens causing pneumonia and meningitis, pertussis, influenza, several HAIs, HPV, foodborne illness, and GC. This program element enables evaluation of the impact of new vaccines against the pneumococcus (PCV13) and HPV, and of infections by antibiotic-resistant organisms such as carbapenem-resistant *Enterobacteriaceae* (CRE), *Candida* and GC. It provides ACDP with additional assistance essential to investigating outbreaks and providing surge response as needed for emerging pathogens.

This Program Element, and all changes to this Program Element are effective the first day of the month noted in Issue Date section of Exhibit C Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

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2. Definitions Specific to Enhanced Communicable Disease Epidemiology Activities
   
a. **Active Bacterial Core Surveillance (ABCs):** Surveillance in the Portland Metropolitan Area for cases of invasive infection by group A streptococcus, *Haemophilus influenzae*, *Neisseria meningitidis*, group B streptococcus, and *Streptococcus pneumoniae*.

b. **Candidemia Database:** Access® database created by CDC and maintained by OHA staff to enter and track cases of laboratory-confirmed candidemia.

c. **Designated Area for HPV Surveillance:** For the purposes of HPV surveillance, a specific 28-zipcode region that falls within the Portland Metropolitan Area.

d. **Pertussis**-specific definitions are as follows:
   
   (1) **Pertussis Case:** There are two categories of Pertussis Case, each with its own set of characteristics, as follows:

   (a) **Pertussis Confirmed Case:**

   i. Culture-positive and a cough illness of any duration, or

   ii. PCR positive and a cough illness lasting at least 2 weeks with any of the following:

   • paroxysms of coughing
   • inspiratory “whoop”
   • post-tussive vomiting, or

   iii. Epidemiologically linked to a case confirmed by either culture or PCR and a cough illness lasting at least 2 weeks with any of the following:

   • paroxysms of coughing
   • inspiratory “whoop”
   • post-tussive vomiting

   (b) **Pertussis Probable Case:**

   An illness compatible with pertussis but neither laboratory confirmed nor in a Pertussis Close Contact of a confirmed case. A compatible illness is defined as cough lasting at least 2 weeks with any of the following:

   i. paroxysms of coughing

   ii. inspiratory “whoop”

   iii. post-tussive vomiting

e. **GAS database:** FileMaker database: FileMaker database developed and maintained by OHA staff to enter and track cases of laboratory-confirmed GAS cases enrolled in the GAS HRI.

f. **GBS database:** Access® database created by CDC and maintained by OHA staff to enter and track cases of laboratory-confirmed GBS cases enrolled in the GBS DBS study.

g. **GISP:**
   
   (1) **CDC:** Centers for Disease Control and Prevention, funder of MCHD’s existing GISP program.

   (2) **GISP:** National Gonorrhea Isolate Surveillance Project site, funded by CDC, in which selected U.S. cities submit *N. gonorrhoeae* specimens from patients with urethral gonorrhea to CDC for antibiotic susceptibility testing.
(3) **ARLN:** CDC’s Antibiotic Resistance Laboratory Network supports nationwide lab capacity to rapidly detect antibiotic resistance. Washington State serves as a regional resource for *N. gonorrhoeae* susceptibility testing for western states.

(4) **OCHIN EPIC:** the electronic medical record system used by the Oregon Community Health Information Network, in which MCHD-STD participates. The STD module already contains data on laboratory test results and anatomic sites of collection in conjunction with demographic factors and detailed sexual behavior.

h. **FluSurv Access® Database:** Access® database created by CDC and maintained by OHA staff to enter and track cases of laboratory-confirmed influenza in hospitalized patients.

i. **HPV-IMPACT:** Histologically confirmed, high-grade cervical dysplasia (CIN2+) among women 18 years and older living in the Designated Area for HPV Surveillance.

j. **Healthcare Acquired Infections and Antibiotic Resistance (HAI/AR).** HAI/AR-specific definitions are as follows:

1. **Multi-site Gram-negative Surveillance Initiative (MuGSI):** Surveillance for cases of carbapenem-resistant *Enterobacteriaceae* [CRE] and *Acinetobacter* in the Portland Metropolitan Area.

2. **Candidemia:** Surveillance for patients with a positive blood culture for *Candida* species isolated in a patient that lives in the Portland Metropolitan Area.

3. **Additional HAI pathogens as needed.**

k. **Healthcare Acquired Infections and Antibiotic Resistance (HAI/AR) Surveillance Databases:** Data from HAI surveillance are typically maintained in Orpheus or in Microsoft Access® databases created by CDC and maintained by OHA staff to enter and track cases of laboratory-confirmed HAIs.

l. **Laboratory-Confirmed Influenza-Associated Hospitalizations:** Metropolitan Area surveillance for persons with laboratory-confirmed influenza admitted at least one night as an inpatient to a hospital.

m. **Laboratory-Confirmed RSV-associated Hospitalizations:** Metropolitan Area surveillance for persons with laboratory-confirmed RSV admitted at least one night as an inpatient to a hospital.

n. **Portland Metropolitan Area:** For the purposes of this Program Element 25, the populations of Clackamas, Multnomah, and Washington Counties and their respective LPHAs.

o. **Orpheus:** A public health condition surveillance database developed and maintained by OHA whose functionality includes reporting cases of communicable diseases electronically from LPHAs to OHA and from OHA to CDC.

p. **PAVE Database:** Access® database created by CDC and maintained by OHA staff to enter and track cases and controls participating in a study of influenza vaccine effectiveness in pregnant women.

q. **Pertussis Close Contacts:** Immediate family members (those who spend many hours together or sleep under the same roof) of and anyone who had direct contact with respiratory secretions from a pertussis case. Pertussis Close Contacts also include those who shared confined space (within ~6 feet) for >1 hour during the communicable period. School children sitting within ~3 feet of a case (i.e., adjacent seating) can also be included. *High-risk* close contacts include infants (<1 year old) and pregnant women in the third trimester.

r. **RSV Access® Database:** Access® database created by CDC and maintained by OHA staff to enter and track cases of laboratory-confirmed RSV in hospitalized patients.

3. **Alignment with Modernization Foundational Programs and Foundational Capabilities.** The activities and services that the LPHA has agreed to deliver under this Program Element align with

a. Foundational Programs and Capabilities (As specified in Public Health Modernization Manual)

<table>
<thead>
<tr>
<th>Program Components</th>
<th>Foundational Program</th>
<th>Foundational Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC surveillance</td>
<td>* X</td>
<td>X</td>
</tr>
<tr>
<td>pertussis</td>
<td>* X</td>
<td>X X</td>
</tr>
<tr>
<td>influenza</td>
<td>* X</td>
<td>X X X</td>
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<tr>
<td>RSV</td>
<td>* X</td>
<td>X X</td>
</tr>
<tr>
<td>HAI-AR</td>
<td>* X</td>
<td>X X</td>
</tr>
<tr>
<td>HPV</td>
<td>* X</td>
<td>X X</td>
</tr>
<tr>
<td>Outbreaks</td>
<td>* X</td>
<td>X X</td>
</tr>
<tr>
<td>Data quality</td>
<td>* X</td>
<td>X</td>
</tr>
<tr>
<td>GISP</td>
<td>* X</td>
<td>X X</td>
</tr>
</tbody>
</table>

Asterisk (*) = Primary foundational program that aligns with each component

X = Foundational capabilities that align with each component

X = Other applicable foundational programs

b. The work in this Program Element helps Oregon’s governmental public health system achieve the following Public Health Accountability Metric:

Communicable Disease Control – Gonorrhea rates

c. The work in this Program Element helps Oregon’s governmental public health system achieve the following Public Health Modernization Process Measure: Not Applicable

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following requirements:

EIP program-related activities must be conducted by LPHA in accordance with the following procedural and operational requirements:
a. LPHA must assign adequate staff to conduct the work described, and as compensated by CDC funding through its cooperative agreements with ACDP. Assigned staff must include a Community Health Nurse to conduct investigations of individuals reported with pertussis; an Epidemiologist to participate in outbreak investigations and special studies, review quality of data collected by OHA EIP staff, and conduct chart reviews and abstractions, literature reviews, and analyses for the EIP projects in Section 1.b. through n.; a Research and Evaluation Analyst to conduct special studies related to the Influenza and ABCs activities (PAVE study, GAS HRI study, and GBS DBS study); a Research and Evaluation Analyst to assist with data collection including chart reviews and interviews of case patients, data entry and cleaning, and preparation of summary data reports for the Influenza and RSV activities; and other staff as needed to investigate cases or to respond to emerging diseases or outbreaks.

b. As available, funds may also be used for reasonable supervisory efforts.

c. LPHA must establish and maintain a more detailed general surveillance system for individuals in the Portland Metropolitan Area reported with pertussis as follows:

(1) Follow-up on reported cases (confirmed and probable using CSTE definition on pertussis).
(2) Complete case investigations on the confirmed and probable cases using Orpheus.
(3) Follow-up on Pertussis Close Contacts using Orpheus.
(4) Conduct medical record reviews for infants hospitalized with pertussis using Orpheus.
(5) Attempt to collect nasopharyngeal (NP) specimens from cases and symptomatic Pertussis Close Contacts as described in the pertussis investigative guideline (www.healthoregon.org/iguides).
(6) Provide to medical and school communities additional education and outreach activities regarding diagnosis and reporting of pertussis.
(7) Encourage physicians, physician assistants, nurse practitioners to test for pertussis patients with appropriate clinical symptoms and encourage specimen submission to the Oregon State Public Health Laboratory.
(8) Coordinate submission to CDC of all *Bordetella pertussis* isolates.
(9) Participate in monthly conference calls with CDC and other staff involved in the enhanced pertussis surveillance project.
(10) Confer with OHA Epidemiologists as requested regarding study data and progress.
(11) Assist with investigation and control of pertussis outbreaks. As position allows, may also assist other counties in outbreak investigation of large pertussis clusters.
(12) Participate in special studies with CDC and other enhanced pertussis surveillance sites.

d. LPHA must conduct chart abstractions for the following EIP surveillance systems.

(1) Cases identified by OHA as potentially having an Invasive Infection by an ABCs Pathogen, at medical centers in the Portland Metropolitan Area. The data-collection form, located in Attachment 2 “Active Bacterial Core Surveillance Case Report” to this Program Element 25, must be completed for each case of Invasive Infection by ABCs Pathogens in residents of the Portland Metropolitan Area identified through review of the foregoing medical records. LPHA must enter data into Orpheus.
(2) The data identified on the form located in Attachment 3 “FluSurv-NET Influenza Hospitalization Surveillance Project Case-Report Form” to this Program Element 25, must be collected through review of medical records of inpatients identified by OHA as
having Laboratory-Confirmed Influenza-Associated Hospitalizations, at medical centers in the Portland Metropolitan Area. LPHA must enter data into the FluSurv Access® Database.

(3) For HAI and Antibiotic Resistance Surveillance, LPHA must collect data to complete the forms located in Attachment 4 “Multi-site Gram-Negative Surveillance Initiative Healthcare Associated Infection Community Interface Case Report” of this Program Element 25. LPHA must collect these data from residents of the Portland Metropolitan Area and enter them into Orpheus and the MuGSI Access® database. LPHA will collect data elements in Attachment 5 “Candidemia” of this Program Element 25 from patients with candidemia in the Portland Metropolitan Area and enter them into the Candidemia Database. As needed, LPHA must collect demographic, clinical, and exposure data for other HAI-related public health surveillance and research activities.

(4) LPHA must collect data on cases within the Designated Area for HPV Surveillance to complete Attachment 6, “Human Papillomavirus Vaccine Impact Monitoring Project,” of this Program Element 25, and enter them into Orpheus.

(5) The data identified on the form located in Attachment 7 “RSV Hospitalization Surveillance Project Case-Report Form” to this Program Element 25, must be collected through review of medical records of inpatients identified by OHA as having Laboratory-Confirmed RSV-Associated Hospitalizations, at medical centers in the Portland Metropolitan Area. LPHA must enter data into the RSV Access® Database.

(6) As needed, LPHA must review quality of data collected by OHA EIP staff for EIP surveillance systems described in this Section d., and additional surveillance systems as needed; generate patient lists of a sample of confirmed cases each quarter and create schedules of charts that require a second reviewer; and review all chart abstractions, identify discrepancies, and prepare summary reports with recommendations for further training to improve information quality for EIP surveillance and special studies. Contingent upon funding and available staff and as directed by ACDP staff, LPHA will interview cases of salmonellosis and campylobacteriosis throughout Oregon, collect enhanced data regarding exposures, and enter the data into Orpheus.

e. LPHA must conduct a case-control study to evaluate the effectiveness of influenza vaccine in preventing influenza hospitalizations in pregnant women as follows:

(1) Review hospital charts of potential cases reported to the Emerging Infections Program FluSurv-NET Influenza Hospitalization Surveillance Project and determine which cases meet eligibility criteria;

(2) Follow study protocols to recruit cases and controls and obtain informed consent;

(3) Collect data through telephone interviews of patients or family members, and follow-up with physicians, ancillary medical staff and Oregon Immunization Registry personnel to determine vaccination status and additional clinical information (Attachments 8);

(4) Enter study data into the PAVE Database; routinely monitor the accuracy and quality of data; and use a computer software package to write routine programs to retrieve, edit and tabulate data;

(5) Document on an ongoing basis the success of case and control recruitment; and

(6) Provide information on the study as needed by the Influenza principal investigator and ACDP epidemiologists for grant reports and continuing reviews by OHA’s Public Health Institutional Review Board.
f. LPHA must conduct a study to determine serological correlates of protection against invasive GBS disease by obtaining DBS from routine neonatal screening from infants with invasive GBS as follows:

   (1) Review hospital charts of potential cases reported to the Emerging Infections Program ABCs Activity and determine which cases meet eligibility criteria using the ABCs CRF (Attachment 2) and the study supplemental case report form (Attachment 9);
   (2) Follow study protocols to recruit cases and obtain informed consent in-person from parents/guardians of cases of GBS;
   (3) Maintain Oregon Notary License for purposes of obtaining notarized consent to use infants’ DBS;
   (4) Document on an ongoing basis the success of case recruitment; and
   (5) Provide information on the study as needed by the Influenza principal investigator and ACDP epidemiologists for grant reports and continuing reviews by OHA’s Public Health Institutional Review Board.

g. LPHA must conduct study of persons with invasive GAS infection to evaluate risks for and means of prevention of invasive GAS as follows:

   (1) Review hospital charts of potential cases reported to the Emerging Infections Program ABCs Activity and determine which cases meet eligibility criteria (Attachment 2);
   (2) Contact hospital personnel to determine if patient is still hospitalized and arrange for interview;
   (3) Conduct interviews using to Attachment 10 and enter data into GAS HRI study database;
   (4) Document on an ongoing basis the success of case recruitment; and
   (5) Provide information on the study as needed by the ABCs principal investigator and ACDP epidemiologists for grant reports.

h. As needed, LPHA must plan and conduct case and outbreak investigations as well as related epidemiologic investigations to address public health threats in the community. LPHA must:

   (1) Plan epidemiologic investigations independently and in close collaboration with state and county;
   (2) Determine the feasibility and approach to epidemiologic investigations;
   (3) Collaborate with colleagues in other county, state, or federal agencies, and with scientists, economists, physicians and other professional colleagues;
   (4) Perform appropriate methodological techniques and processes;
   (5) Conduct epidemiologic outbreak investigations, including on-site reviews of facilities and procedures; and
   (6) Design questionnaires and other data collection instruments; and interview patients, health care providers, and others involved.

i. GISP:

   (1) LPHA must assign adequate staff to conduct the study. The assigned staff must include the following:
   (2) Lab Medical Technologist (0.06 FTE), to: 1) identify and sub-culture isolates of *N. gonorrhoeae* and ship per protocol to ARLN. Disease LPHA must establish and maintain expanded surveillance system for antibiotic-resistant *N. gonorrhoeae* or urethral *N. meningitidis* infections in individuals seen at MCHD-STD, by:

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Collecting swabs and culture from first 25 eligible patients each month; identifying and sub-culturing isolates from submitted specimens; shipping \textit{N. gonorrhoeae} isolates to ARLN

5. **General Revenue and Expense Reporting.** LPHA must complete an “Oregon Health Authority Public Health Division Expenditure and Revenue Report” located in Exhibit C of the Agreement. These reports must be submitted to OHA each quarter on the following schedule:

<table>
<thead>
<tr>
<th>Fiscal Quarter</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>First: July 1 – September 30</td>
<td>October 30</td>
</tr>
<tr>
<td>Second: October 1 – December 31</td>
<td>January 30</td>
</tr>
<tr>
<td>Third: January 1 – March 31</td>
<td>April 30</td>
</tr>
<tr>
<td>Fourth: April 1 – June 30</td>
<td>August 20</td>
</tr>
</tbody>
</table>

a. Detailed Budget Expense Reports for each activity will need to be submitted to OHA in addition to the quarterly Expenditure and Revenue Report.

b. Funds may be shifted between approved budgets on file with OHA up to 10% without requesting permission.

6. **Reporting Requirements.**

a. LPHA must submit all pertussis clinical data in the prescribed Excel® database, along with pertussis isolate shipments (using the isolate spreadsheet and protocol – Attachment 1 “Enhanced Pertussis Surveillance Spreadsheet”) to OHA every other month. Measures of performance: completeness of data, timeliness of reporting, proportion of cases with isolates sent to CDC and percent of isolates that can be linked to the enhanced epi data.

b. LPHA must provide written semi-annual progress reports that detail the work completed, the number of confirmed and probable cases for the year to date, and characteristics of individuals with confirmed or probable pertussis diagnoses and containing such additional information as may be required by CDC. LPHA must submit the progress updates in accordance with a format and reporting schedule determined by OHA in consultation with LPHA.

c. LPHA Epidemiologist must complete chart reviews and data entry of EIP-related surveillance and study cases (ABCs, hospitalized influenza, hospitalized RSV, MuGS1, Candidemia, CDI and HPV) within 30 days of receiving notification of assigned cases to be reviewed. LPHA must enter data monthly into a prescribed Excel® file for submission to CDC.

d. LPHA Epidemiologist must complete quarterly report on findings from data quality review, including number of cases reviewed from each surveillance system, number and nature of discrepancies, and recommendations to EIP staff for improving quality of chart reviews.

e. LPHA Epidemiologist must, as needed, perform statistical analyses related to epidemiologic investigations conducted, either as outbreak investigation or special studies, and provide monthly progress reports to ACDP on study progress and findings to date.

f. GISP:

LPHA must provide written semi-annual progress updates detailing numbers of specimens collected and shipped to appropriate reference lab, percentage of eligible patients for whom appropriate specimens were collected, and summaries of clinical and demographic characteristics of clients tested; and such additional information as may be required by CDC. LPHA must submit the progress updates in accordance with a format and reporting schedule determined by ACDP in consultation with LPHA.
7. **Performance Measures.**

Not Applicable
## Enhanced Pertussis Surveillance Spreadsheet (Example)

**Enhanced Pertussis Surveillance Isolates: Oregon**

<table>
<thead>
<tr>
<th>State</th>
<th>State ID</th>
<th>Accession #</th>
<th>Bacterial Species</th>
<th>Specimen Source</th>
<th>Collection Date</th>
<th>Date Sent to CDC</th>
<th>State PFGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1=Bordetella pertussis</td>
<td>1=NP Aspirate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2=Bordetella parapertussis</td>
<td>2=Swab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3=Bordetella bronchiseptica</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4=Bordetella holmesii</td>
<td></td>
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</tr>
</tbody>
</table>

**Date:** __________

**07/01/2020 (SFY21)**
## Attachment 2
### Active Bacterial Core Surveillance Case Report

<table>
<thead>
<tr>
<th>1. STATE: (Residence of Patient)</th>
<th>2. STATE I.D.:</th>
<th>3. DATE FIRST POSITIVE CULTURE COLLECTED (Date specimen collected)</th>
<th>4. Date reported to EP site:</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. COUNTY: (Residence of Patient)</th>
<th>7a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED:</th>
<th>7b. HOSPITAL/LAB I.D. WHERE PATIENT TREATED:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. DATE OF BIRTH:</th>
<th>9a. AGE:</th>
<th>10. SEX:</th>
<th>11a. ETHNIC ORIGIN:</th>
<th>11b. RACE: (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo. Day Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:</th>
<th>12b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE (specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Neisseria meningitidis</td>
<td></td>
</tr>
<tr>
<td>2. N. gonorrhoeae</td>
<td></td>
</tr>
<tr>
<td>3. Group B: Streptococcus</td>
<td></td>
</tr>
<tr>
<td>4. Group A: Streptococcus</td>
<td></td>
</tr>
<tr>
<td>5. Staphylococcus aureus</td>
<td></td>
</tr>
<tr>
<td>6. Staphylococcus epidermidis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)</th>
<th>14. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>Placenta</td>
</tr>
<tr>
<td>Urine</td>
<td>Wound</td>
</tr>
<tr>
<td>Joint</td>
<td>Sinus</td>
</tr>
<tr>
<td>CSF</td>
<td>Metabolic fluid</td>
</tr>
<tr>
<td>Urine</td>
<td>Middle ear</td>
</tr>
</tbody>
</table>

**INFLUENZA** 15. Did this patient have a positive test 10 days prior to or following any ABCs positive culture?  Yes [ ] No [ ] 9. Unknown [ ]

<table>
<thead>
<tr>
<th>16. WAS PATIENT HOSPITALIZED:</th>
<th>17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes [ ] No [ ]</td>
<td>Yes [ ] No [ ] 9. Unknown [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18a. Where was the patient a resident at time of initial culture?</th>
<th>18b. If resident of a facility, what was the name of the facility?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Private residence</td>
<td>1. Yes [ ] 2. No [ ] 9. Unknown [ ]</td>
</tr>
<tr>
<td>2. Homeless</td>
<td></td>
</tr>
<tr>
<td>3. Non-medical ward</td>
<td></td>
</tr>
<tr>
<td>4. Incarcerated</td>
<td></td>
</tr>
<tr>
<td>5. Other [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19a. Was patient transferred from another hospital?</th>
<th>19b. If Yes, hospital I.D.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes [ ] No [ ] 9. Unknown [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20a. WEIGHT:</th>
<th>21. TYPE OF INSURANCE: (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>lbs. kg.</td>
<td>Private [ ] Military [ ] Other [ ]</td>
</tr>
<tr>
<td>or Unknown</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20b. HEIGHT:</th>
<th>22. If survived, patient discharged to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ft. in. cm.</td>
<td>1. Home [ ] 2. LTC/NF/FAC ID [ ] 3. TACH/FAC ID [ ] 4. Other [ ] 9. Unknown [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22a. COOUTME:</th>
<th>23. If patient died, was the culture obtained on autopsy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Survived</td>
<td>1. Yes [ ] 2. No [ ] 9. Unknown [ ]</td>
</tr>
<tr>
<td>2. Died [ ]</td>
<td></td>
</tr>
<tr>
<td>3. Unknown [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24a. At time of first positive culture, patient was:</th>
<th>24b. If pregnant or postpartum, what was the outcome of fetus:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>25. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply)</th>
<th>25. If patient &lt;1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bacterial meningitis without focal infection</td>
<td>Gestational age: Birth weight: (wks) (lbs)</td>
</tr>
<tr>
<td>2. Pneumonia</td>
<td></td>
</tr>
<tr>
<td>3. Meningitis</td>
<td></td>
</tr>
<tr>
<td>4. Endocarditis</td>
<td></td>
</tr>
<tr>
<td>5. Sepsis</td>
<td></td>
</tr>
<tr>
<td>6. Pertussis</td>
<td></td>
</tr>
<tr>
<td>7. Necrotizing fascián</td>
<td></td>
</tr>
</tbody>
</table>

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Public reporting burden of this collection of information is estimated to average 30 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. Submit comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden to CDC, CDC/ASOR Reports Clearance Office, 1600 Clifton Road, MS D74, Atlanta, GA 30333. ATTN: PA(0920-0878). Do not send the completed form to this address.

---

07/01/2020 (SFY21)
27. UNDERLYING CAUSES OR PRIOR ILLNESSES: (Check all that apply or if None or Chart Unavailable, check appropriate box) None Unknown

1. AIDS or CD4 count <200
2. Alcohol Abuse, Current
3. Alcohol Abuse, Past
4. Asthma
5. Atherosclerotic Cardiovascular Disease (ASCVD)/CAD
6. Bone Marrow Transplant (BMT)
7. Cerebrovascular Accident (CVA)/Stroke
8. Chronic Kidney Disease
9. Current Chronic Dialysis
10. Chronic Skin Breakdown
11. Cirrhosis/Liver Failure
12. Cochlear Implant
13. CVVHD/CVRRT
14. Diabetes Mellitus
15. Dementia
16. Deaf/Profound Hearing Loss
17. DVT/PE
18. Heart Failure/CHF
19. HIV Infection
20. Hodgkin's Disease/Lymphoma
21. Immunoglobulin Deficiency
22. Immunocompromising Therapy (Steroids, Chemotherapy, Radiation)
23. IV Drug Use, Current
24. IV Drug Use, Past
25. Leukemia
26. Malignancy
27. Multiple Myeloma
28. Necrotizing Enteritis
29. Neurological Disorder
30. Neutropenia
31. Obesity
32. Parkinson's Disease
33. Other Drug Use, Current
34. Other Drug Use, Past
35.Peripheral Neuropathy
36. Postmenopausal
37. Polymyalgia/Rheumatica
38. Premature Birth (Specify gestational age at birth in weeks)
39. Seizure/epilepsy Disorder
40. Sickle Cell Anemia
41. Solid Organ Malignancy
42. Solid Organ Transplant
43. Splenectomy/Aplasia
44. Systemic Lupus Erythematosus (SLE)
45. Other Prior Illness (Specify)

HAEMOPHILUS INFLUENZAE

28a. What was the serotype? 1 b 2 c Not Typable 3 d 4 e 5 f 6 g 7 h 8 i 9 j Other (specify) k 0 Not tested or Unknown

28b. If <15 years of age and serotype 'b' or unknown did the patient receive Haemophilus influenza b vaccine? 0 Yes 1 No 2 Unknown

28c. Were records obtained to verify vaccination history? 0 <5 years of age with Hib/unknown serotype, only

29. Is the HI case a stillbirth or fetal death associated with placenta and/or amniotic fluid isolate or a neonate (<22 wks gestation)? 0 Yes 1 No

NEISSERIA MENINGITIS

30. What was the serogroup? A 1 B 2 C 3 D 4 E 5 W135 6 Nontypeable 7 Other 8 Unknown

31. Did the patient receive meningococcal conjugate vaccine (MenACWY)? 0 Yes 1 No 2 Unknown

32. Did the patient receive pneumococcal vaccine? 0 Yes 1 No 2 Unknown

33. Did the patient have surgery or any skin incision? 0 Yes 1 No 2 Unknown

34. Did the patient deliver a baby (intrapartum C-section)? 0 Yes 1 No 2 Unknown

35. Did the patient have:
   1. Vaginal delivery
   2. Cesarean section
   3. Postoperative (post operative)
   4. Blunt trauma
   5. Burns

36. COMMENTS:

37. Was case first identified through audit? 0 Yes 1 No 2 Unknown

38. Does this case have recurrent disease with the same pathogen? 0 Yes 1 No 2 Unknown

39. Initials of S.D.: ____________
### E. Admission and Patient History

1. Was patient discharged from any hospital within one week prior to the current admission date?  
   - Yes  
   - No  
   - Unknown

2. Acute signs/symptoms at admission (within 2 weeks prior to positive flu test):  
   - Altered mental status/confusion
   - Chest pain
   - Cough*  
   - Constricted/rusty nose*
   - Conjunctivitis/pink eye
   - Fatigue/weakness
   - Fever/chills
   - Headache
   - Myalgia/muscle aches
   - Nausea/vomiting
   - Rash
   - Shortness of breath/respiratory distress*
   - Sore throat*
   - Seizure*
   - Wheezing*  
   - Other, non-respiratory

   *These are considered acute respiratory symptoms

3. Date of onset of acute respiratory symptoms (within 2 weeks prior to positive flu test):  
   - / /  
   - Unknown

4. Date of onset of acute respiratory condition resulting in current hospitalization:  
   - / /  
   - Unknown

5. BMI:  
   - Unknown
   - In  
   - Cm  
   - Unknown

6. Height:  
   - Lbs  
   - Kg  
   - Unknown

7. Weight:  
   - Lbs
   - Kg  
   - Unknown

8. Smoker:  
   - Current  
   - Former  
   - Unknown

9. Alcohol abuse:  
   - Current  
   - Former  
   - Unknown

10. Substance abuse:  
    - Current  
    - Former  
    - Unknown

10a. Asthma/Reactive Airway Disease  
    - Yes  
    - No

10b. Chronic Lung Disease  
    - Yes  
    - No

10c. Chronic Metabolic Disease  
    - Yes  
    - No

10d. Blood disorders/Hemoglobinopathy  
    - Yes  
    - No

10e. Cardiovascular Disease  
    - Yes  
    - No

10f. Neuroromuscular disorder  
    - Yes  
    - No

10g. Neurologic disorder  
    - Yes  
    - No

### F. Intensive Care Unit and Interventions

1. Was the patient admitted to an intensive care unit (ICU)?  
   - Yes  
   - No  
   - Unknown

1a. Number of ICU Admissions:  
   - Unknown

1b. Date of first ICU Admission:  
   - Unknown

1c. Date of first ICU Discharge:  
   - Unknown

2. Did patient receive mechanical ventilation?  
   - Yes  
   - No

3. Did patient receive extracorporeal membrane oxygenation (ECMO or ‘on bypass’)?  
   - Yes  
   - No

---

Page 2 of 4

07/01/2020 (SFY21)
G. Bacterial Pathogens – Sterile or respiratory site only

1. Were any bacterial culture tests performed with a collection date within three days of admission? □ Yes □ No □ Unknown
2. If yes, was there a positive culture for a bacterial pathogen? □ Yes □ No □ Unknown

3a. If yes, specify Pathogen 1:

3b. Date of culture: _______/_____/______

3c. Site where pathogen identified:
   □ Blood
   □ Bronchoalveolar lavage (BAL)
   □ Pleural fluid
   □ Other, specify: ________________________________

3d. If Staphylococcus aureus, specify:
   □ Methicillin resistant (MRSA)
   □ Methicillin sensitive (MSSA)
   □ Sensitivity unknown

3e. If Haemophilus influenzae, specify if type B:
   □ Yes □ No □ Unknown

3f. If Neisseria meningitidis, specify serogroup:
   □ B □ C □ Y □ Other □ Unknown

4a. If yes, specify Pathogen 2:

4b. Date of culture: _______/_____/______

4c. Site where pathogen identified:
   □ Blood
   □ Bronchoalveolar lavage (BAL)
   □ Pleural fluid
   □ Other, specify: ________________________________

4d. If Staphylococcus aureus, specify:
   □ Methicillin resistant (MRSA)
   □ Methicillin sensitive (MSSA)
   □ Sensitivity unknown

4e. If Haemophilus influenzae, specify if type B:
   □ Yes □ No □ Unknown

4f. If Neisseria meningitidis, specify serogroup:
   □ B □ C □ Y □ Other □ Unknown

H. Viral Pathogens

1. Was patient tested for any of the following viral respiratory pathogens within 3 days of admission? □ Yes □ No □ Unknown

1a. Respiratory syncytial virus/RSV
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

1b. Adenovirus
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

1c. Parainfluenza 1
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

1d. Parainfluenza 2
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

1e. Parainfluenza 3
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

1f. Parainfluenza 4
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

1g. Human metapneumovirus
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

1h. Rhinovirus/Enterovirus
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

1i. Coronavirus (type): __________________________
   □ Yes, positive □ Yes, negative □ Not tested/Unknown Date: _______/_____/______

I. Influenza Treatment

1. Did patient receive antiviral medication treatment for influenza during the course of this illness? □ Yes □ No □ Unknown

2a. Treatment 1:
   □ Oseltamivir (Tamiflu)
   □ Zanamivir (Relenza)
   □ Peramivir (Rapivab)
   □ Other, specify: ____________________________

2b. Method of Administration:
   □ Oral □ Intravenous (IV) □ Inhaled □ Unknown

2c. Start Date: _______/_____/______ 2d. End Date: _______/_____/______
   □ Start Date Unknown □ End Date Unknown

2e. Dose:
   □ 75 mg □ 30 mg □ 45 mg □ Other ______
   □ Dose Unknown □ QD □ QOD □ BID
   □ Frequency Unknown □ TID □ Other ______

3a. Treatment 2:
   □ Oseltamivir (Tamiflu)
   □ Zanamivir (Relenza)
   □ Peramivir (Rapivab)
   □ Other, specify: ____________________________

3b. Method of Administration:
   □ Oral □ Intravenous (IV) □ Inhaled □ Unknown

3c. Start Date: _______/_____/______ 3d. End Date: _______/_____/______
   □ Start Date Unknown □ End Date Unknown

3e. Dose:
   □ 75 mg □ 30 mg □ 45 mg □ Other ______
   □ Dose Unknown □ QD □ QOD □ BID
   □ Frequency Unknown □ TID □ Other ______

4a. Treatment 3:
   □ Oseltamivir (Tamiflu)
   □ Zanamivir (Relenza)
   □ Peramivir (Rapivab)
   □ Other, specify: ____________________________

4b. Method of Administration:
   □ Oral □ Intravenous (IV) □ Inhaled □ Unknown

4c. Start Date: _______/_____/______ 4d. End Date: _______/_____/______
   □ Start Date Unknown □ End Date Unknown

4e. Dose:
   □ 75 mg □ 30 mg □ 45 mg □ Other ______
   □ Dose Unknown □ QD □ QOD □ BID
   □ Frequency Unknown □ TID □ Other ______

5. Additional Treatment Comments:
### J. Chest Radiograph – Based on radiology report only

1. Was a chest x-ray taken within 3 days of admission?  
   - Yes  
   - No  
   - Unknown

2. Were any of these chest x-rays abnormal?  
   - Yes  
   - No  
   - Unknown

2a. Date of first abnormal chest x-ray:  
   - __/__/____

2b. For first abnormal chest x-ray, please check all that apply:  
   - Report not available  
   - Air space density  
   - Air space opacity  
   - Bronchopneumonia/pneumonia  
   - ARDS (acute respiratory distress syndrome)  
   - Lung infiltrate  
   - Consolidation  
   - Cavitatin  
   - Intersitial infiltrate  
   - Lobar infiltrate  

### K. Discharge Summary

Did the patient have any of the following new diagnoses at discharge? (check all that apply)  

- Acute encephalopathy/encephalitis  
- Acute Myocardial Infarction  
- Acute Myocarditis  
- Acute Renal Failure  
- Acute respiratory distress syndrome (ARDS)  
- Acute respiratory failure  
- Asthma exacerbation  
- Bacteremia  
- No discharge summary available

2a. If discharged alive, please indicate to where:  
   - Private residence  
   - Homeless/Shelter  
   - Nursing home/Skilled Nursing Facility  
   - Alcohol/Drug Abuse Treatment  
   - Home with services  
   - Rehabilitation Facility  
   - Group home/Retirement home  
   - Jail/Prison  
   - Hospice  
   - Assisted living/Residential care  
   - Mental Hospital  
   - LTACH

3. If patient was pregnant on admission, indicate pregnancy status at discharge:  
   - Still pregnant  
   - No longer pregnant  
   - Unknown

3a. If patient was pregnant on admission but no longer pregnant at discharge, indicate pregnancy outcome at discharge:  
   - Miscarriage  
   - Ill newborn  
   - Newborn died  
   - Healthy newborn  
   - Abortion  
   - Unknown

### L. ICD-10 Discharge Diagnoses – To be recorded in order of appearance

<table>
<thead>
<tr>
<th>ICD codes</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
<th>9.</th>
</tr>
</thead>
</table>

### M. Vaccination History

Specify vaccination status and date(s) by source:

1. Medical Chart:  
   - Yes, full date known  
   - Yes, specific date unknown  
   - No  
   - Unknown  
   - Not checked  
   - Unsuccessful Attempt

1a. If yes, specify dosage date information:  
   - __/__/____  
   - Date Unknown  
   - Pediatrics Only  

1b. If patient < 9 yrs, specify vaccine type:  
   - Injected Vaccine  
   - Nasal Spray/FluMist  
   - Combination of both  
   - Unknown type

2. Vaccine Registry:  
   - Yes, full date known  
   - Yes, specific date unknown  
   - No  
   - Unknown  
   - Not checked  
   - Unsuccessful Attempt

2a. If yes, specify dosage date information:  
   - __/__/____  
   - Date Unknown  
   - Pediatrics Only  

2b. If patient < 9 yrs, specify vaccine type:  
   - Injected Vaccine  
   - Nasal Spray/FluMist  
   - Combination of both  
   - Unknown type

3. Primary Care Provider / LTCF:  
   - Yes, full date known  
   - Yes, specific date unknown  
   - No  
   - Unknown  
   - Not checked  
   - Unsuccessful Attempt

3a. If yes, specify dosage date information:  
   - __/__/____  
   - Date Unknown  
   - Pediatrics Only  

3b. If patient < 9 yrs, specify vaccine type:  
   - Injected Vaccine  
   - Nasal Spray/FluMist  
   - Combination of both  
   - Unknown type

4. Interview:  
   - Patient  
   - Proxy  
   - Yes, full date known  
   - Yes, specific date unknown  
   - No  
   - Unknown  
   - Not checked  
   - Unsuccessful Attempt

4a. If yes, specify dosage date information:  
   - __/__/____  
   - Date Unknown  
   - Pediatrics Only  

4b. If patient < 9 yrs, specify vaccine type:  
   - Injected Vaccine  
   - Nasal Spray/FluMist  
   - Combination of both  
   - Unknown type

5. If patient < 9 yrs, did patient receive any seasonal influenza vaccine in previous seasons?  
   - Yes  
   - No  
   - Unknown

### N. Miscellaneous

1. Additional Comments:
### 2016 Multi-site Gram-Negative Surveillance Initiative (MuGSI) Healthcare Associated Infection Community Interface (HAIC) Case Report

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID:</td>
<td>Form Approved OMB No. 0920-0978</td>
</tr>
<tr>
<td>Patient's Name</td>
<td>Phone no. ( )</td>
</tr>
<tr>
<td>Address</td>
<td>MIBN</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>— Patient identifier information is NOT transmitted to CDC —</td>
<td></td>
</tr>
</tbody>
</table>

#### 1. STATE: 2. COUNTY: 3. STATE ID: 4a. LABORATORY ID WHERE CULTURE IDENTIFIED: 4b. FACILITY ID WHERE PATIENT TREATED:

#### 5. Where was the patient located on the 4th calendar day prior to the date of initial culture?
- [ ] Private residence
- [ ] Hospital inpatient
- [ ] LTCF Facility ID: ____________________
- [ ] LTACH Facility ID: ____________________
- [ ] Homeless
- [ ] Incarcerated
- [ ] Other (specify): ____________________
- [ ] Unknown

#### 6. DATE OF BIRTH:
- [ ] Days
- [ ] Month
- [ ] Year

#### 7a. AGE:
- [ ] Days
- [ ] Months
- [ ] Years

#### 8a. SEX:
- [ ] Male
- [ ] Female

#### 8b. RACE (Check all that apply):
- [ ] White
- [ ] Black or African American
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Unknown

#### 8c. ETHNIC ORIGIN:
- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino
- [ ] Unknown

#### 8d. WEIGHT:
- [ ] lbs
- [ ] kg
- [ ] Unknown

#### 8e. HEIGHT:
- [ ] ft
- [ ] in
- [ ] cm
- [ ] Unknown

#### 8f. BMI (Record only if ht and/or wt is not available):
- [ ] Unknown

#### 9. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?
- [ ] Yes
- [ ] No
- [ ] Unknown

If yes: Date of admission | Date of discharge
--- | ---

#### 10a. DATE OF INITIAL CULTURE

#### 10b. LOCATION OF CULTURE COLLECTION:
- [ ] Hospital inpatient
- [ ] Outpatient
- [ ] ICU
- [ ] Clinic/Doctors Office
- [ ] Surgery
- [ ] LTCF Facility ID: ____________________
- [ ] LTACH Facility ID: ____________________
- [ ] Radiology
- [ ] Other Outpatient
- [ ] Autopsy
- [ ] Other Unit
- [ ] Dialysis Center
- [ ] Unknown
- [ ] Emergency Room
- [ ] Observational Unit/Clark Decision Unit

#### 11a. Was the patient in the ICU in the 7 days prior to their initial culture?
- [ ] Yes
- [ ] No
- [ ] Unknown

#### 11b. Was the patient in the ICU on the date of or in the 7 days after the initial culture?
- [ ] Yes
- [ ] No
- [ ] Unknown

#### 12. PATIENT OUTCOME: Survived | Died | Unknown

If survived, transferred to:  
- [ ] Private residence
- [ ] LTCF Facility ID: ____________________
- [ ] LTACH Facility ID: ____________________
- [ ] Unknown
- [ ] Other (specify): ____________________

If died, date of death:
- [ ] Day
- [ ] Month
- [ ] Year

Was the organism cultured from a normally sterile site or urine, < calendar day 7 before death?
- [ ] Yes
- [ ] No
- [ ] Unknown

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13a. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE:
- Carbapenem-resistant:
  - Enterobacteriaceae (CRE):
    - E. coli
    - Enterobacter cloacae
    - Enterobacter aerogenes
    - Klebsiella pneumoniae
    - Klebsiella oxytoca
    - A. baumannii (ETAB)
- [ ] Yes
- [ ] No
- [ ] Unknown

13b. Was the initial culture polymicrobial?
- [ ] Yes
- [ ] No
- [ ] Unknown

13c. Was the initial isolate tested for carbapenemase?
- [ ] Yes
- [ ] No
- [ ] Laboratory Not Testing
- [ ] Unknown

If yes, what testing method was used (check all that apply): Automated Molecular Assay, CarbAP, E Test, PCR, Modified Hodge Test (MHT), Other (specify): ______________________, Unknown

If tested, what was the testing result? Positive, Negative, Indeterminate, Unknown

14. INITIAL CULTURE SITE:
- [ ] Blood
- [ ] CSF
- [ ] Pleural fluid
- [ ] Peritoneal fluid
- [ ] Pericardial fluid
- [ ] Joint/synovial fluid
- [ ] Bone
- [ ] Urine
- [ ] Other normally sterile site

If yes, source (check all that apply): Altered mental status, Acute pain, swelling or tenderness of the testes, epididymis or prostate, Chills, Cloudy, Costovertebral angle pain or tenderness, Dysuria, Fever, Frequency, Hematuria, Incontinence, Leukocytosis, Malodorous, Purulent discharge, Pyuria, Retention, Suprapubic tenderness, Urgency, Unspecified abdominal pain/tenderness, Unknown, Other (specify): ______________________

14a. How was the urine collected?
- [ ] Clean Catch
- [ ] In and Out Catheter
- [ ] Indwelling Catheter
- [ ] Condom Catheter
- [ ] Other: ______________________
- [ ] Unknown

14b. Record the colony count for the organism indicated in Q13a:
- [ ] Unknown

15. Was the same organism (Q13a) cultured from a different sterile site or urine in the 30 days after the date of initial culture (of this current episode)?
- [ ] Yes
- [ ] No
- [ ] Unknown

If yes, source (check all that apply): Blood, Joint/synovial fluid, CSF, Pleural fluid, Urine, Peritoneal fluid, Pericardial fluid

16. Enterobacteriaceae ONLY:
Were cultures of sterile site(s) or urine positive in the 30 days prior to the date of initial culture, for a DIFFERENT organism (Q13a)?
- [ ] Yes
- [ ] No
- [ ] Unknown
- [ ] NA

If yes, source (check all that apply): Blood, Joint/synovial fluid, CSF, Bone, Pleural fluid, Urine, Peritoneal fluid, Pericardial fluid

16a. A. baumannii Cultures ONLY:
Were cultures of OTHER sterile site(s) or urine positive in the 30 days prior to the date of initial culture, for another A. baumannii?
- [ ] Yes
- [ ] No
- [ ] Unknown
- [ ] NA

If yes, source (check all that apply): Blood, Joint/synovial fluid, CSF, Bone, Pleural fluid, Urine, Peritoneal fluid, Pericardial fluid

17a. Was this patient positive for the SAME organism in the year prior to the date of the initial culture (Q10a)?
- [ ] Yes
- [ ] No (GO TO Q17c)
- [ ] Unknown (GO TO Q17c)

17b. If yes, specify date of culture and State ID for the first positive culture in the year prior:

[ ] / [ ] / [ ]

State ID: ______________________

17c. Enterobacteriaceae ONLY:
Was this patient positive for a MUGS Enterobacteriaceae in the year prior to the date of initial culture (Q10a)?
- [ ] Yes
- [ ] No (GO TO Q18)
- [ ] Unknown (GO TO Q18)
- [ ] NA (GO TO Q18)
17d. If yes, specify organism, date of culture and State ID for the first positive *Enterobacteriaceae* culture in the year prior to the date of initial culture (Q10a):

- Carbapenem-resistant *Enterobacteriaceae* (CRE):
  - E. coli
  - Enterobacter cloacae
  - Enterobacter aerogenes
  - Klebsiella pneumoniae
  - Klebsiella oxytoca

Date of Culture: __/__/____
State ID: _______________________

18. Susceptibility Results: (please complete the table below based on the information found in the indicated data source). Shaded antibiotics are required to have the MIC entered into the MUGSI CM system, if available.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Medical Record</th>
<th>Microscan</th>
<th>Vitek</th>
<th>Phoenix</th>
<th>Kirby-Bauer</th>
<th>E-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MIC</td>
<td>Interp</td>
<td>MIC</td>
<td>Interp</td>
<td>MIC</td>
<td>Interp</td>
</tr>
<tr>
<td>Amikacin</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Amoxicillin/Clavulanate</td>
<td></td>
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<tr>
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<td></td>
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<td></td>
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<tr>
<td>Ampicillin/Sulbactam</td>
<td></td>
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<tr>
<td>Aztreonam</td>
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<tr>
<td>Cefazolin</td>
<td></td>
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<tr>
<td><strong>CEFEPIME</strong></td>
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</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td>Cephalothin</td>
<td></td>
<td></td>
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<tr>
<td>Ciprofloxacin</td>
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<tr>
<td><strong>COLISTIN</strong></td>
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<td>Doripenem</td>
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<tr>
<td>Ertapenem</td>
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<tr>
<td>Gentamicin</td>
<td></td>
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<tr>
<td>IMIPENEM</td>
<td></td>
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<td></td>
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<tr>
<td>Levofloxacin</td>
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<tr>
<td>Meropenem</td>
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<tr>
<td>Moxifloxacin</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Nitrofurantoin</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pipracillin/Tazobactam</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>POLYMYXIN B</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tigecycline</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Tobramycin</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimethoprim-sulfamethoxazole</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

19. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S) (check all that apply): None  Unknown

- Abscess, not skin
- AV fistula/graft infection
- Bacteremia
- Burstd
- Catheter site infection (CVC)
- Cellulitis
- Chronic ulcer/wound (not decubitus)
- Decubitus/pressure ulcer
- Empyema
- Endocarditis
- Meningitis
- Osteomyelitis
- Peritonitis
- Pneumonia
- Pyelonephritis
- Septic arthritis
- Sepsis emboli
- Septic shock
- Skin abscess
- Surgical incision infection
- Surgical site infection (internal)
- Traumatic wound
- Urinary tract infection
- Other

20. UNDERLYING CONDITIONS (check all that apply): None  Unknown

- AIDS/CD4 count < 200
- Alcohol abuse
- Chronic Liver Disease
- Chronic Pulmonary Disease
- Chronic Renal Insufficiency
- Chronic Skin Breakdown
- Congestive Heart Failure
- Connective Tissue Disease
- Current Smoker
- CVA/Stroke
- Cystic Fibrosis
- Decubitus/Pressive Ulcer
- Dementia/Chronic Cognitive Deficit
- Diabetes
- Hemiplegia/Paraplegia
- HIV
- Hematologic Malignancy
- IVDU
- Liver failure
- Metastatic Solid Tumor
- Myocardial Infarct
- Neurological Problems
- Obesity or Morbid Obesity
- Peptic Ulcer Disease
- Peripheral Vascular Disease (PVD)
- Premature Birth
- Solid tumor (non metastatic)
- Spina bifida
- Transplant Recipient
- Urinary Tract Problems/Abnormalities
21. RISK FACTORS OF INTEREST (check all that apply): □ None □ Unknown

☐ Culture collected > calendar day 3 after hospital admission
☐ Hospitalized within year before date of initial culture:
  If yes, enter mo/yr: __/___ OR Unknown
  If known, prior hospital ID: ____________________________
  Surgery within year before date of initial culture
  If Yes, not hospital ID: ____________________________
  Current chronic dialysis: □ Peritoneal □ Hemodialysis □ Unknown
  √ Hemodialysis Access: □ AV fistula/graft □ CVC □ Unknown
  Residence in LTCF within year before date of initial culture
  If known, facility ID: ____________________________
  □ Admitted to a LTACH within year before initial culture date
  If known, facility ID: ____________________________

☐ Central venous catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture
☐ Urinary catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture
  If checked, indicate all that apply:
  □ Indwelling Urethral Catheter □ Suprapubic Catheter
  □ Condom Catheter □ Other: ____________________________
  □ Any OTHER indwelling device in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture
  If checked, indicate all that apply:
  □ ET/NT Tube □ Gastrostomy Tube □ NG Tube
  □ Tracheostomy □ Nephrostomy Tube □ Other: ____________________________
  □ Patient traveled internationally in the two months prior to the date of initial culture.
  Country: ____________________________
  □ Patient was hospitalized while visiting country (ies) listed above

SURVEILLANCE OFFICE USE ONLY

22. Was case first identified through audit?
☐ Yes
☐ No
☐ Unknown

23. CRF status:
☐ Complete
☐ Pending
☐ Chart unavailable

24. Date reported to EIP site:

25. SO initials: ____________________________

26. Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Attachment 5: Candidemia

CANDIDEMIA 2016 CASE REPORT FORM

Patient name: __________________________ Medical Record No.: __________________________
Address: _______________________________ Hospital: _______________________________
(Number, Street, Apt. No.) __________________________ Acc No. (incident isolate): __________________________
(City, State) __________________________ Acc No. (subseq isolate): __________________________

Check if not a case: [ ] Out of catchment area [ ] Duplicate entry [ ] Not candidemia [ ] Unable to verify address [ ] Other reason:

1) State ID: __________________________ 2) County: __________________________ 3) Lab ID where positive culture was identified: __________________________

4) Age: [ ] days [ ] mos [ ] yrs (check one) 5) Date of birth: __________________________/____________________/______________ (mm/dd/yyyy)

6) Sex: [ ] Male [ ] Female [ ] Transgendered 7) Date first positive culture for Candida was drawn: __________________________/____________________/______________

8) Source of first positive culture: [ ] Blood, from central venous catheter [ ] Blood, from peripheral stick [ ] Blood, not specified
   [ ] Other (specify) ____________________________ 5) Blood, from arterial line [ ] Unknown

9) Candida species (check all that apply):
   1) [ ] Candida albicans (CA) 6) [ ] Candida tropicalis (CT)
   2) [ ] Candida glabrata (CG) 7) [ ] Candida other (CO)
   3) [ ] Candida krusei (CK) 8) [ ] Candida, gram tube negative/ non albicans (CGN)
   4) [ ] Candida lusitaniae (CL) 9) [ ] Candida species (CS)
   5) [ ] Candida parapsilosis (CP) 10) [ ] Pending

9A) Antifungal susceptibility testing (check here [ ] if no testing done/no test reports available):

<table>
<thead>
<tr>
<th>Date of culture</th>
<th>Species</th>
<th>Drug</th>
<th>MIC</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amphotericin B</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
<tr>
<td></td>
<td>Anidulafungin (Eraxis)</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
<tr>
<td></td>
<td>Caspofungin (Cancidas)</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
<tr>
<td></td>
<td>Fluconazole (Diflucan)</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
<tr>
<td></td>
<td>Flucytosine (SFC)</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
<tr>
<td></td>
<td>Itraconazole (Sporanox)</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
<tr>
<td></td>
<td>Micafungin (Mycamine)</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
<tr>
<td></td>
<td>Posaconazole (Noxafil)</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
<tr>
<td></td>
<td>Voriconazole (Vfend)</td>
<td>Unk</td>
<td>S, SDD</td>
<td>T, R, INS, ND/Unk</td>
</tr>
</tbody>
</table>

9B) Additional Candida species or another C. glabrata isolated within 30d of incident culture (If yes, attach additional CRF: Q1, Q8, Q9, Q9A, and Q10): 1) [ ] Yes 2) [ ] No 3) [ ] Unknown

10) Additional organisms isolated from this blood culture: 1) [ ] Yes 2) [ ] No 3) [ ] Unknown

If yes, specify additional organisms:

---SURVEILLANCE OFFICE USE ONLY---

a) Date reported to EIP site: __________________________
b) Date review completed: __________________________
c) Was case first identified through audit? 1) [ ] Yes 2) [ ] No
d) Isolate available? 1) [ ] Yes 2) [ ] No
e) Previous candidemia episode? 1) [ ] Yes If yes, enter 1st state ID: __________________________
f) CRF status: 1) [ ] Complete 2) [ ] Pending 4) [ ] chart unavailable

g) SD’s initials: __________________________

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07/01/2020 (SFY21)
### DEMOGRAPHICS

11. Race:
   - [ ] White
   - [ ] Native Hawaiian/Pacific Islander
   - [ ] Black/African American
   - [ ] American Indian/Alaska Native
   - [ ] Asian
   - [ ] Unknown

12. Ethnic origin:
   - [ ] Hispanic/Latino
   - [ ] Not Hispanic/Latino
   - [ ] Unknown

13. Date of last recorded patient encounter:
   - [ ] Discharged
   - [ ] Died
   - [ ] Unknown

14. Outcome at last patient encounter:
   - [ ] Alive
   - [ ] Dead
   - [ ] Unknown

15. Where was the patient located on the 4th calendar day prior to the date of initial culture?
   - [ ] Private residence
   - [ ] Hospital Inpatient (if transferred, complete Q16)
   - [ ] LTCH
   - [ ] Other (specify): __________________________
   - [ ] Homeless
   - [ ] Incarcerated
   - [ ] Unknown

### MEDICAL ENCOUNTERS

16. Did the patient require a prior hospitalization in the 90 days before the first positive blood culture for *Candida* was drawn?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

17. Was patient transferred from another hospital to the first treatment hospital?
   - [ ] Yes (If yes, transferred hospital ID: ___________)
   - [ ] No
   - [ ] Unknown

18. Was patient hospitalized?
   - [ ] Yes (If yes, treatment hospital ID: ___________)
   - [ ] No
   - [ ] Unknown

18A. If patient was hospitalized:
   - Date of Admit: ____________
   - Date of Discharge: ____________

19A. Was the patient ever in an ICU in the 14 days before the date of first positive culture?
   - [ ] Yes
   - [ ] No
   - [ ] Not applicable
   - [ ] Unknown

19B. Was the patient ever in an ICU on the day of culture or in the 14 days after the date of first positive culture?
   - [ ] Yes
   - [ ] No
   - [ ] Not applicable
   - [ ] Unknown

20. If the patient was alive at discharge, where was the patient discharged to?
   - [ ] Home
   - [ ] Hospice care at home or in facility
   - [ ] Skilled nursing facility/nursing home
   - [ ] Rehabilitation facility
   - [ ] Long term acute care hospital
   - [ ] Another acute care hospital
   - [ ] Other, specify: __________________________
   - [ ] Unknown

### PREVIOUS CONDITIONS

21. Underlying conditions prior to positive *Candida* culture (check all that apply):
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

   **Cancer-related diagnoses:**
   - [ ] Leukemia/Lymphoma/Multiple myeloma
   - [ ] Solid organ malignancy
   - [ ] Other cancer (specify): __________________________

   **Inflammatory/Bowel Disease:**
   - [ ] Circumcision
   - [ ] Cytomegalovirus
   - [ ] Hepatitis A
   - [ ] Hepatitis C
   - [ ] HIV
   - [ ] Non-alcoholic fatty liver disease
   - [ ] Other liver disease (specify):

   **Diabetes:**
   - [ ] Type 1 Diabetes
   - [ ] Type 2 Diabetes
   - [ ] Other diabetes (specify):

   **Connective Tissue Disease:**
   - [ ] Scleroderma
   - [ ] Lupus
   - [ ] Raynaud’s
   - [ ] Other connective tissue disease (specify):

   **Surgical procedures in the 90 days prior:**
   - [ ] Abdominal surgery
   - [ ] Non-abdominal surgery (specify):

   **Diabetes-related complications:**
   - [ ] Diabetic retinopathy
   - [ ] Diabetic nephropathy
   - [ ] Diabetic foot
   - [ ] Other diabetes complications (specify):

   **Renal diagnoses:**
   - [ ] Chronic kidney disease
   - [ ] Dialysis
   - [ ] Renal transplant
   - [ ] Other renal disease (specify):

   **Liver diagnoses:**
   - [ ] hepatocellular carcinoma
   - [ ] bile duct obstruction
   - [ ] other liver disease (specify):

   **Other diagnoses:**
   - [ ] Other diagnosis (specify):

   **Current or recent cancer therapy:**
   - [ ] Chemotherapy
   - [ ] Radiation therapy
   - [ ] Hormonal therapy
   - [ ] Other cancer therapy (specify):

   **Other conditions:**
   - [ ] Other condition (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):

   **Current or recent infection:**
   - [ ] Other infection (specify):
# Other Conditions

<table>
<thead>
<tr>
<th>22. HIV related diagnoses:</th>
<th>1</th>
<th>HIV infection without AIDS</th>
<th>2</th>
<th>AIDS/CD4 count &lt; 200</th>
<th>9</th>
<th>No HIV-related diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. IV drug user:</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>3</td>
<td>Drug user - access type unknown</td>
</tr>
<tr>
<td>24. Premature Birth (only for ≤ 1 year of age):</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>2</td>
<td>Not applicable</td>
</tr>
<tr>
<td>If yes, gestational age at birth:</td>
<td></td>
<td>weeks</td>
<td>AND Birth weight:</td>
<td></td>
<td>grams</td>
<td>or 9</td>
</tr>
<tr>
<td>25. Infection with <em>Clostridium difficile</em> 90 days before to 30 days after initial culture date:</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>If yes, date of C. Diff diagnosis:</td>
<td></td>
<td>/</td>
<td>/</td>
<td></td>
<td>or 9</td>
<td>Unknown</td>
</tr>
<tr>
<td>26. Did the patient have a central venous catheter 2 days before, the day before, or on the day the first positive culture was drawn?</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>3</td>
<td>Not applicable</td>
</tr>
<tr>
<td>27. Were all CVCs removed or changed within 7 days after the date of first positive culture?</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>3</td>
<td>Not applicable (no CVC)</td>
</tr>
<tr>
<td>28. Was the patient neutropenic* 2 days before, the day before, or on the day the first positive culture was drawn?</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>3</td>
<td>CVC removed, but can't find dates</td>
</tr>
<tr>
<td>*Neutropenia: ANC ≤ 500 OR calculated as: WBC count: (% polys + % bands) ≤500</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Laboratory calculated ANC:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29. Did the patient receive any of these medications in the 14 days before initial positive <em>Candida</em> culture date?</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>Antibacterial:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total parenteral nutrition (TPN):</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>30. Did the patient receive systemic antifungal medication in the 14 days before initial positive <em>Candida</em> culture date?</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>31. Did the patient receive systemic antifungal medication to treat candidemia on or after positive culture date?</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>32. If antifungal medication was not given to treat current candidemia infection, what was the reason?</td>
<td>1</td>
<td>Patient died before culture result available to clinicians</td>
<td>2</td>
<td>Comfort care only measures were instituted</td>
<td>3</td>
<td>Patient discharged before culture result available to clinician</td>
</tr>
<tr>
<td>6</td>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. If antifungal medication was given to treat current candidemia, what was the reason for stopping?</td>
<td>1</td>
<td>Completion of treatment</td>
<td>2</td>
<td>Hospital discharge</td>
<td>3</td>
<td>Withdrawal of care/transition to comfort care only</td>
</tr>
<tr>
<td>5</td>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
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</table>

**Version: Short Form 2016**

**Last updated: 11/01/2015**

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**IF ANY ANTIMICROBIAL MEDICATION WAS GIVEN, COMPLETE NEXT PAGE. OTHERWISE END OF CHART REVIEW FORM ---**

---
## ANTIFUNGAL MEDICATION TABLES

**Drug abbreviations:**
- Amphotericin – any IV formulation (Amphotec, Amphocil, Fungizone, Albucel)
- Ambisome, etc. = AMB
- Amphotericin – any inhalation formulation = AMBNH
- Anidulafungin (Eraxis) = ANF
- Caspofungin (Cancidas) = CAS
- Fluconazole (Diflucan) = FLC
- Fluconazole (Vfend) = VRC
- Itraconazole (Sporanox) = ITZ
- Micafungin (Mycamine) = MFG
- Posaconazole (Novalast) = PSC
- Other = OTH
- Voriconazole (Vfend) = VRC
- Pevsnerine (SFC) = SFC

**Date of initial culture:**

### ANTIFUNGAL MEDICATION PRIOR TO CULTURE, DAY -14 TO DAY -1

<table>
<thead>
<tr>
<th>Drug Abbrev</th>
<th>Indication</th>
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### ANTIFUNGAL MEDICATION TABLE, DAY 0 TO DAY 30

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**END OF CHART REVIEW FORM**

Version: Short Form 2016  
Last updated: 11/01/2015  
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07/01/2020 (SFY21)
**Human Papillomavirus Vaccine Impact Monitoring Project (HPV-IMPACT) Case Report Form**

**I. Patient Identifiers and Other Information**

- **Patient Name (Last, First, M.I.):** __________
- **Address:** __________
- **City:** __________
- **County:** __________
- **State:** __________
- **Zip Code:** __________
- **Phone No.:** ( ) __________
- **Last 4 digits of SSN:** __________

- **Submitting Pathologist Name:** __________
- **Pathology Lab Name:** __________
- **Address:** __________
- **City:** __________
- **State:** __________
- **Zip Code:** __________
- **Phone No.:** ( ) __________
- **Fax No.:** ( ) __________
- **Email Address:** __________

- **Pathology Lab Medical Record Number/PtID:** __________

- **Ordering Provider Name:** __________
- **Practice/Clinic Name:** __________
- **Address:** __________
- **City:** __________
- **State:** __________
- **Zip Code:** __________
- **Phone No.:** ( ) __________
- **Fax No.:** ( ) __________
- **Email Address:** __________

- **Ordering Provider Medical Record Number/PtID:** __________

- **Other Managing Provider Name:** __________
- **Practice/Clinic Name:** __________
- **Address:** __________
- **City:** __________
- **State:** __________
- **Zip Code:** __________
- **Phone No.:** ( ) __________
- **Fax No.:** ( ) __________
- **Email Address:** __________

- **Other Managing Provider Medical Record Number/PtID:** __________

**II. Demographics and Insurance**

- **Patient Unique Identifier:** __________
- **Date of Birth:** __________
- **mm/dd/yyyy**

- **Race (select all that apply):**
  - White
  - Black or African American
  - Hawaiian/Pacific Islander
  - Other (specify) __________
  - Asian
  - American Indian/Alaska Native
  - Unknown

- **Source of information (select all that apply):**
  - Lab Report
  - Medical Record
  - Patient Interview
  - Intake Form
  - Vaccine Registry
  - Other (specify) __________

- **Ethnicity:**
  - Hispanic or Latino
  - Not Hispanic or Latino
  - Unknown

- **Source of information (select all that apply):**
  - Lab Report
  - Medical Record
  - Patient Interview
  - Intake Form
  - Vaccine Registry
  - Other (specify) __________

- **Health insurance (select all that apply):**
  - Private/HMO/PPO/managed care plan
  - Medicaid/state assistance
  - Indian Health Service
  - Medicare
  - Military/VA
  - No coverage
  - Unknown

- **Source of information (select all that apply):**
  - Lab Report
  - Medical Record
  - Patient Interview
  - Intake Form
  - Other (specify) __________
III. Histopathology Results

Specimen Collection Date: mm/dd/yyyy Specimen ID (Accession #): __________________________

Final Diagnosis: ☐ CIN 2 ☐ CIN 2/3 ☐ CIN 3 ☐ CIN 2 + AIS ☐ CIN 2/3 + AIS ☐ CIN 3 + AIS ☐ AIS
Used LAST terminology: ☐ HSIL (CIN2) ☐ HSIL (CIN3) ☐ HSIL (not specified)

Block No.: __________________________ Specimen Diagnosis: ☐ CIN 2 ☐ CIN 2/3 ☐ CIN 3 ☐ CIN 2 + AIS ☐ CIN 2/3 + AIS ☐ CIN 3 + AIS ☐ AIS
IHC stain: ☐ Yes ☐ No ☐ Unknown
IHC antigen (select all that apply): p16 Ki-67(MIB-1) BD ProEx C™ Other (specify) __________________________

Block No.: __________________________ Specimen Diagnosis: ☐ CIN 2 ☐ CIN 2/3 ☐ CIN 3 ☐ CIN 2 + AIS ☐ CIN 2/3 + AIS ☐ CIN 3 + AIS ☐ AIS
IHC stain: ☐ Yes ☐ No ☐ Unknown
IHC antigen (select all that apply): p16 Ki-67(MIB-1) BD ProEx C™ Other (specify) __________________________

Block No.: __________________________ Specimen Diagnosis: ☐ CIN 2 ☐ CIN 2/3 ☐ CIN 3 ☐ CIN 2 + AIS ☐ CIN 2/3 + AIS ☐ CIN 3 + AIS ☐ AIS
IHC stain: ☐ Yes ☐ No ☐ Unknown
IHC antigen (select all that apply): p16 Ki-67(MIB-1) BD ProEx C™ Other (specify) __________________________

IV. HPV Vaccine History

Any HPV Vaccine? ☐ Yes, documented ☐ No, documented ☐ Unknown
Source of information (select all that apply): ☐ Lab Report ☐ Medical Record ☐ Patient Interview ☐ Vaccine Registry
☐ Vaccine Provider Record ☐ Administrative Database ☐ Other
Specialty of Vaccine Provider: ☐ Pediatrician ☐ Family/Internal Medicine ☐ Ob/Gyn ☐ Other (specify) __________________________ ☐ Unknown

Number of doses: ☐ 1 ☐ 2 ☐ 3 ☐ >3 ☐ Unknown
Date of 1st Dose __________________________ Date of 2nd Dose __________________________ Date of 3rd Dose __________________________ Date of 4th Dose __________________________
Type 1st Dose: ☐ Quadrivalent (Gardasil) ☐ Bivalent (Cervarix) ☐ Unknown
☐ Unknown
Type 2nd Dose: ☐ Quadrivalent (Gardasil) ☐ Bivalent (Cervarix) ☐ Unknown
☐ Unknown
Type 3rd Dose: ☐ Quadrivalent (Gardasil) ☐ Bivalent (Cervarix) ☐ Unknown
☐ Unknown
Type 4th Dose: ☐ Quadrivalent (Gardasil) ☐ Bivalent (Cervarix) ☐ Unknown
☐ Unknown

Approximate age at vaccination (if date unknown) __________________________
Comments: __________________________
V. Cervical Cancer Screening

Most recent screening test result (trigger test that led to current diagnosis)

<table>
<thead>
<tr>
<th>Date of Pap test</th>
<th>mm / dd / yyyy</th>
</tr>
</thead>
</table>

PapTest Result:  
- [ ] Not done  
- [ ] Normal  
- [ ] ASCUS/ASC-H  
- [ ] AGUS/AGC  
- [ ] LSIL  
- [ ] HSIL  
- [ ] AIS  
- [ ] Other  
- [ ] Unknown

<table>
<thead>
<tr>
<th>Date of HPV test</th>
<th>mm / dd / yyyy</th>
</tr>
</thead>
</table>

HPV Test:  
- [ ] Not done  
- [ ] Cervista  
- [ ] Aptima  
- [ ] HC2  
- [ ] cobas  
- [ ] Other  
- [ ] Unknown

If HPV test performed:  
- [ ] High Risk Positive  
- [ ] High Risk Negative  
- [ ] Unknown

If type-specific test used:  
- [ ] HPV Types (select all that apply):  
  - [ ] HPV16  
  - [ ] HPV18  
  - [ ] Other high risk types

VI. Underlying Illness

HIV infection or AIDS:  
- [ ] Yes  
- [ ] No  
- [ ] Unknown

Immunocompromised (ever):  
- [ ] Yes  
- [ ] No  
- [ ] Unknown

VII. Case Reporting  
**SURVEILLANCE OFFICE USE ONLY**

Was case first identified by audit?  
- [ ] Yes  
- [ ] No

If yes, type of audit:  
- [ ] Lab audit  
- [ ] Medical record  
- [ ] Administrative database  
- [ ] Other

If yes, was report eventually received?  
- [ ] Yes  
- [ ] No  
- [ ] Needs to be requested

CRF Status:  
- [ ] Complete  
- [ ] Incomplete

Initials of person completing form:  
[ ]

Initials of data entry staff:  
[ ]

VIII. HPV DNA Typing

CDC barcode label:  
[ ]

IX. Geocoding

Status of geocoding:  
- [ ] Matched  
- [ ] Unmatched

FIPS code (2010 census tract):  
[ ]

County:  
[ ]

ArcGIS

- Match score:  
  - [ ] Automatic (A)  
  - [ ] Manual (M)  
  - [ ] Picked from map (PP)

- Geographic level:  
  - [ ] Rooftop (1)  
  - [ ] Street (2)  
  - [ ] Other (3)  
  - [ ] Insufficient (4)

Centuris

- Match code:  
  - [ ] Location code:  
    - [ ] Address geocodes (1)  
    - [ ] Street centroids (2)  
    - [ ] ZIP+4 centroids (3)  
    - [ ] Not geocoded (blank)

- Address type:  
  - [ ] Residential (1)  
  - [ ] Post office box (2)  
  - [ ] Long term care facility (3)  
  - [ ] Corrections (4)  
  - [ ] Military (5)  
  - [ ] Homeless (6)  
  - [ ] Other (6)  
  - [ ] Insufficient (8)  
  - [ ] Missing (9)
## A. Patient Data – THIS INFORMATION IS NOT SENT TO CDC

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<th>Details</th>
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<td>Zip Code</td>
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## B. Abstractor Information – THIS INFORMATION IS NOT SENT TO CDC

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## C. Enrollment Information

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<td>4. Case Type</td>
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</tr>
<tr>
<td>5. Date of Birth</td>
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<tr>
<td>6. Age</td>
<td></td>
</tr>
<tr>
<td>7. Sex</td>
<td></td>
</tr>
</tbody>
</table>

### 6. Age

- Years
- Months (0-11 months)
- Days (12-23 months)

### 7. Sex

- Male
- Female
- Not Specified

## D. RSV Testing Results

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<td>1a. Result</td>
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</tr>
<tr>
<td>1b. Specimen collection date</td>
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<tr>
<td>1c. Testing facility ID</td>
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</tr>
<tr>
<td>2. Test 2</td>
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<td>2a. Result</td>
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<tr>
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<tr>
<td>2c. Testing facility ID</td>
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## E. Intensive Care Unit Interventions

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<td>1. Was the patient admitted to an intensive care unit (ICU)?</td>
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</tr>
<tr>
<td>2. Non-invasive mechanical ventilation?</td>
<td></td>
</tr>
<tr>
<td>3. Invasive mechanical ventilation?</td>
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</tr>
<tr>
<td>4. ECMO?</td>
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<tr>
<td>5. Vasopressors in ICU?</td>
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## F. Outcome

<table>
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<th>Field</th>
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</thead>
<tbody>
<tr>
<td>1. What was the outcome of the patient?</td>
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</tbody>
</table>

### 1a. Date of death

STOP HERE IF NOT ICU OR DEATH CASE
### G. Admission and Patient History (complete ONLY if ICU or death)

1. **Acute signs/symptoms present at admission (began or worsened within 2 weeks prior to admission):**
   -☐ None of the below signs/symptoms
   -☐ Altering mental status/confusion
   -☐ Fever/chills
   -☐ Seizures
   -☐ Congested/runny nose
   -☐ Cough
   -☐ Shortness of breath/respiratory distress
   -☐ Sore throat
   -☐ URI/ILI
   -☐ Wheezing
   -☐ Cyanosis
   -☐ Decreased vocalization/stridor
   -☐ Dehydration
   -☐ Ages < 2 years

2. **Date of onset of acute respiratory symptoms (within 2 weeks before a positive RSV test):**
   -☐ Unknown
   -☐ Not applicable

3. **Maximum respiratory rate (breaths/min) (within 24 hours of admission):**
   -☐ Unknown

4. **Lowest systolic blood pressure (within 24 hours of admission):**
   -☐ Unknown

5. **Minimum oxygen saturation (within 24 hours admission and if on room air [RA] only):**
   -☐ Unknown

6. **BMI:**
   -☐ Unknown
   -☐ Height:
   -☐ Inch
   -☐ Cm
   -☐ Unknown

7. **Weight:**
   -☐ Lbs
   -☐ Kg
   -☐ Unknown

8. **Where did patient reside at the time of hospitalization:**
   -☐ Private residence
   -☐ Hospice
   -☐ Homeless/shelter
   -☐ Facility
   -☐ Corrections facility
   -☐ Other:

### H. Underlying Medical Conditions (complete ONLY if ICU or death)

1. **Did patient have any of the following pre-existing medical conditions? (check at least one)**
   -☐ Asthma/Reactive Airway Disease
   -☐ Chronic Lung Disease
     -☐ Tuberculous/TB
     -☐ Cystic fibrosis
     -☐ Emphysema/COPD
     -☐ Chronic bronchitis
     -☐ Chronic respiratory failure
     -☐ Other:
   -☐ Chronic Metabolic Disease
     -☐ Diabetes mellitus
     -☐ Thyroid dysfunction
     -☐ Other:
   -☐ Blood disorders/Hemoglobinopathy
     -☐ Aplastic anemia
     -☐ Sickle cell disease
     -☐ Spleenectomy/Asplenia
     -☐ Other:
   -☐ Cardiovascular Disease
     -☐ Aortic aneurysm
     -☐ Aortic stenosis
     -☐ Atrial fibrillation
     -☐ Cardiomyopathy
     -☐ Atherosclerotic cardiovascular disease (ASCVD)
     -☐ Cardiac vascular incident/Stroke
     -☐ Congestive heart disease
     -☐ Coronary artery disease (CAD)
     -☐ Heart failure/CHF
     -☐ Other:
   -☐ Neurological disorder
     -☐ Dystrophy muscular dystrophy
     -☐ Muscular dystrophy
     -☐ Multiple sclerosis
     -☐ Mitochondrial disorder
     -☐ Myasthenia gravis
     -☐ Parkinson’s disease
     -☐ Other:
   -☐ Neurological disorder
     -☐ Cerebral palsy
     -☐ Cognitive dysfunction
     -☐ Dementia/Alzheimer’s disease
     -☐ Developmental delay
     -☐ Down syndrome
     -☐ Plegia/Paralysis
     -☐ Seizure/Seizure disorder
     -☐ Other:
   -☐ History of Guillain-Barre Syndrome
     -☐ Yes
     -☐ No
     -☐ Unknown

10. **History and physical examination: (check if applicable)**
   -☐ Prematurity (gestational age at birth:
   -☐ Unknown gestational age at birth

---

**Note:**
- CDC Version 19 July 2016
- Page 2 of 4
- CS230308

07/01/2020 (SFY21)
### 1. Bacterial Pathogens - Stated or respiratory site only (complete ONLY if ICU or death)

1. Were any bacterial culture tests performed with a collection date within 3 days of admission, or if deceased, within 3 days prior to death or 24 hours after death?  
   - Yes  
   - No  
   - Unknown  

2. If yes, was there a positive culture for a bacterial pathogen?  
   - Yes  
   - No  
   - Unknown  

2a. If yes, specify Pathogen 1:  

2b. Date of culture:  

2c. Site where pathogen identified:  
   - Blood  
   - Bronchoalveolar lavage (BAL)  
   - Pleural fluid  
   - Cerebrospinal fluid (CSF)  
   - Endotracheal aspirate  
   - Other, specify:  

2d. If *Staphylococcus aureus*, specify:  
   - Methicillin resistant (MRSA)  
   - Methicillin sensitive (MSSA)  
   - Sensitivity unknown  

3a. If yes, specify Pathogen 2:  

3b. Date of culture:  

3c. Site where pathogen identified:  
   - Blood  
   - Bronchoalveolar lavage (BAL)  
   - Pleural fluid  
   - Cerebrospinal fluid (CSF)  
   - Endotracheal aspirate  
   - Other, specify:  

3d. If *Staphylococcus aureus*, specify:  
   - Methicillin resistant (MRSA)  
   - Methicillin sensitive (MSSA)  
   - Sensitivity unknown  

### J. Viral Pathogens (complete ONLY if ICU or death)

1. Was patient tested for any of the following viral respiratory pathogens within 14 days prior to or within 3 days after admission, or if deceased, 14 days prior to death or 24 hours after death?  
   - Yes  
   - No  
   - Unknown  

1a. Flu (type):  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1b. Flu A (type):  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1c. Flu B (type):  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1d. Adenovirus:  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1e. Parainfluenza 1:  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1f. Parainfluenza 2:  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1g. Parainfluenza 3:  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1h. Parainfluenza 4:  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1i. Human metapneumovirus:  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1j. Rhinovirus/Enterovirus:  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

1k. Coronavirus (type):  
   - Yes, positive  
   - Yes, negative  
   - Not tested/Unknown  

### K. Treatment (complete ONLY if ICU or death)

1. Did the patient receive ribavirin or an RSV antiviral treatment during the course of this illness?  
   - Yes  
   - No  
   - Unknown  

2a. Treatment:  
   - ribavirin  
   - Other, specify:  
   - Unknown  

2b. Start date:  

2c. End date:  

For pediatric cases <2 years:  

1. Did the patient receive palivizumab (Synagis) for the current RSV season?  
   - Yes  
   - No  
   - Unknown  

### L. Discharge Summary (complete ONLY if ICU or death)

1. Did the patient have any of the following new diagnosis at discharge? (check all that apply)  
   - No discharge summary available  

   - Acute encephalopathy/encephalitis  
   - Acute Myocardial Infarction  
   - Acute Myocarditis  
   - Acute Renal Failure/Acute Kidney Injury  
   - Acute respiratory distress syndrome (ARDS)  
   - Acute respiratory failure  
   - Asthma exacerbation  
   - Bacteremia  
   - Bronchiolitis  
   - Chronic lung disease of prematurity/BPD  
   - Congestive Heart Failure  
   - COPD exacerbation  
   - Diabetic Ketoacidosis  
   - Guillain-Barre syndrome  
   - Hemolytic-uremic syndrome  
   - Invasive pulmonary aspergillosis  
   - Reye's syndrome  
   - Rhabdomyolysis  
   - Sepsis  
   - Seizures  
   - Stroke (CVA)
<table>
<thead>
<tr>
<th>L. Discharge Summary (cont.) (complete ONLY if ICU or death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For pregnant patients:</td>
</tr>
<tr>
<td>2. Indicate pregnancy status at discharge or death:</td>
</tr>
<tr>
<td>- Still pregnant</td>
</tr>
<tr>
<td>- No longer pregnant</td>
</tr>
<tr>
<td>2a. If patient was pregnant on admission but no longer</td>
</tr>
<tr>
<td>pregnant at discharge or death, indicate pregnancy</td>
</tr>
<tr>
<td>outcome:</td>
</tr>
<tr>
<td>- Healthy newborn</td>
</tr>
<tr>
<td>- Preterm delivery, gestational age in weeks:</td>
</tr>
<tr>
<td>- Ill newborn</td>
</tr>
<tr>
<td>- Miscarriage (intrauterine death at &lt;22 weeks GA)</td>
</tr>
<tr>
<td>- Stillbirth (intrauterine death at ≥ 22 weeks GA)</td>
</tr>
<tr>
<td>- Newborn died</td>
</tr>
<tr>
<td>- Abortion</td>
</tr>
<tr>
<td>2b. If no longer pregnant, indicate date of delivery or</td>
</tr>
<tr>
<td>end of pregnancy:</td>
</tr>
<tr>
<td>- / / / / / / / / / / / / / / / / / / / / / / / / / / /</td>
</tr>
<tr>
<td>3. If patient discharged alive, please indicate to where:</td>
</tr>
<tr>
<td>- Private residence</td>
</tr>
<tr>
<td>- Hospice</td>
</tr>
<tr>
<td>- Homeless/shelter</td>
</tr>
<tr>
<td>- Unknown</td>
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<tr>
<td>- Home with services</td>
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<tr>
<td>- Facility</td>
</tr>
<tr>
<td>- Corrections facility</td>
</tr>
<tr>
<td>- Other, specify:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>M. ICD 10 Discharge Diagnoses (complete ONLY if ICU or death, to be recorded in order of appearance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD 10 codes available? Yes  No</td>
</tr>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<tr>
<td>6.</td>
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<tr>
<td>7.</td>
</tr>
<tr>
<td>8.</td>
</tr>
<tr>
<td>9.</td>
</tr>
</tbody>
</table>

| N. Additional Comments |
1. Since August [insert flu season year], did [you/patient’s name] receive a flu vaccine or flu shot? This vaccine is offered every year to protect against the flu.

☐ Yes → go to Q1a-1f
☐ No → go to Q2
☐ Unknown → go to Q2
☐ Not specified → go to Q2

1a) Do you know the year that you received the flu vaccine? ________ ☐ Unknown

1b) Do you know the month that you received the flu vaccine? ________ ☐ Unknown

1c) Do you know the day that you received the flu vaccine? ________ ☐ Unknown

[If unknown, go to Q1d, otherwise go to Q1e]

1d) Do you know the time of month that you received the flu vaccine?

☐ 1st–15th of month
☐ 16th–end of month
☐ Unknown

1e) Did [you/patient’s name] receive the flu shot at a... [Read choices]:

☐ Primary Care Doctor’s office
☐ Prenatal Care Provider’s Office
☐ School clinic
☐ Public health clinic
☐ Hospital
☐ Pharmacy
☐ Other, specify: ____________________
☐ Unknown [skip to question 2]
☐ Not specified [skip to question 2]

1f) Could you tell me the name and any contact information for the doctor’s office(s), hospitals, public health clinics or pharmacies where you received this shot? If you don’t know exactly where you received the flu shot, but think you received one, can you tell me the names and any contact information for any locations where you have received any shots since August?

<table>
<thead>
<tr>
<th>Healthcare provider name</th>
<th>Facility Type*</th>
<th>Facility Name</th>
<th>Phone number</th>
<th>Address</th>
<th>City/Zip</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

*Facility Type: 1= Primary Care; 2=OB/GYN Clinic; 3=Hospital; 4=Public Health Clinic; 5=Pharmacy; 6=Work; 7= ‘Other, specify’

→ Go to Q2
2) Outside of when you were hospitalized on [insert dates] has a healthcare provider diagnosed you with a respiratory illness during this pregnancy?

- Yes → go to Q2a
- No → go to Q3
- Unknown → go to Q3
- Not specified → go to Q3

2a) When were you diagnosed with the respiratory illness?

Year ________    □ Unknown
Month ________    □ Unknown
Day ________      □ Unknown

2b) Did your healthcare provider test you for flu, and if so, did the test come back positive?

- Tested for flu and tested positive   → go to Q3
- Tested for flu and tested negative  → go to Q3
- Tested for flu and unknown test result → go to Q3
- Not tested for flu                   → go to Q3
- Unknown if tested for flu           → go to Q3
- Not specified                       → go to Q3

3) Outside of when you were hospitalized, have you taken antiviral medication for the flu during this pregnancy? [A doctor must prescribe antivirals medicines. Names of some antiviral medications include oseltamivir, Tamiflu, Relenza, Rapivab].

- Yes → go to Q3a-b
- No → go to Q4
- Unknown → go to Q4
- Not specified → go to Q4

3a) Can you tell me the date [you/patient’s name] started taking the antiviral medicine?

Year ________    □ Unknown
Month ________    □ Unknown
Day ________      □ Unknown

3b) For how many days did you take the medication?

- 0
- 1
- 2
- 3
- 4
- 5
- Other, specify: ______________
- Unknown

→ go to Q4

4) How many times have you been pregnant in your life?

Number: _________ □ Unknown □ Not specified → go to Q5

5) How many of the pregnancies resulted in a live birth?

Number: _________ □ Unknown □ Not specified → go to Q6
6) Were you pregnant at the time that you were hospitalized on [insert date of hospital admission]?
   □ Yes         → go to Q6a-b
   □ No          → go to Q7
   □ Unknown     → go to Q7
   □ Not specified → go to Q7

6a) How many weeks were you pregnant when you were hospitalized?
   Number of weeks: _______ [go to Q7]  □ Unknown [go to Q6b]  □ Not specified go to Q6b

6b) How many months were you pregnant when you were hospitalized?
   Number of months: _______  □ Unknown  □ Not specified  → go to Q7

7) For your current (most recent) pregnancy, with how many fetuses are/were you pregnant?
   □ One  □ Two  □ Three  □ More than three  □ Not specified
   → If race needed, go to Q8
   → If ethnicity needed, go to Q8
   → If none needed, go to END

8) What is [your /patient’s name] race? (Check only one)
   □ White
   □ Black or African American
   □ Asian/Pacific Islander
   □ American Indian or Alaska Native
   □ Multiracial
   □ Not specified (refused)
   → If ethnicity needed go to Q9
   → If none needed, go to END

11) What is [your/patient’s name] ethnicity?
   □ Hispanic or Latino  □ Non-Hispanic or Latino  □ Not Specified (refused to answer)

THE END. These are all my questions. Do you have any questions for me? Thank you for your time.
**Attachment 9: Supplemental GBS study case report form**

**Neonatal Infection Expanded Tracking Form**

**Infant Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant's Name</td>
<td></td>
</tr>
<tr>
<td>Mother's Name</td>
<td></td>
</tr>
<tr>
<td>Infant's Chart No.</td>
<td></td>
</tr>
<tr>
<td>Mother's Chart No.</td>
<td></td>
</tr>
<tr>
<td>Mother's Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Culture date</td>
<td></td>
</tr>
<tr>
<td>Hospital Name</td>
<td></td>
</tr>
</tbody>
</table>

**Patient Identifier Information is NOT transmitted to CDC**

**Active Bacterial Core Surveillance (ABCs)**

**Neonatal Infection Expanded Tracking Form**

1. **Date of Birth:** __/__/____  
   **Time of birth:** __:__ (times in military format)  
   **Gestational age of infant at birth in completed weeks:** __ (do not round up)

2. **Did this birth occur outside of the hospital?**  
   - Yes (1)  
   - No (0)  
   - Unknown (9)

3a. **Date of maternal last menstrual period (LMP):** __/__/____  
3b. **Birth weight:** __ lbs __ oz OR __ grams

4. **Date & time of newborn discharge from hospital of birth:** __/__/____  
   **Outcome:**  
   - Survived (1)  
   - Died (2)  
   - Unknown (9)

5. **Was the infant discharged to home and readmitted to the birth hospital?**  
   - Yes (1)  
   - No (0)

6. **Was the infant admitted to a different hospital from home?**  
   - Yes (1)  
   - No (0)

7. **Were any ICD-9 codes reported in the discharge diagnosis of the infant's chart?**  
   - Yes (1)  
   - No (0)  
   - Unknown (9)

8. **Were any of the following ICD-9 codes reported in the discharge diagnosis of the chart? (Check all that apply)**  
   - 041.02: Streptococcus group b (1)  
   - 038.0: Streptococcus septicaemia (1)

9. **Were any ICD-10 codes reported in the discharge diagnosis of the infant's chart?**  
   - Yes (1)  
   - No (0)  
   - Unknown (9)

10. **Did the baby receive breast milk from the mother?**  
    - Yes (1)  
    - No (0)  
    - Unknown (9)

---

*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/ASTS: Report Clearance Officer, 1600 Clifton Road, MS D77, Atlanta, GA 30333, OMB No. 0920-0119. Do not send the completed form to this address.*
Maternal Information

11. Maternal admission date & time: __/__/____ Time: __:__

12. Maternal age at delivery (years): ___ years

13. Maternal blood type: A (1) B (2) AB (3) O (4)

14. Did mother have a prior history of penicillin allergy? Yes (1) No (0)

IF YES, was a previous maternal history of anaphylaxis noted? Yes (1) No (0)

15. Date & time of membrane rupture: __/__/____ Time: __:__

16. Was duration of membrane rupture >18 hours? Yes (1) No (0) Unknown (9)

17. If membranes ruptured at <37 weeks, did membranes rupture before onset of labor? Yes (1) No (0) Unknown (9)

18. Type of rupture: Spontaneous (1) Artificial (2)

19. 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 begin before C-section? Yes (1) No (0) Unknown (9)

Did membrane rupture happen before C-section? Yes (1) No (0) Unknown (9)

20. 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: __/__/____ Time: __:__

21. Were antibiotics given to the mother intrapartum? Yes (1) No (0) Unknown (9)

IF YES, answer a-b and Questions 22-23

a) Date & time antibiotics 1st administered: (before delivery)

- IV (1) IM (2) PO (3) # doses given before delivery:

Start date: __/__/____ Stop date: __/__/____

Antibiotic 1: __________________________

Start date: __/__/____ Stop date: __/__/____

Antibiotic 2: __________________________

Start date: __/__/____ Stop date: __/__/____

Antibiotic 3: __________________________

Start date: __/__/____ Stop date: __/__/____

Antibiotic 4: __________________________

Start date: __/__/____ Stop date: __/__/____

Antibiotic 5: __________________________

Start date: __/__/____ Stop date: __/__/____

Antibiotic 6: __________________________

Start date: __/__/____ Stop date: __/__/____
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)
☐ GBS prophylaxis (1) ☐ Prolonged latency (1) ☐ Mitral valve prolapse prophylaxis (1)
☐ Suspected amnionitis/chorioamnionitis (1) ☐ Cesarean section prophylaxis (1) ☐ Other (1)
☐ Unknown (1)

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

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

26. 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: _______ / _______ / _______
month day year (4 digits) month day year (4 digits) ☐ Unknown (1)

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:

<table>
<thead>
<tr>
<th>Test date (list most recent first)</th>
<th>Test type:</th>
<th>Test Result (Do not include urine here!)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. _______ / _______ / _______</td>
<td>Culture (1)</td>
<td>Positive (1) ☐ Negative (3) ☐ Unknown (9)</td>
</tr>
<tr>
<td></td>
<td>PCR (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid antigen (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unknown (9)</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Test date (list most recent first)</th>
<th>Test type:</th>
<th>Test Result (Do not include urine here!)</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______ / _______ / _______</td>
<td>Culture (1)</td>
<td>Positive (1) ☐ Negative (3) ☐ Unknown (9)</td>
</tr>
<tr>
<td></td>
<td>PCR (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid antigen (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unknown (9)</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>32b. If the most recent test was GBS positive, was antimicrobial susceptibility performed AFTER admission?</td>
<td>□ Yes (1) □ No (0) □ Unknown (9)</td>
<td></td>
</tr>
<tr>
<td>IF YES, Was the isolate resistant to clindamycin?</td>
<td>□ Yes (1) □ No (0) □ Unknown (9)</td>
<td></td>
</tr>
<tr>
<td>Was the isolate resistant to erythromycin?</td>
<td>□ Yes (1) □ No (0) □ Unknown (9)</td>
<td></td>
</tr>
<tr>
<td>33. Were GBS test results available to care givers at the time of delivery?</td>
<td>□ Yes (1) □ No (0) □ Unknown (9)</td>
<td></td>
</tr>
<tr>
<td>34. COMMENTS:</td>
<td></td>
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</tr>
<tr>
<td>35. Neonatal Infection Expanded Form Tracking Status:</td>
<td>□ Complete (1) □ Incomplete (2) □ Edited &amp; corrected (3) □ Chart unavailable after 3 requests (4)</td>
<td></td>
</tr>
</tbody>
</table>
GBS Blood Spot Study – case supplemental data collection form

1. StateID: ______________

2. Gestational age of infant at birth: __ __ (in weeks, do not round up)

2a. Determined by: ☐ Dates (1) ☐ Physical exam (2) ☐ Ultrasound (3) ☐ Unknown (4)

3. Maternal underlying or prior illnesses:
(check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box)

☐ AIDS or CD4 count <200 ☐ Connective tissue disease (Lupus, etc...)
☐ Immunosuppressive therapy (Steroids, etc.)

☐ Asthma ☐ Atherosclerotic CVD (ASCVD)/CAD

☐ Bone Marrow Transplant (BMT)

☐ Diabetes Mellitus, HbA1C___(%) Date ___/____/_______

☐ CSF Leak ☐ Dementia

☐ Leukemia ☐ Multiple Myeloma

☐ Immunosuppressive therapy (Steroids, etc.)

☐ Peripheral Neuropathy ☐ Peripheral Vascular Disease

☐ Plegias/Paralysis

☐ Seizure/Seizure Disorder

☐ CVA/Stroke/TIA ☐ Emphysema/COPD

☐ Heart Failure/CHF

☐ Myocardial Infarction

☐ Nephrotic Syndrome

☐ Neuromuscular Disorder

☐ Obesity

☐ Other prior illness (specify):

4. Did the infant receive antibiotics anytime during the birth hospitalization? ☐ Yes ☐ None ☐ Unknown

4a. If YES, was it a beta-lactam? ☐ Yes ☐ None ☐ Unknown

COMMENTS:
Attachment 10: GAS HRI Interview

Invasive Group A Streptococcus High-Risk Questionnaire

Interviewer name: __________________________ Date of Interview: __ __ / __ __ / __ __

ABCs ID: __________________________ State ID: __________________________

Hospital: __________________________

Collect from hospital chart: Date of birth: __ __ / __ __ / __ __ Age: ____________

Date of hospital admission for GAS infection: __ __ / __ __ / __ __

Script: Hello. My name is ____ and I am associated with the Oregon Health Authority. Because you have been hospitalized with ____________________, I would like to spend a few minutes talking with you about your health and your activities before getting ill. The information you provide will help us understand these infections in the Portland area better, so we can try to prevent others, even you, from getting it in the future. Your name will never be used in connection with any of the information that you tell me. None of the information you tell me will be shared with your physician or law enforcement. You do not have to answer any questions that you do not want to answer and you may end this interview at any time. Your choice to participate will not affect the medical care that you receive. It should take about 30 minutes. You are also welcome to ask any questions during the interview.

1. Do you agree to participate?
   □ Yes □ No – Reason for refusal: ____________

DEMOGRAPHIC QUESTIONS

Introduction: All the questions that I ask during this interview are confidential and optional. Please let me know if you need me to repeat myself or slow down

2. With what gender do you identify?
   □ Male □ Female □ Other, specify: __________________________

SYMPTOM QUESTIONS

3. In the last year before your illness, did you visit any healthcare providers? □ Yes □ No

   If yes, please list visits

<table>
<thead>
<tr>
<th>Name/Location</th>
<th>Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

SKIN BREAKDOWN QUESTIONS

4. In the last month, did you have any skin infections or wounds?

   Cut or scrape □ Yes □ No If yes, where? __________________________
   Open wound/ulcer □ Yes □ No If yes, where? __________________________
   Burn □ Yes □ No If yes, where? __________________________
   Trauma (e.g., falling, being hit, bit) □ Yes □ No If yes, where? __________________________
   Frost bite □ Yes □ No
   Bed bugs □ Yes □ No
   Skin lice □ Yes □ No
5. In the last month, have you received any care for your wounds from a healthcare provider?
   □ Yes  □ No □ Don’t know □ Refused
   If yes, where did you receive care? ______________________________

6. If you perform your own wound care, do you do any of the following?
   Bandaging wound □ Yes  □ No
   Picking/popping/lancing wound □ Yes  □ No
   Lancing wound □ Yes  □ No
   Cleaning wound □ Yes  □ No
   Applying ointment □ Yes  □ No

LOCATION QUESTIONS
7. Do you usually live in the Portland area? □ Yes  □ No
   If no, where do you usually live? ______________________________
   Do you live in other cities or states? For example, do you live in one state for some part of the year and another for a different part?
   □ Yes Specify: ______________________
   □ No

8. In the 30 days before you came to the hospital, were you living in (please check all that apply):
   House/apartment that I rent or own □
   Nursing home □ Specify:____________________
   Group home □ Specify:____________________
   Jail/prison □ Specify:____________________
   At a shelter □ Specify:____________________
   Not in my own private house or apartment □ Specify:____________________
   (e.g., outdoor in a camp or alone, in an abandoned building, living out of a car, couch surfing, or staying with family or friends)
   Other □ Specify:____________________

   INTERVIEWER: If person DOES NOT live in their own private residence, please continue on with QUESTION 9. If person DOES live in their own private residence, resides in a nursing home, a group home, or is currently in jail/prison, please skip to QUESTION 21.

PERSONS WHO DO NOT LIVE IN THEIR OWN PRIVATE RESIDENCE QUESTIONS
9. In the 30 days before you became ill, did you spend the night in: (select all that apply)
   Outside (e.g. street, under a bridge, in a park) □ Specify:____________________
   Camping in a tent □
   In a car alone or with others □
   At a friend’s or a relative’s □
   Other □ Specify:____________________

10. How long has this been your housing situation? ________ years ________ months □ Don’t know

11. How long has it been since you lived in a house or apartment that you rented or owned?

12. How would you describe your employment situation?
   □ Employed – full time (more than 25 hours) □ Employed – part time (25 hours or less) □ Day labor □ Disabled and unable to work □ Panhandling □ Recycling □ Seasonal □ Temporary
   □ Unemployed; actively looking for work □ Unemployed; not actively looking for work □ None of the above □ Don’t know □ Refused

13. Do you own a car?
   □ Yes  □ No □ Don’t know □ Refused

07/01/2020 (SFY21)
14. Did you access any services such as meal centers, day centers, showers in the last 30 days?

☐ Yes  ☐ No  ☐ Don’t know  ☐ Refused

If yes, what were the names of the facilities where you accessed these services?

Name: _______________________________________________
Name: _______________________________________________
Name: _______________________________________________
Name: _______________________________________________

15. In the last month before you became ill, where did you get your drinking water (check all that apply):

- Shelter  ☐
- Restaurant  ☐
- Public water fountain  ☐
- Public bathroom  ☐
- River/stream  ☐
- Grocery/convenience store  ☐
- Other  ☐ Specify: ______________________

16. In the last month before you became ill, where did you go to the bathroom (please check all that apply):

- Shelter  ☐
- Restaurant  ☐
- Public bathroom  ☐
- Outside  ☐
- Other  ☐ Specify: ______________________

17. How often do you have access to soap and water or hand sanitizer after you go to the bathroom?

☐ Frequently  ☐ Sometimes  ☐ Never  ☐ Don’t know  ☐ Refused

18. In the last month before you became ill, how often did you share blankets or clothes?

☐ Frequently  ☐ Sometimes  ☐ Never  ☐ Don’t know  ☐ Refused

19. In the last month before you became ill, how often did you share utensils (e.g., forks and spoons) or drink containers (e.g., cups or water bottles)?

☐ Frequently  ☐ Sometimes  ☐ Never  ☐ Don’t know  ☐ Refused

20. In the last month before you became ill, did you have regular (i.e., weekly) access to laundry facilities?

☐ Yes  ☐ No  ☐ Don’t know  ☐ Refused

RISK FACTOR QUESTIONS

Now I am going to ask you some questions about behaviors that may have an effect on your health. Please remember that your answers to these questions are strictly confidential.

21. In the 7 days before you got sick, how often were you in close contact with any child(ren) less than 5 years old? By close contact, we mean hugging, sharing cups or forks/spoons, or sitting close enough to touch.

☐ Frequently  ☐ Sometimes  ☐ Never  ☐ Don’t know  ☐ Refused

22. In the 7 days before you got sick, did you have close contact with anyone with sore throat?

☐ Yes  ☐ No  ☐ Don’t know  ☐ Refused

23. In the 7 days before you got sick:

- how many times did you take a shower or have a bath? _________________
- how many times did you brush your teeth? _________________

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28. In the last 30 days, have you smoked tobacco, marijuana, or other legal substances?
   ☐ Yes  ☐ No  ☐ Don’t know  ☐ Refused

   **IF NO, DON’T KNOW, REFUSED, skip to 29a.**

28a. If yes, what do you smoke?
   - Cigarettes  ☐ Yes  ☐ No
   - E-cigarettes  ☐ Yes  ☐ No
   - Cigars  ☐ Yes  ☐ No
   - Marijuana  ☐ Yes  ☐ No
   - K2/spice  ☐ Yes  ☐ No
   - Other  ☐ Yes  ☐ No
   - Unknown  ☐ Yes  ☐ No
   - Refused  ☐ Yes  ☐ No

   If yes, specify: ________________________

28b. If yes, how often do you smoke?
   - Daily  ☐ Weekly  ☐ Occasionally

29. If you do smoke, do you share cigarettes, cigars, vaporizers, smokeless tobacco, or marijuana with others?
   ☐ Yes  ☐ No  ☐ Don’t know  ☐ Refused

   **If yes, how often?**
   - Daily  ☐ Weekly  ☐ Occasionally  ☐ Refused

30. In the last 30 days, have you used smokeless tobacco (e.g., chew)?
   ☐ Yes  ☐ No  ☐ Don’t know  ☐ Refused

   **If yes, how often?**
   - Daily  ☐ Weekly  ☐ Occasionally  ☐ Refused

30. Do you drink alcohol?
   ☐ Yes  ☐ No  ☐ Don’t know  ☐ Refused

   **IF NO, DON’T KNOW, REFUSED, skip to 31.**

   If yes, how often do you have a drink containing alcohol?
   - Monthly or less  ☐ 2-4 times month  ☐ 2-3 times per week  ☐ 4 or more times per week

   How many drinks containing alcohol do you have on a typical day when you are drinking?
   - 1 or 2  ☐ 3 or 4  ☐ 5 or 6  ☐ 7, 8, or 9  ☐ 10 or more

   For men, how many times during the past 30 days did you have 5 or more for drinks in about two hours?
   - _____ times  ☐ None  ☐ Don’t know  ☐ Refused

   For women, how many times during the past 30 days did you have 4 or more for drinks in about two hours?
   - _____ times  ☐ None  ☐ Don’t know  ☐ Refused

   Have you ever felt you needed to cut down on your drinking?
   - Yes  ☐ No  ☐ Refused

   Have people annoyed you by criticizing your drinking?
   - Yes  ☐ No  ☐ Refused

   Have you ever felt guilty about your drinking?
   - Yes  ☐ No  ☐ Refused

   Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves for get rid of a hangover?
   - Yes  ☐ No  ☐ Refused
The following questions ask about use of substances not prescribed by a doctor, such as cocaine, heroin, methadone, other opioids, or methamphetamines. These are questions that we ask everybody and they are strictly confidential.

31. In the month before your illness, did you use any substances (in any form) not prescribed to you by a doctor, such as cocaine, heroin, methadone, other opioids, or methamphetamines?

[ ] Yes
[ ] No
[ ] Don't know
[ ] Refused

INTERVIEWER: If the answer to question 31 is YES or DON'T KNOW or OTHER, then continue to QUESTION 32. If the answer is NO or REFUSED, then skip to QUESTION 50.

32. Now I am going to ask you about substances you may have used in the last 30 days and how you use these substances. Your answers to these questions are strictly confidential. None of the information you tell me will be shared with your physician or law enforcement.

<table>
<thead>
<tr>
<th>Did you use:</th>
<th>How do you use this substance, check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine or methamphetamine</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td></td>
<td>[ ] No</td>
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<tr>
<td></td>
<td>[ ] Don't know</td>
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<tr>
<td></td>
<td>[ ] Refused</td>
</tr>
<tr>
<td></td>
<td>[ ] Inject (IDU)</td>
</tr>
<tr>
<td></td>
<td>[ ] Non-IDU (smoke, snort, oral)</td>
</tr>
<tr>
<td></td>
<td>[ ] Skin popping</td>
</tr>
<tr>
<td></td>
<td>[ ] Other, specify:  __________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>[ ] Don't know</td>
</tr>
<tr>
<td></td>
<td>[ ] Refused</td>
</tr>
<tr>
<td>Marijuana/cannabinoid (other than smoking)</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td></td>
<td>[ ] No</td>
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<tr>
<td></td>
<td>[ ] Don't know</td>
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<tr>
<td></td>
<td>[ ] Refused</td>
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<td>[ ] Inject (IDU)</td>
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<td>[ ] Non-IDU (oral)</td>
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<td>[ ] Skin popping</td>
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<td>[ ] Other, specify:  __________________________________________________________________</td>
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<td></td>
<td>[ ] Don't know</td>
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<tr>
<td></td>
<td>[ ] Refused</td>
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<tr>
<td>Opioid, DEA schedule I (e.g., heroin)</td>
<td>[ ] Yes</td>
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<tr>
<td></td>
<td>[ ] No</td>
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<tr>
<td></td>
<td>[ ] Don't know</td>
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<tr>
<td></td>
<td>[ ] Refused</td>
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<td></td>
<td>[ ] Inject (IDU)</td>
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<td></td>
<td>[ ] Non-IDU (smoke, snort, oral)</td>
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<td></td>
<td>[ ] Skin popping</td>
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<td>[ ] Other, specify:  __________________________________________________________________</td>
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<td></td>
<td>[ ] Don't know</td>
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<tr>
<td></td>
<td>[ ] Refused</td>
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<tr>
<td>Opioid, DEA schedule II (e.g., methadone, oxycodone)</td>
<td>[ ] Yes</td>
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<td></td>
<td>[ ] No</td>
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<td></td>
<td>[ ] Don't know</td>
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<td>[ ] Skin popping</td>
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<td>[ ] Other, specify:  __________________________________________________________________</td>
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<td></td>
<td>[ ] Don't know</td>
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<tr>
<td></td>
<td>[ ] Refused</td>
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<tr>
<td>Other (includes hallucinogens [LSD, mushrooms], club drugs [MDMA, GHB, etc.], dissociative drugs [ketamine], kratom, inhalants)</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td></td>
<td>[ ] No</td>
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<td></td>
<td>[ ] Don't know</td>
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<td>[ ] Refused</td>
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<td>[ ] Inject (IDU)</td>
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<td>[ ] Non-IDU (snort, oral)</td>
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<td></td>
<td>[ ] Skin popping</td>
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<td></td>
<td>[ ] Other, specify:  __________________________________________________________________</td>
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<td></td>
<td>[ ] Don't know</td>
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<tr>
<td></td>
<td>[ ] Refused</td>
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<tr>
<td>Unknown substance</td>
<td>[ ] Yes</td>
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<td></td>
<td>[ ] No</td>
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<td></td>
<td>[ ] Don't know</td>
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<td>[ ] Refused</td>
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<td>[ ] Skin popping</td>
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<td></td>
<td>[ ] Other, specify:  __________________________________________________________________</td>
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<td></td>
<td>[ ] Don't know</td>
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<tr>
<td></td>
<td>[ ] Refused</td>
</tr>
</tbody>
</table>

07/01/2020 (SFY21)
33. Where do you usually use substances (please select all that apply)?
   - Your home
   - Someone else’s house or apartment
   - Public space (e.g., park, alley, doorway, street), specify________________________
   - Vehicle
   - Public toilet
   - Other, specify: ____________
   - Refused

34. In the last month, have you ever stored/hidden or stashed substances in your mouth?
   - Yes  □  No  □  Don’t know  □  Refused

35. In the last month, have you ever received substances that were stored in someone else’s mouth?
   - Yes  □  No  □  Don’t know  □  Refused

36. In the last month, when you have used substances, how did you usually use them:
   - Alone  □  Yes  □  No
   - With less than 5 other people  □  Yes  □  No
   - More than 5 other people  □  Yes  □  No

INTERVIEWER: IF person injects proceed to question 37. IF person does NOT inject, skip to 55.

37. If you have injected substances in the last 30 days, at what age did you start injecting? ____Age  □ N/A

38. If you have injected in the last 30 days, how often do you inject in the same day? ___times  □ N/A

39. Who usually injects you?
   - Self  □  Yes  □  No
   - Partner  □  Yes  □  No
   - Friend  □  Yes  □  No

40. Do you re-use needles  □  Yes  □  No

41. How do you usually inject or are injected?
   - Skin popping (under the skin)  □  Yes  □  No
   - Muscling (directly into a muscle)  □  Yes  □  No
   - Mainlining (directly into a vein)  □  Yes  □  No

42. Please list the locations on your body where you usually inject: _______________________________

43. Do you usually clean your injecting site prior to injecting?
   - Yes  □  No  □  Don’t know  □  Refused

43a. If yes, what do you use to clean the site (check all that apply)?
   - Water  □
   - Alcohol pad  □
   - Soap and water  □
   - Other  □  If other, please specify: ______________________
   - Don’t know  □
   - Refused  □
44. What do you usually use to mix/cook your substance (check all that apply)?
- Tap water ☐
- Bottled water ☐
- Sterile water ☐
- River water ☐
- Lemon juice ☐
- Vinegar ☐
- Fruit punch ☐
- Other ☐ If other, please specify: ____________________
- Don’t know ☐
- Refused ☐

45. What material have you used for a filter in the last 30 days (check all that apply)? N/A
- Cigarette filters ☐ Yes ☐ No
- Cotton balls ☐ Yes ☐ No
- Prepackaged kit filter ☐ Yes ☐ No
- Other ☐ Yes ☐ No If other, please specify: ______
- Don’t use filters ☐ Yes

46. In the last 30 days, how often have you reused filters (even if not shared with anyone)?
- Frequently ☐ Sometimes ☐ Never ☐ Don’t know ☐ Refused ☐ N/A

47. In the 7 days before you got sick, have you had “cotton fever” (e.g., developed shakes and/or chills after reusing a filter)?
- Yes ☐ No ☐ Don’t know ☐ Refused ☐ N/A

48. In the past year, have you received any treatment intended to help reduce or stop your substance use?
- Yes ☐ No ☐ Don’t know ☐ Refused

48a. If yes, what type of treatment (select all that apply)?
- Inpatient rehab ☐
- Outpatient rehab ☐
- AA ☐
- NA ☐
- Other, specify: ____________________________

49. Have you ever received services from a syringe access or needle exchange program?
- Yes ☐ No ☐ Don’t know ☐ Refused

If yes, name of program: ____________________________

50. In the past year, have you received Medication-assisted treatment, such as methadone or suboxone?
- Yes ☐ No ☐ Don’t know ☐ Refused

50a. If yes, are you still using MAT?
- Yes ☐ No ☐ Don’t know ☐ Refused

SHARING PARAPHERNELIA QUESTIONS

Now I’m going to ask you about sharing equipment that you might use when you take substances. We’re asking these questions because infections may spread by sharing items.

51. In the past month, how many times have you lent the following to others:
- Needles/syringes ☐ Frequently ☐ Sometimes ☐ Never ☐ Don’t know ☐ Refused ☐ N/A
- Cooker ☐ Frequently ☐ Sometimes ☐ Never ☐ Don’t know ☐ Refused ☐ N/A
- Filter/cotton ☐ Frequently ☐ Sometimes ☐ Never ☐ Don’t know ☐ Refused ☐ N/A
- Dissolving liquid ☐ Frequently ☐ Sometimes ☐ Never ☐ Don’t know ☐ Refused ☐ N/A
- Tourniquet ☐ Frequently ☐ Sometimes ☐ Never ☐ Don’t know ☐ Refused ☐ N/A
- Pipes ☐ Frequently ☐ Sometimes ☐ Never ☐ Don’t know ☐ Refused ☐ N/A
- Straw/utensil used to snort ☐ Frequently ☐ Sometimes ☐ Never ☐ Don’t know ☐ Refused ☐ N/A

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52. In the past month, how many times have you borrowed the following from others:

- Needles/syringes
  - Frequent
  - Sometimes
  - Never
  - Don’t know
  - Refused
  - N/A
- Cooker
  - Frequent
  - Sometimes
  - Never
  - Don’t know
  - Refused
  - N/A
- Filter/cotton
  - Frequent
  - Sometimes
  - Never
  - Don’t know
  - Refused
  - N/A
- Dissolving liquid
  - Frequent
  - Sometimes
  - Never
  - Don’t know
  - Refused
  - N/A
- Tourniquet
  - Frequent
  - Sometimes
  - Never
  - Don’t know
  - Refused
  - N/A
- Pipes
  - Frequent
  - Sometimes
  - Never
  - Don’t know
  - Refused
  - N/A
- Straw/utensil to snort substances
  - Frequent
  - Sometimes
  - Never
  - Don’t know
  - Refused
  - N/A

53. Has anyone you share equipment with been ill with symptoms such as fever, a wound infection, skin redness, rash, or sore throat?
   - Yes
   - No
   - Don’t know
   - Refused

54. In the last 30 days, have you or someone else ever licked the needle prior to you being injected?
   - Yes
   - No
   - Don’t know
   - Refused
   - N/A

**DIABETES QUESTIONS**

55. Do you have diabetes?
   - Yes
   - No
   - Don’t know
   - Refused

   If yes, please complete the following questions:

   - Do you have a primary care doctor or specialist taking care of your diabetes?
     - Yes
     - No
     - Don’t know
     - Refused

   - Do you monitor your glucose?
     - Yes
     - No
     - Don’t know
     - Refused

   - Do you ever share your glucose monitor?
     - Yes
     - No
     - Don’t know
     - Refused

   - Are you on insulin?
     - Yes
     - No
     - Don’t know
     - Refused

   - Do you have access to your diabetes medications?
     - Yes
     - No
     - Don’t know
     - Refused

56. In the past week, have you had any of the following symptoms?
   - Blurry vision
   - Frequent urination
   - Night-time urination
   - Numbness/tingling of hands/feet
   - None

**COMMUNICATION QUESTIONS**

We are now on the last section of the survey. I am briefly going to ask you some questions about how people communicate. These questions will help us with how to reach out to people to give them information about how to prevent disease with this type of bacteria.

56. Do you have a mobile phone?
   - Yes
   - No
   - Refused

57. Do you have a landline where you receive calls?
   - Yes
   - No
   - Refused

   57a. If there is no telephone access, how do you communicate with family or friends?

   ____________________________________________________________
58. Do you regularly use email?
   □ Yes  □ No  □ Don’t know  □ Refused

59. Do you use the public library to access email/internet?
   □ Yes  □ No  □ Don’t know  □ Refused

60. Would social media be a good way to reach you or your family and friends with health information?
   □ Yes  □ No  □ Don’t know  □ Refused

These are all of the questions that I have for today. Thank you very much for participating. We appreciate your time and help.

Interviewer comments: ____________________________________________

________________________________________________________________________________________

INFORMATION TO BE OBTAINED FROM MEDICAL RECORD/ABCs CRF

Please check all symptoms that are described in the medical chart. This is not part of the interview with the case.

Fever  □ Yes  □ No  If yes, max temp ________  □ Unknown
Red/swollen/warm skin  □ Yes  □ No
Wound  □ Yes  □ No
Shortness of breath  □ Yes  □ No
Fainting/passing out  □ Yes  □ No
Other  □ Yes  □ No  If other, please specify: _______________
Unknown  □ Yes  □ No

07/01/2020 (SFY21)