PATIENT ID: ____ ____ ____ ____ ____ ____ ____ ____ ____

Form Approved
OMB No. 0920-0009

Invasive Methicillin-resistant *Staphylococcus aureus* Active Bacterial Core Surveillance (ABCs) Case Report

Patient Name:_____ **Phone: ( ) _____-_____**
(Last, First, M.I.)

Address: _____ **Chart number:**_____
(Number, Street, Apt#)

_____ _____ _____ **Hospital:** _____
(City) (State) (Zip)

- Patient Identifier Information Is Not Transmitted to CDC -

1. STATE: (Residence of patient) ☐☐

2. COUNTY: (Residence of Patient) _____

3. STATE I.D.: ☐☐☐☐☐☐☐

4a. HOSPITAL/LAB WHERE CULTURE IDENTIFIED: ☐☐☐☐☐

4b. HOSPITAL ID WHERE PATIENT TREATED: ☐☐☐☐☐

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

6a. AGE: ☐☐☐

6b. Is age in day/mo/yr?
1 ☐ Days
2 ☐ Mos.
3 ☐ Yrs.

7a. SEX:
1 ☐ Male
2 ☐ Female

7b. ETHNIC ORIGIN:
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

7c. RACE: (*Check ALL that apply*)
1 ☐ American Indian or Alaskan Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Native Hawaiian or other Pacific Islander
1 ☐ White
1 ☐ Unknown

7f. TYPE OF INSURANCE: (ICheck ALL that apply)
1 ☐ Medicare
1 ☐ Military/VA
1 ☐ Medicaid/state assistance program
1 ☐ Indian Health Service (HIS)
1 ☐ Private/HMO/PPO/managed care
1 ☐ Other: (*specify*)_____
1 ☐ No health coverage
1 ☐ Unknown

7d. WEIGHT: _____**lb** _____**oz OR** _____ **kg** ☐ **Unk**

7e. HEIGHT: _____**ft** _____ **in OR** _____**cm** ☐ **Unk**

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

If YES: Date of Admission Mo ☐☐ Day ☐☐ Year ☐☐☐☐
Date of Discharge Mo ☐☐ Day ☐☐ Year ☐☐☐☐

9. WAS AN INFECTION RELATED TO THE INITIAL CULTURE INCLUDED IN THE ADMISSION DIAGNOSIS? (Was MRSA infection the reason for hospital admission?)
1 ☐ Yes
2 ☐ No
9 ☐ Unknown

10. LOCATION OF CULTURE COLLECTION: (*Check ONE*)
Hospital Inpatient
1 ☐ ICU
2 ☐ Other Unit
3 ☐ Emergency Room
4 ☐ Outpatient
5 ☐ Nursing Home
6 ☐ Rehabilitation Facility
7 ☐ Home Health
8 ☐ Prison/Jail
9 ☐ Unknown
10 ☐ Other: (*specify*)_____

12. DATE OF INITIAL CULTURE: Mo ☐☐ Day ☐☐ Year ☐☐☐☐

11. PATIENT OUTCOME: 9 ☐ UNKNOWN

1 ☐ SURVIVED
Discharged to: (*Check ONE*)
1 ☐ Home
2 ☐ Nursing Home
3 ☐ Rehabilitation
4 ☐ Hospital
5 ☐ Prison/Jail
9 ☐ Unknown
6 ☐ Other (*specify*):_____

2 ☐ DIED
Date of Death: Mo ☐☐ Day ☐☐ Year ☐☐☐☐
Was MRSA contributory or causal?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

13. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED: (*Check ALL that apply*)
1 ☐ Blood
1 ☐ CSF
1 ☐ Pleural fluid
1 ☐ Peritoneal fluid
1 ☐ Pericardial fluid
1 ☐ Joint/Synovial fluid
1 ☐ Bone
1 ☐ Internal body site (*specify*) _____
1 ☐ Other sterile site (*specify*)

14. Were cultures of the SAME sterile site(s) positive between 7 and 30 days after initial culture?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

15. Were cultures of <u>OTHER</u> sterile site(s) positive within 30 days of initial culture? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, list site(s):
1 ☐ Blood
1 ☐ CSF
1 ☐ Pleural fluid
1 ☐ Peritoneal fluid
1 ☐ Pericardial fluid
1 ☐ Joint/Synovial fluid
1 ☐ Bone
1 ☐ Internal body site (*specify*) _____
1 ☐ Other sterile site (*specify*) _____

16. NON-STERILE SITE(S) FROM WHICH MRSA WAS ISOLATED <u>WITHIN 72 HOURS BEFORE OR AFTER</u> INITIAL STERILE SITE CULTURE COLLECTION: (*Check ALL that apply*)
☐ NONE ☐ UNKNOWN
1 ☐ Sputum
1 ☐ Nares
1 ☐ Skin
1 ☐ Urine
1 ☐ Catheter/Device
1 ☐ Rectal/Stool
1 ☐ Throat/Nasopharynx
1 ☐ Other

If SKIN, check culture type(s) below: (*Check ALL that apply*)
1 ☐ Traumatic Wound
1 ☐ Surgical Incision
1 ☐ Abscess
1 ☐ Pressure Ulcer
1 ☐ Wound
1 ☐ Exit site
1 ☐ Not Specified
1 ☐ Other: (*specify*) _____

17. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S): (*Check **ALL** that apply*) 1 ☐ NONE 1 ☐ UNKNOWN

Bacteremia
1 ☐ Primary
2 ☐ Secondary
9 ☐ Not Specified
1 ☐ Empyema
1 ☐ Meningitis
1 ☐ Peritonitis
1 ☐ Pneumonia
1 ☐ Osteomyelitis
1 ☐ Urinary Tract
Endocarditis
1 ☐ Native valve
2 ☐ Prosthetic valve
1 ☐ Abscess (not skin)
1 ☐ Surgical site (internal)
Septic Arthritis
1 ☐ Native Joint
2 ☐ Prosthetic Joint
1 ☐ Bursitis
1 ☐ Septic Shock
1 ☐ Cellulitis
1 ☐ Traumatic Wound
1 ☐ Surgical Incision
1 ☐ Pressure Ulcer
1 ☐ Other: (*specify*) _____

18. UNDERLYING CONDITIONS: (*Check ALL that apply*) (If none or no chart available, check appropriate box) 1☐NONE 1☐UNKNOWN

1☐Current Smoker
1☐Alcohol Abuse
1☐IVDU
1☐HIV
1☐AIDS or CD4 count<200
1☐Solid Organ Malignancy
1☐Hematologic Malignancy
1☐Peripheral Vascular Disease (PVD)
1☐Heart Failure/CHF
1☐Atherosclerotic Cardiovascular Disease (ASCVD)/CAD
1☐CVA/Stroke (Not TIA)
1☐Emphysema/COPD
1☐Asthma
1☐Systemic Lupus Erythematosus
1☐Sickle Cell Anemia
1☐Diabetes
1☐Chronic Renal Insufficiency
1☐Chronic Liver Disease
1☐Rheumatoid Arthritis
1☐Obesity
1☐Influenza (*within 10 days of initial culture*)
1☐Immunosuppressive Therapy
1☐Spider/Insect Bite 1☐Abscess/Boil
1☐Eczema 1☐Psoriasis
1☐Other Dermatological Condition(s): (*specify*) _____
_____
1☐Other condition(s): (*specify*) _____
_____

19. CLASSIFICATION – Healthcare-associated and Community-associated: (*Check ALL that apply*) 1☐NONE 1☐UNKNOWN

1☐Previous documented MRSA infection or colonization
If YES: Month ☐☐ Year ☐☐☐☐ OR previous STATEID: ☐☐☐☐☐☐☐☐

1☐Culture collected > 48 hours after hospital admission.

1☐Hospitalized within year before index culture date.

1☐Surgery within year before index culture date.

1☐Dialysis within year before index culture date.
(*Hemodialysis or Peritoneal dialysis*)

1☐Residence in a long-term care facility within year before index culture date:
If YES: 1☐Nursing Home 3☐Other: (*specify*) _____
2☐Rehabilitation Facility
9☐Unknown
Resident at time of culture: 1☐Yes 2☐No 9☐Unknown

1☐Invasive device or catheter in place at time of admission/evaluation?
If YES: (*Check ALL that apply*)
1☐Urinary 1☐Gastrointestinal 1☐Other
1☐Respiratory 1☐Central Vascular _____

20. SUSCEPTIBILITY RESULTS: [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)]

Ciprofloxacin: ☐S ☐I ☐R ☐U	Oxacillin: ☐S ☐I ☐R ☐U	Cefazolin: ☐S ☐I ☐R ☐U
Clindamycin: ☐S ☐I ☐R ☐U	Penicillin: ☐S ☐I ☐R ☐U	Chloramphenicol: ☐S ☐I ☐R ☐U
Daptomycin: ☐S ☐I ☐R ☐U	Quinupristin/Dalfopristin: ☐S ☐I ☐R ☐U	Moxifloxacin: ☐S ☐I ☐R ☐U
Doxycycline: ☐S ☐I ☐R ☐U	Rifampin: ☐S ☐I ☐R ☐U	Nafcillin: ☐S ☐I ☐R ☐U
Erythromycin: ☐S ☐I ☐R ☐U	Tetracycline: ☐S ☐I ☐R ☐U	Ampicillin: ☐S ☐I ☐R ☐U
Gatifloxacin: ☐S ☐I ☐R ☐U	Trimethoprim-sulfamethoxazole: ☐S ☐I ☐R ☐U	Imipenem: ☐S ☐I ☐R ☐U
Gentamicin: ☐S ☐I ☐R ☐U	Vancomycin: ☐S ☐I ☐R ☐U	
Levofloxacin: ☐S ☐I ☐R ☐U	Other: ☐S ☐I ☐R ☐U	
Linezolid: ☐S ☐I ☐R ☐U		

22. WAS CULTURE POLYMICROBIAL? **If YES, list other bacterial species isolated:**

1☐Yes 2☐No 9☐Unknown 1_____ 3_____
2_____ 4_____

23. WAS PATIENT RECEIVING ANTIBIOTICS AT TIME OF CULTURE?

1☐Yes **If YES, please list:** (*Use codes in appendix 1*)
2☐No 1_____ 3_____ 5_____
9☐Unknown 2_____ 4_____ 6_____

24. WAS PATIENT PRESCRIBED ANTIBIOTICS AT THE TIME OF CULTURE?
(Was antibiotic treatment initiated or changed?)

1☐Yes **If YES, please list:** (*Use codes in appendix 1*)
2☐No 1_____ 3_____ 5_____
9☐Unknown 2_____ 4_____ 6_____

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

26. CRF status:
1☐Complete
2☐Incomplete
3☐Edited & Corrected
4☐Chart unavailable after 3 requests

27. Does this case have recurrent MRSA disease?
1☐Yes
2☐No
9☐Unknown

If YES, previous (1st) STATEID: ☐☐☐☐☐☐☐

28. DATE REPORTED TO EIP SITE:
Mo ☐☐ Day ☐☐ Year ☐☐☐☐

29. Initials of S.O.: _____

30. COMMENTS: _____
_____