

PATIENT ID: \_\_\_\_\_

### 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 -

<b>1. STATE:</b> (Residence of patient) [ ][ ]	<b>2. COUNTY:</b> (Residence of Patient) _____	<b>3. STATE I.D.:</b> [ ][ ][ ][ ][ ][ ][ ][ ]	<b>4a. HOSPITAL/LAB WHERE CULTURE IDENTIFIED:</b> [ ][ ][ ][ ][ ]	<b>4b. HOSPITAL ID WHERE PATIENT TREATED:</b> [ ][ ][ ][ ][ ]
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<b>5. DATE OF BIRTH:</b> Mo Day Year [ ][ ][ ][ ][ ][ ][ ]	<b>6a. AGE:</b> [ ][ ][ ]	<b>6b. Is age in day/mo/yr?</b> 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.	<b>7a. SEX:</b> 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	<b>7b. ETHNIC ORIGIN:</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown	<b>7c. RACE: (Check ALL that apply)</b> 1 <input type="checkbox"/> American Indian or Alaskan Native 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> Native Hawaiian or other Pacific Islander 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Unknown
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<b>7f. TYPE OF INSURANCE: (ICheck ALL that apply)</b> 1 <input type="checkbox"/> Medicare 1 <input type="checkbox"/> Military/VA 1 <input type="checkbox"/> Medicaid/state assistance program 1 <input type="checkbox"/> Indian Health Service (HIS) 1 <input type="checkbox"/> Private/HMO/PPO/managed care 1 <input type="checkbox"/> Other: (specify) _____ 1 <input type="checkbox"/> No health coverage 1 <input type="checkbox"/> Unknown	<b>7d. WEIGHT:</b> _____ lb _____ oz OR _____ kg <input type="checkbox"/> Unk	<b>7e. HEIGHT:</b> _____ ft _____ in OR _____ cm <input type="checkbox"/> Unk
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<b>8. WAS PATIENT HOSPITALIZED?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  If YES: Date of Admission Mo Day Year [ ][ ][ ][ ][ ][ ][ ] Date of Discharge Mo Day Year [ ][ ][ ][ ][ ][ ][ ]	<b>9. WAS AN INFECTION RELATED TO THE INITIAL CULTURE INCLUDED IN THE ADMISSION DIAGNOSIS? (Was MRSA infection the reason for hospital admission?)</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>10. LOCATION OF CULTURE COLLECTION: (Check ONE)</b> Hospital Inpatient 1 <input type="checkbox"/> ICU 2 <input type="checkbox"/> Other Unit 3 <input type="checkbox"/> Emergency Room 4 <input type="checkbox"/> Outpatient 5 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Rehabilitation Facility 7 <input type="checkbox"/> Home Health 10 <input type="checkbox"/> Other: (specify) _____ 8 <input type="checkbox"/> Prison/Jail 9 <input type="checkbox"/> Unknown	<b>12. DATE OF INITIAL CULTURE:</b> Mo Day Year [ ][ ][ ][ ][ ][ ][ ]
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<b>11. PATIENT OUTCOME:</b> 1 <input type="checkbox"/> SURVIVED Discharged to: (Check ONE) 1 <input type="checkbox"/> Home 4 <input type="checkbox"/> Hospital 2 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Prison/Jail 3 <input type="checkbox"/> Rehabilitation 9 <input type="checkbox"/> Unknown 6 <input type="checkbox"/> Other (specify): _____ 2 <input type="checkbox"/> DIED Date of Death: Mo Day Year [ ][ ][ ][ ][ ][ ][ ] Was MRSA contributory or causal? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>13. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED: (Check ALL that apply)</b> 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> Other sterile site (specify) _____
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<b>14. Were cultures of the SAME sterile site(s) positive between 7 and 30 days after initial culture?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>16. NON-STERILE SITE(S) FROM WHICH MRSA WAS ISOLATED WITHIN 72 HOURS BEFORE OR AFTER INITIAL STERILE SITE CULTURE COLLECTION: (Check ALL that apply)</b> [ ] NONE [ ] UNKNOWN 1 <input type="checkbox"/> Sputum 1 <input type="checkbox"/> Urine 1 <input type="checkbox"/> Throat/Nasopharynx 1 <input type="checkbox"/> Nares 1 <input type="checkbox"/> Catheter/Device 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> Skin 1 <input type="checkbox"/> Rectal/Stool
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<b>15. Were cultures of OTHER sterile site(s) positive within 30 days of initial culture?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, list site(s): 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Joint/Synovial fluid _____ 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> Other sterile site (specify) _____ 1 <input type="checkbox"/> Peritoneal fluid	<b>If SKIN, check culture type(s) below: (Check ALL that apply)</b> 1 <input type="checkbox"/> Traumatic Wound 1 <input type="checkbox"/> Pressure Ulcer 1 <input type="checkbox"/> Not Specified 1 <input type="checkbox"/> Surgical Incision 1 <input type="checkbox"/> Wound 1 <input type="checkbox"/> Other: (specify) _____ 1 <input type="checkbox"/> Abscess 1 <input type="checkbox"/> Exit site _____
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<b>17. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S): (Check ALL that apply)</b> Bacteremia 1 <input type="checkbox"/> Meningitis Endocarditis Septic Arthritis 1 <input type="checkbox"/> Cellulitis 1 <input type="checkbox"/> Other: (specify) _____ 1 <input type="checkbox"/> Primary 1 <input type="checkbox"/> Peritonitis 1 <input type="checkbox"/> Native valve 1 <input type="checkbox"/> Native Joint 1 <input type="checkbox"/> Traumatic Wound _____ 2 <input type="checkbox"/> Secondary 1 <input type="checkbox"/> Pneumonia 2 <input type="checkbox"/> Prosthetic valve 2 <input type="checkbox"/> Prosthetic Joint 1 <input type="checkbox"/> Surgical Incision _____ 9 <input type="checkbox"/> Not Specified 1 <input type="checkbox"/> Osteomyelitis 1 <input type="checkbox"/> Abscess (not skin) 1 <input type="checkbox"/> Bursitis 1 <input type="checkbox"/> Pressure Ulcer _____ 1 <input type="checkbox"/> Empyema 1 <input type="checkbox"/> Urinary Tract 1 <input type="checkbox"/> Surgical site (internal) 1 <input type="checkbox"/> Septic Shock
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