

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 -

1. STATE: (Residence of patient) <input type="text"/>	2. COUNTY: (Residence of Patient) <input type="text"/>	3. STATE I.D.: <input type="text"/>	4a. HOSPITAL/LAB WHERE CULTURE IDENTIFIED: <input type="text"/>	4b. HOSPITAL ID WHERE PATIENT TREATED: <input type="text"/>
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5. DATE OF BIRTH: Mo Day Year <input type="text"/>	6a. AGE: <input type="text"/>	6b. Is age in day/mo/yr? 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.	7a. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	7b. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown	7c. RACE: (Check ALL that apply) 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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7f. TYPE OF INSURANCE: (ICheck ALL that apply) 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	7d. WEIGHT: _____ lb _____ oz OR _____ kg <input type="checkbox"/> Unk	7e. HEIGHT: _____ ft _____ in OR _____ cm <input type="checkbox"/> Unk
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8. WAS PATIENT HOSPITALIZED? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If YES: Date of Admission Mo Day Year <input type="text"/> Date of Discharge Mo Day Year <input type="text"/>	9. WAS AN INFECTION RELATED TO THE INITIAL CULTURE INCLUDED IN THE ADMISSION DIAGNOSIS? (Was MRSA infection the reason for hospital admission?) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	10. LOCATION OF CULTURE COLLECTION: (Check ONE) 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	12. DATE OF INITIAL CULTURE: Mo Day Year <input type="text"/>
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11. PATIENT OUTCOME: 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 <input type="text"/> Was MRSA contributory or causal? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	13. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED: (Check ALL that apply) 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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14. Were cultures of the SAME sterile site(s) positive between 7 and 30 days after initial culture? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	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) <input type="checkbox"/> NONE <input type="checkbox"/> 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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15. Were cultures of OTHER sterile site(s) positive within 30 days of initial culture? 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	If SKIN, check culture type(s) below: (Check ALL that apply) 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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17. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S): (Check ALL that apply) 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

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

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

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

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|---|-------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|
| <p>1 <input type="checkbox"/> Previous documented MRSA infection or colonization</p> <p>If YES: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="text-align: center; padding: 0 5px;">Month</td><td style="text-align: center; padding: 0 5px;">Year</td></tr><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> OR previous STATEID: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table></p> <p>1 <input type="checkbox"/> Culture collected > 48 hours after hospital admission.</p> <p>1 <input type="checkbox"/> Hospitalized within year before index culture date.</p> <p>1 <input type="checkbox"/> Surgery within year before index culture date.</p> <p>1 <input type="checkbox"/> Dialysis within year before index culture date.
(Hemodialysis or Peritoneal dialysis)</p> | Month | Year | | | | | | | | | | | | | | | | | | | | | <p>1 <input type="checkbox"/> Residence in a long-term care facility within year before index culture date:</p> <p>If YES: 1 <input type="checkbox"/> Nursing Home 3 <input type="checkbox"/> Other: (specify) _____</p> <p>2 <input type="checkbox"/> Rehabilitation Facility _____</p> <p>9 <input type="checkbox"/> Unknown</p> <p>Resident at time of culture: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>1 <input type="checkbox"/> Invasive device or catheter in place at time of admission/evaluation?</p> <p>If YES: (Check ALL that apply)</p> <p>1 <input type="checkbox"/> Urinary 1 <input type="checkbox"/> Gastrointestinal 1 <input type="checkbox"/> Other _____</p> <p>1 <input type="checkbox"/> Respiratory 1 <input type="checkbox"/> Central Vascular _____</p> |
| Month | Year | | | | | | | | | | | | | | | | | | | | | | |
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20. SUSCEPTIBILITY RESULTS: [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)]

- | | | |
|--|--|--|
| Ciprofloxacin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Oxacillin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Cefazolin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Clindamycin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Penicillin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Chloramphenicol: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Daptomycin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Quinupristin/Dalfopristin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Moxifloxacin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Doxycycline: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Rifampin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Nafcillin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Erythromycin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Tetracycline: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Ampicillin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Gatifloxacin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Trimethoprim-sulfamethoxazole: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Imipenem: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U |
| Gentamicin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Vancomycin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | |
| Levofloxacin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | Other: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | |
| Linezolid: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U | | |

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

- | | | |
|---|---------|---------|
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 1 _____ | 3 _____ |
| | 2 _____ | 4 _____ |

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

- | | |
|---|---|
| <p>1 <input type="checkbox"/> Yes If YES, please list: (Use codes in appendix 1)</p> <p>2 <input type="checkbox"/> No 1 _____ 3 _____ 5 _____</p> <p>9 <input type="checkbox"/> Unknown 2 _____ 4 _____ 6 _____</p> | <p>1 <input type="checkbox"/> Yes If YES, please list: (Use codes in appendix 1)</p> <p>2 <input type="checkbox"/> No 1 _____ 3 _____ 5 _____</p> <p>9 <input type="checkbox"/> Unknown 2 _____ 4 _____ 6 _____</p> |
|---|---|

- | | | | | | | | | | | | | | | | | | | | |
|---|---|--|--|--|--|--|--|--|--|--|--|---|----|-----|------|--|--|--|--|
| <p>25. Was case first identified through audit?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> Unknown</p> | <p>26. CRF status:</p> <p>1 <input type="checkbox"/> Complete</p> <p>2 <input type="checkbox"/> Incomplete</p> <p>3 <input type="checkbox"/> Edited & Corrected</p> <p>4 <input type="checkbox"/> Chart unavailable after 3 requests</p> | <p>27. Does this case have recurrent MRSA disease?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> Unknown</p> | <p>If YES, previous (1st) STATEID:</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> | | | | | | | | | <p>28. DATE REPORTED TO EIP SITE:</p> <table style="width: 100%; text-align: center;"> <tr> <td style="padding: 0 5px;">Mo</td> <td style="padding: 0 5px;">Day</td> <td style="padding: 0 5px;">Year</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | Mo | Day | Year | | | | <p>29. Initials of S.O.:</p> <p>_____</p> |
| | | | | | | | | | | | | | | | | | | | |
| Mo | Day | Year | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |

30. COMMENTS: _____
