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 - -SHADED AREAS FOR OFFICE USE ONLY-

1. STATE: (Re tient)

2. COUNTY: (Residence of Patient)

3. STATE I.D.:

4a. HOSPITAL/LAB WHERE CU :

4b. HOSPITAL ID WHERE P

5. DATE OF BIRTH: Mo Day Year

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 Alaska Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ White
1 ☐ Unknown

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

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

7f. TYPE OF INSURANCE: (Check 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

8. WAS PATIENT HOSPITALIZED?
1 ☐ Yes 2 ☐ No 9 Unknown

If YES: Date of Admission Mo Day Year

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*)
0 ☐ Hospital Inpatient
3 ☐ Emergency Room
4 ☐ Outpatient
5 ☐ Long Term Care Facility
9 ☐ Unknown
10 ☐ Other (specify) _____

11. PATIENT OUTCOME:
1 ☐ SURVIVED
2 ☐ DIED
9 ☐ UNKNOWN

Date of Death: Mo Day Year

Was MRSA contributory or causal? 1 ☐ Yes 2 ☐ No

12. DATE OF INITIAL CULTURE: Mo Day Year

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 OTHER sterile site(s) positive within 30 days of initial culture?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, list site(s):
1 ☐ Blood
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*) _____

1 ☐ Bacteremia
1 ☐ Empyema
1 ☐ Meningitis
1 ☐ Peritonitis
1 ☐ Pneumonia
1 ☐ Osteomyelitis
1 Urinary Tract
1 Endocarditis
1 Skin Abscess
1 Abscess (not skin)
1 ☐ Surgical site (internal)
1 ☐ Septic Arthritis
1 ☐ Bursitis
1 ☐ Septic Shock
1 ☐ Cellulitis
1 ☐ Traumatic Wound
1 ☐ Surgical Incision
1 ☐ Pressure Ulcer
1 ☐ Other: (*specify*) _____

Public reporting burden of this collection of information is estimated to average 10 minute
data needed, and completing and reviewing the collection of information. An agency may
valid OMB control number. Send comments regarding this burden estimate or any other
Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-000

17. 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 ☐ Other Drug Use
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 ☐ Immunosuppressive Therapy
1 ☐ Influenza (within 10 days of initial culture)
1 ☐ Decubitus Ulcer
1 ☐ Abscess/Boil
1 ☐ Eczema
1 ☐ Psoriasis
1 ☐ Other Dermatological Condition(s): (*specify*) _____
1 ☐ Other condition(s): (*specify*) _____

18. 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

1 ☐ Central vascular catheter in place at time of admission/evaluation

19. 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
Clindamycin:	☐S	☐I	☐R	☐U	Penicillin:	☐S	☐I	☐R	☐U
Daptomycin:	☐S	☐I	☐R	☐U	Quinupristin/Dalfopristin:	☐S	☐I	☐R	☐U
Doxycycline:	☐S	☐I	☐R	☐U	Rifampin:	☐S	☐I	☐R	☐U
Erythromycin:	☐S	☐I	☐R	☐U	Tetracycline:	☐S	☐I	☐R	☐U
Gatifloxacin:	☐S	☐I	☐R	☐U	Trimethoprim-sulfamethoxazole:	☐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	_____				

Cefazolin:	☐S	☐I	☐R	☐U
Chloramphenicol:	☐S	☐I	☐R	☐U
Moxifloxacin:	☐S	☐I	☐R	☐U
Nafcillin:	☐S	☐I	☐R	☐U
Ampicillin:	☐S	☐I	☐R	☐U
Imipenem:	☐S	☐I	☐R	☐U

- SURVEILLANCE OFFICE USE ONLY -

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

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

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

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

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

24. Initials of S.O.: _____

25. COMMENTS: _____