

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#)

\_\_\_\_\_  
(City) (State) (Zip) Hospital: \_\_\_\_\_

- Patient Identifier Information Is Not Transmitted to CDC -

- SHADED AREAS FOR OFFICE USE ONLY -

<b>1. STATE:</b> (Residence of Patient)	<b>2. COUNTY:</b> (Residence of Patient)	<b>3. STATE ID:</b>	<b>4a. HOSPITAL ID WHERE CULTURE WAS OBTAINED:</b>	<b>4b. HOSPITAL ID WHERE PATIENT WAS ADMITTED:</b>
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<b>5. DATE OF BIRTH:</b> Mo Day Year	<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 Alaska 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: (Check 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 9 <input type="checkbox"/> Unknown If YES: Date of Admission Mo Day Year 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> 0 <input type="checkbox"/> Hospital Inpatient 3 <input type="checkbox"/> Emergency Room 4 <input type="checkbox"/> Outpatient 5 <input type="checkbox"/> Long Term Care Facility 9 <input type="checkbox"/> Unknown 10 <input type="checkbox"/> Other (specify) _____
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<b>11. PATIENT OUTCOME:</b> 1 <input type="checkbox"/> SURVIVED 2 <input type="checkbox"/> DIED 9 <input type="checkbox"/> UNKNOWN Date of Death: Mo Day Year Was MRSA contributory or causal? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<b>12. DATE OF INITIAL CULTURE:</b> Mo Day Year
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<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>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"/> 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) _____	1 <input type="checkbox"/> Bacteremia 1 <input type="checkbox"/> Empyema 1 <input type="checkbox"/> Meningitis 1 <input type="checkbox"/> Peritonitis 1 <input type="checkbox"/> Pneumonia 1 <input type="checkbox"/> Osteomyelitis 1 <input type="checkbox"/> Urinary Tract 1 <input type="checkbox"/> Endocarditis	1 <input type="checkbox"/> Skin Abscess 1 <input type="checkbox"/> Abscess (not skin) 1 <input type="checkbox"/> Surgical site (internal) 1 <input type="checkbox"/> Septic Arthritis 1 <input type="checkbox"/> Bursitis 1 <input type="checkbox"/> Septic Shock 1 <input type="checkbox"/> Cellulitis 1 <input type="checkbox"/> Traumatic Wound	<b>UL</b> <b>INI</b> 1 <input type="checkbox"/> Surgical Incision 1 <input type="checkbox"/> Pressure Ulcer 1 <input type="checkbox"/> Other: (specify) _____
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Public reporting burden of this collection of information is estimated to average 10 minutes per response, including reviewing the collection of information. An agency may not collect information that burdens the public, unless it has the approval of the Office of Management and Budget (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 Washington Headquarters Office, Paperwork Project, 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).

**17. UNDERLYING CONDITIONS:** (Check ALL that apply) (If none or no chart available, check appropriate box)

<input type="checkbox"/> Current Smoker	<input type="checkbox"/> Peripheral Vascular Disease (PVD)	<input type="checkbox"/> Systemic Lupus Erythematosus	<input type="checkbox"/> Immunosuppressive Therapy	<input type="checkbox"/> NONE	<input type="checkbox"/> UNKNOWN
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Heart Failure/CHF	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Decubitus Ulcer	<input type="checkbox"/> 1	<input type="checkbox"/> Influenza (within 10 days of initial culture)
<input type="checkbox"/> IVDU	<input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema	<input type="checkbox"/> 1	<input type="checkbox"/> Abscess/Boil
<input type="checkbox"/> Other Drug Use	<input type="checkbox"/> CVA/Stroke (Not TIA)	<input type="checkbox"/> Chronic Renal Insufficiency	<input type="checkbox"/> Other Dermatological Condition(s): (specify)	_____	
<input type="checkbox"/> HIV	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Chronic Liver Disease	<input type="checkbox"/> _____	_____	
<input type="checkbox"/> AIDS or CD4 count < 200	<input type="checkbox"/> Asthma	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other condition(s): (specify)	_____	
<input type="checkbox"/> Solid Organ Malignancy		<input type="checkbox"/> Obesity			
<input type="checkbox"/> Hematologic Malignancy					

**18. CLASSIFICATION - Healthcare-associated and Community-associated:** (Check ALL that apply)

<input type="checkbox"/> Previous documented MRSA infection or colonization	<input type="checkbox"/> Surgery within year before index culture date.	<input type="checkbox"/> Residence in a long-term care facility within year before index culture date
If YES: Month Year OR previous STATEID: _____	<input type="checkbox"/> Dialysis within year before index Culture date.	<input type="checkbox"/> Central vascular catheter in place at time of admission/evaluation
<input type="checkbox"/> Culture collected > 48 hours after hospital admission.	<input type="checkbox"/> Hospitalized within year before index culture date. (Hemodialysis or Peritoneal dialysis)	

**19. 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		

**- SURVEILLANCE OFFICE USE ONLY -**

<b>20. Was case first identified through audit?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>21. CRF status:</b> <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete <input type="checkbox"/> Edited & Corrected <input type="checkbox"/> Chart unavailable after 3 requests	<b>22. Does this case have recurrent MRSA disease?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, previous (1 <sup>st</sup> ) STATEID: _____	<b>23. DATE REPORTED TO EIP SITE:</b> Mo Day Year _____	<b>24. Initials of S.O.:</b> _____
<b>25. COMMENTS:</b> _____ _____				