Patient ID: ____ ____ ____ ____ ____ ____ ____ ____

– ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT –

Patient's Name: _____ (Last, First, M.I.) Phone No.: ( ) _____

Address: _____ (Number, Street, Apt. No.) Patient Chart No.: _____

_____ (City, State) _____ (Zip Code) Hospital: _____

– Patient identifier information is NOT transmitted to CDC –

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

INVASIVE METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS*
ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

– SHADED AREAS FOR OFFICE USE ONLY –

Form Approved OMB No. 0920-0009

1. STATE: (Residence of patient) ☐☐

2. COUNTY: (Residence of Patient) _____

3. STATE I.D.: ☐☐☐☐☐☐☐

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

4b. HOSPITAL I.D. WHERE PATIENT TREATED ☐☐☐☐☐

5. Where was the patient a resident prior to admission at time of first positive culture?
1 ☐ Private Residence 1 ☐ Incarcerated 1 ☐ Unk
1 ☐ Long Term Care Facility 1 ☐ Transferred from hospital/acute care facility
1 ☐ Homeless 1 ☐ Other _____

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

7a. AGE: ☐☐☐

7b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

8a. SEX:
1 ☐ Male
2 ☐ Female

8b. ETHNIC ORIGIN:
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unk

8c. RACE: (*Check all that apply*)
1 ☐ White 1 ☐ Asian
1 ☐ Black or African American 1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ American Indian or Alaska Native 1 ☐ Unk

8d. WEIGHT: _____ lbs _____ oz **OR** _____ kg ☐ Unk

8e. HEIGHT: _____ ft _____ in **OR** _____ cm ☐ Unk

8f. TYPE OF INSURANCE: (*Check all that apply*)
1 ☐ Medicare 1 ☐ Medicaid/state assistance program 1 ☐ Private/HMO/PPO/managed care 1 ☐ No health coverage
1 ☐ Military/VA 1 ☐ Indian Health Service (HIS) 1 ☐ Other: (*specify*) _____ 1 ☐ Unk

9. WAS PATIENT HOSPITALIZED?
1 ☐ Yes 2 ☐ No 9 ☐ Unk

If YES: Date of admission Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

Date of discharge Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

10. 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 ☐ Unk

11a. LOCATION OF CULTURE COLLECTION: (*Check one*)
0 ☐ Hospital Inpatient 5 ☐ Long Term Care Facility
3 ☐ Emergency Room 9 ☐ Unk
4 ☐ Outpatient 10 ☐ Other: (*specify*) _____

11b. DATE OF INITIAL CULTURE: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

12. PATIENT OUTCOME:
1 ☐ Survived — If survived, was the patient transferred to a LTCF? 1 ☐ Yes 2 ☐ No
2 ☐ Died — Date of Death: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐
Was MRSA contributory or causal? 1 ☐ Yes 2 ☐ No 9 ☐ Unk
9 ☐ Unk

13a. At time of first positive culture, patient was:
1 ☐ Pregnant
2 ☐ Post-partum
3 ☐ Neither
9 ☐ Unk

13b. If pregnant or post-partun, what was the outcome of the fetus:
1 ☐ Survived, no apparent illness 4 ☐ Abortion/ stillbirth
2 ☐ Survived, clinical infection 5 ☐ Induced abortion
3 ☐ Live birth/neonatal death 9 ☐ Unk

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

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

16. Were cultures of <u>OTHER</u> sterile site(s) positive within 30 days of initial culture?
1 ☐ Yes 2 ☐ No 9 ☐ Unk
If Yes, list site(s):
1 ☐ Blood 1 ☐ Joint/Synovial fluid
1 ☐ CSF 1 ☐ Bone
1 ☐ Pleural fluid 1 ☐ Internal body site (*specify*) _____
1 ☐ Peritoneal fluid
1 ☐ Pericardial fluid 1 ☐ Other sterile site (*specify*) _____

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

17. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S): (*Check all that apply*) 1 ☐ None 1 ☐ Unk

1 ☐ Bacteremia
1 ☐ Empyema
1 ☐ Meningitis
1 ☐ Peritonitis
1 ☐ Pneumonia (*If checked, go to question 21*)
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 ☐ Septic Emboli
1 ☐ Other: (*specify*) _____

18. UNDERLYING CONDITIONS: (*Check all that apply*) (if none or no chart available, check appropriate box) 1 ☐ None 1 ☐ Unk

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

19. CLASSIFICATION – Healthcare-associated and Community-associated: (*Check all that apply*) 1 ☐ None 1 ☐ Unk

1 ☐ Previous documented MRSA infection or colonization
If YES: Month ☐☐ Year ☐☐☐☐ OR previous STATE I.D.: ☐☐☐☐☐☐☐☐
1 ☐ Culture collected >48 hours after hospital admission.
1 ☐ Hospitalized within year before index culture date.
If YES: Month ☐☐ Year ☐☐☐☐ 1 ☐ Unk
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.

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

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

21. SUPPLEMENTAL PNEUMONIA QUESTIONS. Please complete if the patient was determined to have pneumonia per question 17.

a. Are any of the following listed in the discharge summary **narrative**?
1 ☐ MRSA pneumonia
1 ☐ Pneumonia
1 ☐ Aspiration pneumonia
1 ☐ Staphylococcal pneumonia
1 ☐ No pneumonia specified

b. Discharge diagnosis (*Check all that apply*) 1 ☐ N/A 1 ☐ Unk
1 ☐ 482.40 1 ☐ 482.41 1 ☐ 482.49 1 ☐ V09.0 1 ☐ None listed

c. Chest Radiograph Results (*Check all that apply*) 1 ☐ Not done
1 ☐ Bronchopneumonia/pneumonia
1 ☐ Air space density/opacity
1 ☐ Cavitation
1 ☐ Cannot rule out pneumonia
1 ☐ New or changed infiltrates
1 ☐ Pleural effusion
1 ☐ Consolidation
1 ☐ Not available
1 ☐ Other: (*specify*) _____

d. 1 ☐ MRSA positive non-sterile respiratory specimens

– SURVEILLANCE OFFICE USE ONLY –

22. Was case first identified through audit? 1 ☐ Yes 2 ☐ No 9 ☐ Unk

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

24. Does this case have recurrent MRSA disease? 1 ☐ Yes 2 ☐ No 9 ☐ Unk
If YES, previous (1st) STATE I.D.: ☐☐☐☐☐☐☐☐

25. Date reported to EIP site: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

26. Initials of S.O: _____

27. COMMENTS: _____