

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**



Form Approved OMB No. 0920-0802

- SHADED AREAS FOR OFFICE USE ONLY -

1. STATE: (Residence of patient) <input type="checkbox"/> <input type="checkbox"/>	2. COUNTY: (Residence of Patient) _____	3. STATE I.D.: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4b. HOSPITAL I.D. WHERE PATIENT TREATED <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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5. Where was the patient a resident prior to admission at time of first positive culture? <input type="checkbox"/> Private Residence <input type="checkbox"/> Incarcerated <input type="checkbox"/> Unk <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Transferred from hospital/acute care facility <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____	6. DATE OF BIRTH: Mo. Day Year <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	7a. AGE: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	7b. Is age in day/mo/yr? 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.
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8a. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	8b. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unk	8c. RACE: (Check all that apply) 1 <input type="checkbox"/> White 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"/> American Indian or Alaska Native 1 <input type="checkbox"/> Unk	8d. WEIGHT: _____ lbs _____ oz OR _____ kg <input type="checkbox"/> Unk 8e. HEIGHT: _____ ft _____ in OR _____ cm <input type="checkbox"/> Unk
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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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk If YES: Date of admission Mo. Day Year <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date of discharge Mo. Day Year <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10. 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"/> Unk	11a. LOCATION OF CULTURE COLLECTION: (Check one) 0 <input type="checkbox"/> Hospital Inpatient 5 <input type="checkbox"/> Long Term Care Facility 3 <input type="checkbox"/> Emergency Room 9 <input type="checkbox"/> Unk 4 <input type="checkbox"/> Outpatient 10 <input type="checkbox"/> Other: (specify) _____	11b. DATE OF INITIAL CULTURE: Mo. Day Year <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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12. PATIENT OUTCOME: 1 <input type="checkbox"/> Survived If survived, was the patient transferred to a LTCF? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Date of Death: Mo. Day Year <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Was MRSA contributory or causal? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk 9 <input type="checkbox"/> Unk	13a. At time of first positive culture, patient was: 1 <input type="checkbox"/> Pregnant 2 <input type="checkbox"/> Post-partum 3 <input type="checkbox"/> Neither 9 <input type="checkbox"/> Unk	13b. If pregnant or post-partun, what was the outcome of the fetus: 1 <input type="checkbox"/> Survived, no apparent illness 4 <input type="checkbox"/> Abortion/stillbirth 2 <input type="checkbox"/> Survived, clinical infection 5 <input type="checkbox"/> Induced abortion 3 <input type="checkbox"/> Live birth/neonatal death 9 <input type="checkbox"/> Unk
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14. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED: (Check all that apply) 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Other sterile site (specify) _____	15. 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"/> Unk	16. 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"/> Unk If Yes, list site(s): 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Other sterile site (specify) _____
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Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid 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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0802).

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

<input type="checkbox"/> Bacteremia	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Surgical Site (internal)	<input type="checkbox"/> Traumatic Wound
<input type="checkbox"/> Empyema	<input type="checkbox"/> Urinary Tract	<input type="checkbox"/> Septic Arthritis	<input type="checkbox"/> Surgical Incision
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Pressure Ulcer
<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Skin Abscess	<input type="checkbox"/> Septic Shock	<input type="checkbox"/> Septic Emboli
<input type="checkbox"/> Pneumonia (If checked, go to question 21)	<input type="checkbox"/> Abscess (not skin)	<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Other: (specify)

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

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

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

Previous documented MRSA infection or colonization
 Month Year OR previous STATE I.D.:
 If YES:

Culture collected >48 hours after hospital admission.

Hospitalized within year before index culture date.
 Month Year
 If YES: 1 Unk

Surgery within year before index culture date. 1 Residence in a long-term care facility within year before index culture date.

Dialysis within year before index culture date. (Hemodialysis or Peritoneal dialysis) 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: <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		

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 Staphylococcal pneumonia 1 Pleural effusion
 1 Pneumonia 1 No pneumonia specified 1 Consolidation
 1 Aspiration pneumonia 1 Not available

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 Other: (specify)

d. 1 MRSA positive non-sterile respiratory specimens

- SURVEILLANCE OFFICE USE ONLY -

<p>22. Was case first identified through audit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk</p>	<p>23. CRF status: 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Incomplete 3 <input type="checkbox"/> Edited & Correct 4 <input type="checkbox"/> Chart unavailable after 3 requests</p>	<p>24. Does this case have recurrent MRSA disease? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk</p> <p>If YES, previous (1st) STATE I.D.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>25. Date reported to EIP site: Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>26. Initials of S.O.: _____</p>
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27. COMMENTS: _____

