

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 -

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"/>
---	--	--	---	---

5. Where was the patient a resident at time of initial culture ? 1 <input type="checkbox"/> Private Residence 1 <input type="checkbox"/> Long Term Care Facility 1 <input type="checkbox"/> Homeless 1 <input type="checkbox"/> Incarcerated 1 <input type="checkbox"/> Transferred from hospital/acute care facility 1 <input type="checkbox"/> Other _____ 1 <input type="checkbox"/> Unknown	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"/>	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.
---	--	---	--

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"/> Unknown	8c. RACE: (Check all that apply) 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> Unknown	8d. WEIGHT: _____ lbs _____ oz OR _____ kg Unknown <input type="checkbox"/> 8e. HEIGHT: _____ ft _____ in OR _____ cm Unknown <input type="checkbox"/>
---	---	--	---

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 (IHS)
 1 Other: (specify) _____
 1 Unknown

9. WAS PATIENT HOSPITALIZED? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 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"/> 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"/>	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"/> Unknown	11a. LOCATION OF CULTURE COLLECTION: (Check one) 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) _____	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"/>
--	--	--	--

12. PATIENT OUTCOME: 1 <input type="checkbox"/> Survived 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown - If survived, was the patient transferred to a LTCF? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Died, 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"/> - Was MRSA contributory or causal? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown - Was the culture obtained on autopsy? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	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"/> Unknown	13b. If pregnant or post-partum, what was the outcome of the fetus: 1 <input type="checkbox"/> Survived, no apparent illness 2 <input type="checkbox"/> Survived, clinical infection 3 <input type="checkbox"/> Live birth/neonatal death 4 <input type="checkbox"/> Abortion/stillbirth 5 <input type="checkbox"/> Induced abortion 9 <input type="checkbox"/> Unknown
---	--	--

14. 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) _____	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"/> Unknown	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"/> Unknown If Yes, list site(s): 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) _____
--	---	--

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

1 <input type="checkbox"/> Bacteremia	1 <input type="checkbox"/> Osteomyelitis	1 <input type="checkbox"/> Surgical Site (internal)	1 <input type="checkbox"/> Traumatic Wound
1 <input type="checkbox"/> Empyema	1 <input type="checkbox"/> Urinary Tract	1 <input type="checkbox"/> Catheter Site Infection	1 <input type="checkbox"/> Surgical Incision
1 <input type="checkbox"/> Meningitis	1 <input type="checkbox"/> Endocarditis	1 <input type="checkbox"/> AV Fistula / Graft Infection	1 <input type="checkbox"/> Pressure Ulcer
1 <input type="checkbox"/> Peritonitis	1 <input type="checkbox"/> Skin Abscess	1 <input type="checkbox"/> Septic Arthritis	1 <input type="checkbox"/> Septic Emboli
1 <input type="checkbox"/> Pneumonia (If checked, go to question 21)	1 <input type="checkbox"/> Abscess (not skin)	1 <input type="checkbox"/> Bursitis	1 <input type="checkbox"/> Other: (specify) _____
		1 <input type="checkbox"/> Septic Shock	_____
		1 <input type="checkbox"/> Cellulitis	_____

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

1 <input type="checkbox"/> Abscess/Boil	1 <input type="checkbox"/> Current Smoker	1 <input type="checkbox"/> Hemiplegia/Pareplegia	1 <input type="checkbox"/> Peripheral Vascular Disease (PVD)
1 <input type="checkbox"/> AIDS or CD4 count<200	1 <input type="checkbox"/> CVA/Stroke (Not TIA)	1 <input type="checkbox"/> HIV	1 <input type="checkbox"/> Premature Birth
1 <input type="checkbox"/> Alcohol Abuse	1 <input type="checkbox"/> Cystic Fibrosis	1 <input type="checkbox"/> Immunosuppressive Therapy	1 <input type="checkbox"/> Rheumatoid Arthritis
1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Decubitus Ulcer	1 <input type="checkbox"/> Influenza (within 10 days of initial culture)	1 <input type="checkbox"/> Sickle Cell Anemia
1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> IVDU	1 <input type="checkbox"/> Solid Organ Malignancy
1 <input type="checkbox"/> Chronic Liver Disease	1 <input type="checkbox"/> Diabetes	1 <input type="checkbox"/> Metastatic Solid Tumor	1 <input type="checkbox"/> Systemic Lupus Erythematosus
1 <input type="checkbox"/> Chronic Renal Insufficiency	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Other condition(s): (specify) _____
1 <input type="checkbox"/> Chronic Skin Breakdown	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Other Drug Use	_____
	1 <input type="checkbox"/> Hematologic Malignancy	1 <input type="checkbox"/> Peptic Ulcer Disease	_____

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

1 <input type="checkbox"/> Previous documented MRSA infection or colonization Month Year OR previous STATE I.D.: If YES: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1 <input type="checkbox"/> Surgery within year before initial culture date.	1 <input type="checkbox"/> Residence in a long-term care facility within year before initial culture date.
1 <input type="checkbox"/> Culture collected ≥ 3 calendar days after hospital admission.	1 <input type="checkbox"/> Dialysis within year before initial culture date. (Hemodialysis or Peritoneal dialysis)	1 <input type="checkbox"/> Central vascular catheter in place at any time in the 2 calendar days prior to initial culture.
1 <input type="checkbox"/> Hospitalized within year before initial culture date. Month Year If YES: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 1 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Current chronic dialysis Type <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis Type of vascular access <input type="checkbox"/> AV fistula / graft <input type="checkbox"/> Hemodialysis CVC <input type="checkbox"/> Unknown	

20. SUSCEPTIBILITY RESULTS: [S=Sensitive (1), I = Intermediate (2), R = Resistant (3), NS = Non-susceptible (4), U = Unknown/Not reported (9)]

Ampicillin: <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	Quinupristin/Dalfopristin: <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	Imipenem: <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
Chloramphenicol: <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	Tetracycline: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U
Ciprofloxacin: <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U	Linezolid: <input type="checkbox"/> S <input type="checkbox"/> NS <input type="checkbox"/> U	Trimethoprim-sulfamethoxazole: <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	Moxifloxacin: <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
Daptomycin: <input type="checkbox"/> S <input type="checkbox"/> NS <input type="checkbox"/> U	Nafcillin: <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
Doxycycline: <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	_____
Erythromycin: <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	_____
Gatifloxacin: <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?	c. Chest Radiology Results (Check all that apply) 1 <input type="checkbox"/> Not done
1 <input type="checkbox"/> MRSA pneumonia	Type <input type="checkbox"/> CT <input type="checkbox"/> X-Ray
1 <input type="checkbox"/> Staphylococcal pneumonia	1 <input type="checkbox"/> Bronchopneumonia/pneumonia
1 <input type="checkbox"/> Hemorrhagic pneumonia	1 <input type="checkbox"/> Consolidation
1 <input type="checkbox"/> Necrotizing pneumonia	1 <input type="checkbox"/> Air space density/opacity
1 <input type="checkbox"/> No pneumonia specified	1 <input type="checkbox"/> No evidence of pneumonia
b. Discharge diagnosis (Check all that apply) 1 <input type="checkbox"/> N/A 1 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Cavitation
1 <input type="checkbox"/> 482.40 1 <input type="checkbox"/> 482.42 1 <input type="checkbox"/> V09.0	1 <input type="checkbox"/> Cannot rule out pneumonia
1 <input type="checkbox"/> 482.41 1 <input type="checkbox"/> 482.49 1 <input type="checkbox"/> None of these listed	1 <input type="checkbox"/> New or changed infiltrates
	1 <input type="checkbox"/> Pleural effusion
	1 <input type="checkbox"/> Other: (specify) _____
	d. 1 <input type="checkbox"/> MRSA positive non-sterile respiratory specimens

- SURVEILLANCE OFFICE USE ONLY -

22. Was case first identified through audit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	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	24. Does this case have recurrent MRSA disease? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, previous (1 st) STATE I.D.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	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"/>	26. Initials of S.O: _____
---	--	--	--	--------------------------------------

27. COMMENTS: _____

