Form Approved
OMB No. **0920**-XXXX
Exp. Date xx/xx/20xx

2010 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY:
PRIMARY TEAM DATA COLLECTION FORM

Form Approved
OMB No. **0920**-XXXX
Exp. Date xx/xx/20xx

CDC ID: ☐☐-☐☐☐☐☐ **Survey date:** ☐☐/☐☐/☐☐☐☐

I. Identifiers *(for Primary Team and EIP Team use only; Identifiers are not transmitted to CDC)*

Patient name: _____
(Last, First, MI)

Date of birth: ☐☐/☐☐/☐☐☐☐ **Hospital name:** _____

Hospital unit name: _____ **Room number:** _____

Medical record no.: _____ **Data collector initials:** _____

II. Demographics

Age: _____ ☐years ☐months ☐days	**Admission date:** ☐☐/☐☐/☐☐☐☐
Gender: ☐M ☐F ☐Unknown	**CDC location code:** _____

III. Risk factors *(in place on the survey date)*

Urinary catheter:	☐No ☐Yes ☐Unknown	
Ventilator:	☐No ☐Yes ☐Unknown	
Central line:	☐No ☐Yes →	*If "Yes," check all that apply:*
	☐Unknown	☐PICC ☐Femoral line ☐Other central line

IV. Antimicrobials

On antimicrobials on the survey date <u>or</u> the calendar day prior to the survey date:	☐No ☐Yes ☐Unknown
*****Qualification for hemodialysis and peritoneal dialysis patients ONLY*****	☐NA, not a dialysis patient
On <u>any</u> of the following antimicrobials in the <u>4 calendar days prior to the survey date</u>: vancomycin, amikacin, gentamicin, tobramycin, streptomycin, kanamycin →	☐No ☐Yes ☐Unknown

FORM IS COMPLETE

Form Approved
OMB No. **0920**-XXXX
Exp. Date xx/xx/20xx

2010 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: EIP TEAM ANTIMICROBIAL USE FORM

Date: ☐☐/☐☐/☐☐☐☐ **Data collector initials**: ________ **CDC ID:** ☐☐-☐☐☐☐☐

Check here ☐ if no antimicrobials administered/scheduled to be administered. Otherwise, fill in table(s) below, for up to 6 antimicrobial agents.

Therapeutic site codes:
BJI = Bone or joint, **BSI** = Bloodstream infection, **CNS** = Central nervous system, **CVI** = Cardiovascular (other than BSI), **DIS** = Systemic, disseminated infection, **ENT** = Eyes, ears, nose, throat (includes upper respiratory infection, **GTI** = Gastrointestinal tract, **HEB** = hepatic and biliary system infections (including pancreas), **IAB** = intraabdominal infection other than GTI and HEB (e.g., spleen abscess), **LRI** = Lower respiratory infection, **REP** = Reproductive tract infection, **SST** = Skin or soft tissue infection (includes muscle infection), **UTI** = Urinary tract infection, **UND** = Undetermined, **Other** = specify other site.

Drug name	Route *(check one)*:	Rationale *(check all that apply)*:				→	If treatment of active infection, then complete the following:		
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection		Clinician-defined therapeutic site *(check all that apply)*:		Infection onset *(check all that apply)*:
	☐IV or IM ☐Oral/enteral ☐Inhaled	☐	☐	☐	☐	→	☐BJI ☐GTI ☐SST ☐BSI ☐HEB ☐UTI ☐CNS ☐IAB ☐UND ☐CVI ☐LRI ☐Unknown ☐DIS ☐REP ☐Other: ________ ☐ENT	AND	☐Your hospital ☐Other healthcare facility ☐Community ☐Unknown

Drug name	Route *(check one)*:	Rationale *(check all that apply)*:				→	If treatment of active infection, then complete the following:		
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection		Clinician-defined therapeutic site *(check all that apply)*:		Infection onset *(check all that apply)*:
	☐IV or IM ☐Oral/enteral ☐Inhaled	☐	☐	☐	☐	→	☐BJI ☐GTI ☐SST ☐BSI ☐HEB ☐UTI ☐CNS ☐IAB ☐UND ☐CVI ☐LRI ☐Unknown ☐DIS ☐REP ☐Other: ________ ☐ENT	AND	☐Your hospital ☐Other healthcare facility ☐Community ☐Unknown

Drug name	Route *(check one)*:	Rationale *(check all that apply)*:				→	If treatment of active infection, then complete the following:		
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection		Clinician-defined therapeutic site *(check all that apply)*:		Infection onset *(check all that apply)*:
	☐IV or IM ☐Oral/enteral ☐Inhaled	☐	☐	☐	☐	→	☐BJI ☐GTI ☐SST ☐BSI ☐HEB ☐UTI ☐CNS ☐IAB ☐UND ☐CVI ☐LRI ☐Unknown ☐DIS ☐REP ☐Other: ________ ☐ENT	AND	☐Your hospital ☐Other healthcare facility ☐Community ☐Unknown

Continued on next page →

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Exp. Date xx/xx/20xx

CDC ID: ☐☐-☐☐☐☐☐

Drug name	**Route** *(check one)*:	**Rationale** *(check all that apply)*: **None documented**	**Medical prophylaxis**	**Surgical prophylaxis**	**Treatment of active infection**
	☐IV or IM ☐Oral/enteral ☐Inhaled	☐	☐	☐	☐

➔ **If treatment of active infection, then complete the following:**

Clinician-defined therapeutic site *(check all that apply)*:				**Infection onset** *(check all that apply)*:
☐BJI ☐BSI ☐CNS ☐CVI ☐DIS ☐ENT	☐GTI ☐HEB ☐IAB ☐LRI ☐REP	☐SST ☐UTI ☐UND ☐Unknown ☐Other: ________	**AND**	☐Your hospital ☐Other healthcare facility ☐Community ☐Unknown

Drug name	**Route** *(check one)*:	**Rationale** *(check all that apply)*: **None documented**	**Medical prophylaxis**	**Surgical prophylaxis**	**Treatment of active infection**
	☐IV or IM ☐Oral/enteral ☐Inhaled	☐	☐	☐	☐

➔ **If treatment of active infection, then complete the following:**

Clinician-defined therapeutic site *(check all that apply)*:				**Infection onset** *(check all that apply)*:
☐BJI ☐BSI ☐CNS ☐CVI ☐DIS ☐ENT	☐GTI ☐HEB ☐IAB ☐LRI ☐REP	☐SST ☐UTI ☐UND ☐Unknown ☐Other: ________	**AND**	☐Your hospital ☐Other healthcare facility ☐Community ☐Unknown

Drug name	**Route** *(check one)*:	**Rationale** *(check all that apply)*: **None documented**	**Medical prophylaxis**	**Surgical prophylaxis**	**Treatment of active infection**
	☐IV or IM ☐Oral/enteral ☐Inhaled	☐	☐	☐	☐

➔ **If treatment of active infection, then complete the following:**

Clinician-defined therapeutic site *(check all that apply)*:				**Infection onset** *(check all that apply)*:
☐BJI ☐BSI ☐CNS ☐CVI ☐DIS ☐ENT	☐GTI ☐HEB ☐IAB ☐LRI ☐REP	☐SST ☐UTI ☐UND ☐Unknown ☐Other: ________	**AND**	☐Your hospital ☐Other healthcare facility ☐Community ☐Unknown

☐ **If Rationale for ANY drug listed above is “None documented” or “Treatment of active infection” → *GO TO HAI FORM.***

☐ **If Rationale for ALL drugs listed above is “Medical prophylaxis” or “Surgical prophylaxis” → *DON’T fill out HAI Form. Data collection complete.***

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2010 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY:
EIP TEAM HAI FORM

Date: ☐☐/☐☐/☐☐☐☐ **Data collector initials**: _____ **CDC ID:** ☐☐-☐☐☐☐☐☐

Does the patient have an HAI?
☐ No → *data collection complete*
☐ Yes → ***complete the table below.***

Enter only one HAI on each HAI Form. This is HAI Form # _____ out of _____ total HAI Forms for this patient.

HAI	*Specific Site*	*Device and Procedure Information*	*Comments*
☐ **UTI**	☐ SUTI ☐ ABUTI ☐ OUTI	**Catheter-associated?** ☐ No ☐ Yes	
☐ **PNEU**	☐ PNU1 ☐ PNU2 ☐ PNU3	**Ventilator-associated?** ☐ No ☐ Yes	
☐ **BSI**	☐ LCBI ☐ CSEP	**Central line-associated?** ☐ No ☐ Yes	
☐ **SSI**	☐ SUP INC ☐ DEEP INC ☐ ORGAN/SPACE *(for ORGAN/SPACE, specify site : _____)*	**NHSN operative procedure category code :** ☐☐☐☐☐ **OR *(if operative procedure but not NHSN)* check the following:** ☐ OTH	
☐ **BJ**	☐ BONE ☐ JNT ☐ DISC		
☐ **CNS**	☐ IC ☐ MEN ☐ SA		
☐ **CVS**	☐ VASC ☐ CARD ☐ ENDO ☐ MED		
☐ **EENT**	☐ CONJ ☐ ORAL ☐ EYE ☐ SINU ☐ EAR ☐ UR		
☐ **GI**	☐ GE ☐ IAB ☐ GIT ☐ NEC ☐ HEP		
☐ **LRI**	☐ BRON ☐ LUNG		
☐ **REPR**	☐ EMET ☐ VCUF ☐ EPIS ☐ OREP		
☐ **SST**	☐ SKIN ☐ BRST ☐ ST ☐ UMB ☐ DECU ☐ PUST ☐ BURN ☐ CIRC		
☐ **SYS**	☐ DI		

Was there a Secondary Bloodstream Infection associated with this HAI? ☐ No ☐ Yes ☐ Unknown

Enter up to three pathogen codes for this HAI: 1) _____ 2)_____ 3) _____ **OR** ☐No pathogen identified

Enter the CDC location of attribution for this HAI: _____ ☐Unknown ☐Not applicable (i.e., SSI)

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2010 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: HAI FORM

Date: ☐☐/☐☐/☐☐☐☐ **Data collector initials**: _____

CDC ID: ☐☐-☐☐☐☐☐

Antimicrobial Susceptibility Testing—Instructions:

1) Check the appropriate box(es) to indicate which of the pathogen(s) below (if any) caused this HAI. "*E. coli*"=*Escherichia coli;* "*E. faecium*"=*Enterococcus faecium*; "*E. faecalis*"=*Enterococcus faecalis*; "*P. aeruginosa*"=*Pseudomonas aeruginosa*; "*S. aureus*"=*Staphylococcus aureus*.
2) Check the appropriate susceptibility test results for the antimicrobial agents listed: S=sensitive/susceptible. I=intermediate, R=resistant, N=not tested.
3) Antimicrobial agent abbreviations: AMK=amikacin, AMP=ampicillin, AMPSUL=ampicillin/sulbactam,CEFEP=cefepime, CEFOT=cefotetan, CEFTAZ=ceftazidime, CEFTRX=ceftriaxone, CIPRO=ciprofloxacin, CLINDA=clindamycin, DAPTO=daptomycin, DOXY=doxycycline, ERYTH=erythromycin, GENT=gentamicin, IMI=imipenem, LEVO=levofloxacin, LNZ=linezolid, MERO=meropenem, OX=oxacillin, PENG=penicillin G, PIP=piperacillin, PIPTAZ=piperacillin/tazobactam, QUIDAL=quinupristin/dalfopristin, RIF=rifampin, TETRA=tetracycline, TMZ=trimethoprim/sulfamethoxazole, VANC=vancomycin.

Check here ☐ if NONE of the organisms below are pathogens for this HAI *(data collection is now complete)*.

	AMK	AMPSUL	CEFEP	CEFTAZ	CIPRO	COL/PB	GENT	IMI	LEVO	MERO	PIPTAZ	TOBRA	TIG
Acinetobacter ☐ *baumannii* ☐ *other*	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N

	AMK	AZT	CEFEP	CEFOT	CEFTAZ	CEFTRX	CIPRO	GENT	IMI	LEVO	MERO	TOBRA
☐ *E. coli*	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N

Positive test for extended-spectrum beta lactamase (ESBL) production? ☐Yes ☐No ☐Don't know

Positive test for carbapenemase production? ☐Yes ☐No ☐Don't know

	AMP	DAPTO	LNZ	PENG	QUIDAL	VANC
☐ *E. faecium*	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N

	AMP	DAPTO	LNZ	PENG	VANC
☐ *E. faecalis*	S I R N	S I R N	S I R N	S I R N	S I R N

Klebsiella	AMK	AZT	CEFEP	CEFOT	CEFTAZ	CEFTRX	CIPRO	GENT	IMI	LEVO	MERO	TOBRA
☐ *pneumoniae* ☐ *oxytoca* ☐ *other*	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N

Positive test for extended-spectrum beta lactamase (ESBL) production? Positive test for carbapenemase production?

2010 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: HAI FORM

	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

	AMK	AZT	CEFEP	CEFTAZ	CIPRO	GENT	IMI	LEVO	MERO	PIP	PIPTAZ	TOBRA
☐ *P. aeruginosa*	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N

	CLIND	DAPTO	DOXY	ERYTH	GENT	LNZ	OX	QUIDAL	RIF	TETRA	TMZ	VANC
☐ *S. aureus*	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N	☐ S ☐ I ☐ R ☐ N

FORM IS COMPLETE