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 –

CDC SAFER·HEALTHIER·PEOPLE™

Form Approved OMB No. 0920-0802

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 the date of initial culture?

1 ☐ Private Residence
1 ☐ Long Term Care Facility
1 ☐ Long Term Acute Care Hospital
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Transferred from hospital/acute care facility
1 ☐ Other _____
1 ☐ Unknown

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 ☐ Unknown

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

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

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

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 ☐ Yes 2 ☐ No 9 ☐ Unknown

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 ☐ Unknown

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

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

12. PATIENT OUTCOME: 1 ☐ Survived 2 ☐ Died 9 ☐ Unknown
- If survived, was the patient transferred to a LTCF? 1 ☐ Yes 2 ☐ No
- If survived, was the patient transferred to a LTACH? 1 ☐ Yes 2 ☐ No
- If Died, Date of Death: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐
- Was MRSA contributory or causal? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
- Was the culture obtained on autopsy? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

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

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

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

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

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

1 ☐ Bacteremia
1 ☐ Empyema
1 ☐ Meningitis
1 ☐ Peritonitis
1 ☐ Pneumonia (*If checked, go to question 21*)
1 ☐ Chronic Ulcer/Wound (non-decubitus)
1 ☐ Osteomyelitis
1 ☐ Urinary Tract
1 ☐ Endocarditis
1 ☐ Skin Abscess
1 ☐ Abscess (not skin)
1 ☐ Surgical Site (internal)
1 ☐ Catheter Site Infection
1 ☐ AV Fistula / Graft Infection
1 ☐ Septic Arthritis
1 ☐ Bursitis
1 ☐ Septic Shock
1 ☐ Cellulitis
1 ☐ Traumatic Wound
1 ☐ Surgical Incision
1 ☐ Decubitus/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 ☐ Unknown

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

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

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

1 ☐ Culture collected ≥ 3 calendar days after hospital admission.

1 ☐ Hospitalized within year before initial culture date.
If YES: Month ☐☐ Year ☐☐☐☐ 1 ☐ Unknown

1 ☐ Surgery within year before initial culture date.
1 ☐ Dialysis within year before initial culture date. (*Hemodialysis or Peritoneal dialysis*)
1 ☐ Current chronic dialysis
Type ☐ Peritoneal ☐ Hemodialysis
Type of vascular access ☐ AV fistula / graft ☐ Hemodialysis CVC ☐ Unknown

1 ☐ Residence in a long-term care facility within year before initial culture date.
1 ☐ Central vascular catheter in place at any time in the 2 calendar days prior to initial culture.

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

Ampicillin: ☐S ☐I ☐R ☐U
Cefazolin: ☐S ☐I ☐R ☐U
Chloramphenicol: ☐S ☐I ☐R ☐U
Ciprofloxacin: ☐S ☐I ☐R ☐U
Clindamycin: ☐S ☐I ☐R ☐U
Daptomycin: ☐S ☐NS ☐U
Doxycycline: ☐S ☐I ☐R ☐U
Erythromycin: ☐S ☐I ☐R ☐U
Gatifloxacin: ☐S ☐I ☐R ☐U
Gentamicin: ☐S ☐I ☐R ☐U
Imipenem: ☐S ☐I ☐R ☐U
Levofloxacin: ☐S ☐I ☐R ☐U
Linezolid: ☐S ☐NS ☐U
Moxifloxacin: ☐S ☐I ☐R ☐U
Nafcillin: ☐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

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 ☐ Hemorrhagic pneumonia
1 ☐ Necrotizing pneumonia
1 ☐ No pneumonia specified

b. Discharge diagnosis (*Check all that apply*) 1 ☐ N/A 1 ☐ Unknown

1 ☐ 482.40
1 ☐ 482.41
1 ☐ 482.42
1 ☐ 482.49
1 ☐ V09.0
1 ☐ None of these listed

c. Chest Radiology Results (*Check all that apply*) 1 ☐ Not done
Type ☐ CT ☐ X-Ray

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 ☐ No evidence of pneumonia
1 ☐ None listed
1 ☐ Not available
1 ☐ Other: (*specify*) _____

d. 1 ☐ MRSA positive non-sterile respiratory specimens

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

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 ☐ Unknown
If YES, previous (1st) STATE I.D.: ☐☐☐☐☐☐☐

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

26. Initials of S.O: _____

27. COMMENTS: _____