

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

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

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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: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Hospital name: _____
Hospital unit name: _____	Room number: _____
Medical record no.: _____	Data collector initials: _____

II. Demographics	
Age: _____ <input type="checkbox"/> years <input type="checkbox"/> months <input type="checkbox"/> days	Admission date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown	CDC location code: _____

III. Risk factors (in place on the survey date)	
Urinary catheter: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
Ventilator: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
Central line: <input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/> Unknown	If "Yes," check all that apply: <input type="checkbox"/> PICC <input type="checkbox"/> Femoral line <input type="checkbox"/> Other central line

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

FORM IS COMPLETE

Public reporting burden of this collection of information is estimated to average 5 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 D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-xxxx.

**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):			
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection
	<input type="checkbox"/> IV or IM <input type="checkbox"/> Oral/enteral <input type="checkbox"/> Inhaled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



If <u>treatment of active infection</u> , then complete the following:			
Clinician-defined therapeutic site (check all that apply):			Infection onset (check all that apply):
<input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> DIS <input type="checkbox"/> ENT	<input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> REP	<input type="checkbox"/> SST <input type="checkbox"/> UTI <input type="checkbox"/> UND <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown
AND			

Drug name	Route (check one):	Rationale (check all that apply):			
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection
	<input type="checkbox"/> IV or IM <input type="checkbox"/> Oral/enteral <input type="checkbox"/> Inhaled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



If <u>treatment of active infection</u> , then complete the following:			
Clinician-defined therapeutic site (check all that apply):			Infection onset (check all that apply):
<input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> DIS <input type="checkbox"/> ENT	<input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> REP	<input type="checkbox"/> SST <input type="checkbox"/> UTI <input type="checkbox"/> UND <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown
AND			

Drug name	Route (check one):	Rationale (check all that apply):			
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection
	<input type="checkbox"/> IV or IM <input type="checkbox"/> Oral/enteral <input type="checkbox"/> Inhaled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



If <u>treatment of active infection</u> , then complete the following:			
Clinician-defined therapeutic site (check all that apply):			Infection onset (check all that apply):
<input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> DIS <input type="checkbox"/> ENT	<input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> REP	<input type="checkbox"/> SST <input type="checkbox"/> UTI <input type="checkbox"/> UND <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown
AND			

Continued on next page →

CDC ID: -

Drug name	Route (check one):	Rationale (check all that apply):			
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection
	<input type="checkbox"/> IV or IM <input type="checkbox"/> Oral/enteral <input type="checkbox"/> Inhaled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



If treatment of active infection, then complete the following:				
Clinician-defined therapeutic site (check all that apply):			AND	Infection onset (check all that apply):
<input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> DIS <input type="checkbox"/> ENT	<input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> REP	<input type="checkbox"/> SST <input type="checkbox"/> UTI <input type="checkbox"/> UND <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown

Drug name	Route (check one):	Rationale (check all that apply):			
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection
	<input type="checkbox"/> IV or IM <input type="checkbox"/> Oral/enteral <input type="checkbox"/> Inhaled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



If treatment of active infection, then complete the following:				
Clinician-defined therapeutic site (check all that apply):			AND	Infection onset (check all that apply):
<input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> DIS <input type="checkbox"/> ENT	<input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> REP	<input type="checkbox"/> SST <input type="checkbox"/> UTI <input type="checkbox"/> UND <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown

Drug name	Route (check one):	Rationale (check all that apply):			
		None documented	Medical prophylaxis	Surgical prophylaxis	Treatment of active infection
	<input type="checkbox"/> IV or IM <input type="checkbox"/> Oral/enteral <input type="checkbox"/> Inhaled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



If treatment of active infection, then complete the following:				
Clinician-defined therapeutic site (check all that apply):			AND	Infection onset (check all that apply):
<input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> DIS <input type="checkbox"/> ENT	<input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> REP	<input type="checkbox"/> SST <input type="checkbox"/> UTI <input type="checkbox"/> UND <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> 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.

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

DRAFT

2010 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: HAI FORM

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Date: / /

Data collector initials: _____

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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	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N
baumannii	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N
other	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N

	AMK	AZT	CEFEP	CEFOT	CEFTAZ	CEFTRX	CIPRO	GENT	IMI	LEVO	MERO	TOBRA
<input type="checkbox"/> E. coli	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N
Positive test for extended-spectrum beta lactamase (ESBL) production? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know						Positive test for carbapenemase production? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know						

	AMP	DAPTO	LNZ	PENG	QUIDAL	VANC
<input type="checkbox"/> E. faecium	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N

	AMP	DAPTO	LNZ	PENG	VANC
<input type="checkbox"/> E. faecalis	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N

	AMK	AZT	CEFEP	CEFOT	CEFTAZ	CEFTRX	CIPRO	GENT	IMI	LEVO	MERO	TOBRA
Klebsiella	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N
pneumoniae	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N
oxytoca	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N
other	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> 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

<input type="checkbox"/> <i>P. aeruginosa</i>	AMK	AZT	CEFEP	CEFTAZ	CIPRO	GENT	IMI	LEVO	MERO	PIP	PIPTAZ	TOBRA
	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I
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<input type="checkbox"/> <i>S. aureus</i>	CLIND	DAPTO	DOXY	ERYTH	GENT	LNZ	OX	QUIDAL	RIF	TETRA	TMZ	VANC
	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I	<input type="checkbox"/> S <input type="checkbox"/> I
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FORM IS COMPLETE

