Laboratory-identified MDRO or CDI Event for LTCF

OMB No. xxxx-xxxx
Exp. Date: xx-xx-xxxx

*required for saving

Facility ID: Event #:

*Resident ID: *Social Security #:

Medicare number (or comparable railroad insurance number):

Resident Name, Last: First: Middle:

*Gender: M F Other *Date of Birth: ___/___/_____

*Resident type: Short-stay (<90 days) Long-stay (>90 days)

*Date of Original Admission to Facility: ___/___/_____

Ethnicity (Specify): Race (Specify):

Event Details

*Event Type: LabID *Date Specimen Collected: ___/___/_____

*Specific Organism Type: (Check one)

☐ MRSA ☐ MSSA ☐ VRE ☐ *C. difficile*

☐ CephR-*Klebsiella* ☐ CRE-*Ecoli* ☐ CRE-*Klebsiella* ☐ MDR-*Acinetobacter*

*Specimen Body Site/System: *Specimen Source:

*Resident Care Location:

*Primary Resident Service Type: (Check one)

☐ Long-term general nursing ☐ Long-term dementia ☐ Long-term psychiatric

☐ Skilled nursing/Short-term rehab (subacute) ☐ Ventilator ☐ Bariatric ☐ Other

*Has resident been transferred from an acute care facility in the past 3 months? Yes No

If Yes, date of last transfer from acute care to your facility: ___/___/_____

If Yes, was the resident on antibiotic therapy for this specific organism type at the time of transfer to your facility? Yes No

Custom Fields

Label		Label	
_____	___/___/___	_____	___/___/___
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Comments