

# Laboratory-identified MDRO or CDI Event for LTCF

*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)	
<input type="checkbox"/> MRSA <input type="checkbox"/> MSSA <input type="checkbox"/> VRE <input type="checkbox"/> <i>C. difficile</i> <input type="checkbox"/> CephR-Klebsiella <input type="checkbox"/> CRE-Ecoli <input type="checkbox"/> CRE-Klebsiella <input type="checkbox"/> MDR-Acinetobacter	
*Specimen Body Site/System:	*Specimen Source:
*Resident Care Location:	
*Primary Resident Service Type: (Check one)	
<input type="checkbox"/> Long-term general nursing <input type="checkbox"/> Long-term dementia <input type="checkbox"/> Long-term psychiatric <input type="checkbox"/> Skilled nursing/Short-term rehab (subacute) <input type="checkbox"/> Ventilator <input type="checkbox"/> Bariatric <input type="checkbox"/> Other	
*Has resident been transferred from an acute care facility in the past 3 months? Yes No	
If Yes, <u>date of last transfer</u> 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