Patient ID: _____ _____ _____ _____ _____ _____ _____ _____

– ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT –

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ Patient Chart No.: _____
(Number, Street, Apt. No.)

_____ _____ Hospital: _____
(City, State) (Zip Code)

– 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 – 2012

CDC SAFER·HEALTHIER·PEOPLE™

– SHADED AREAS FOR OFFICE USE ONLY –

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? (See CRF Instructions)

1 ☐ Private Residence
1 ☐ Long Term Care Facility
1 ☐ Long Term Acute Care Hospital
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Hospital Inpatient
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.

7c. If case is ≤12 months of age, type of birth hospitalization:
1 ☐ NICU/SCN
2 ☐ Well Baby Nursery
9 ☐ Unknown

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. BMI:
_____ ☐ Unknown

9. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES: Date of admission
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

Date of discharge
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

10a. LOCATION OF CULTURE COLLECTION: (Check one)

Hospital Inpatient
1 ☐ ICU
6 ☐ Surgery/OR
7 ☐ Radiology
2 ☐ Other Unit
3 ☐ Emergency Room
16 ☐ Observational Unit/Clinical Decision Unit

Outpatient
8 ☐ Clinic/ Doctors Office
11 ☐ Surgery
15 ☐ Dialysis/Renal Clinic
4 ☐ Other Outpatient
5 ☐ LTCF
13 ☐ LTACH
14 ☐ Autopsy
9 ☐ Unknown
10 ☐ Other

10b. DATE OF INITIAL CULTURE:
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

11. 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 cultured from a normally sterile site, < calender day 7 before death?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

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

13. 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 ☐ Muscle
1 ☐ Internal body site (specify) _____
1 ☐ Other sterile site (specify) _____

14. Were cultures of the SAME or OTHER sterile site(s) positive within 30 days after initial culture date?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If yes, indicate site and date of last positive culture:
1 ☐ Blood, Date: _____
1 ☐ CSF, Date: _____
1 ☐ Pleural fluid, Date: _____
1 ☐ Peritoneal fluid, Date: _____
1 ☐ Pericardial fluid, Date: _____
1 ☐ Joint/Synovial fluid, Date: _____
1 ☐ Bone, Date: _____
1 ☐ Muscle, Date: _____
1 ☐ Internal body site Date: _____
1 ☐ Other sterile site (specify) _____ Date: _____

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

1 ☐ Abscess (not skin)
1 ☐ AV Fistula/Graft Infection
1 ☐ Bacteremia
1 ☐ Bursitis
1 ☐ Catheter Site Infection
1 ☐ Cellulitis
1 ☐ Chronic Ulcer/Wound (non-decubitus)
1 ☐ Decubitus/Pressure Ulcer
1 ☐ Empyema
1 ☐ Endocarditis
1 ☐ Meninigitis
1 ☐ Peritonitis
1 ☐ Pneumonia
1 ☐ Osteomyelitis
1 ☐ Septic Arthritis
1 ☐ Septic Emboli
1 ☐ Septic Shock
1 ☐ Skin Abscess
1 ☐ Surgical Incision
1 ☐ Surgical Site (Internal)
1 ☐ Traumatic Wound
1 ☐ Urinary Tract
1 ☐ Other: (specify) _____

16. 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 ☐ Chronic Liver Disease
1 ☐ Chronic Pulmonary Disease
1 ☐ Chronic Renal Insufficiency
1 ☐ Chronic Skin Breakdown
1 ☐ Congestive Heart Failure
1 ☐ Connective Tissue Disease
1 ☐ Current Smoker
1 ☐ CVA/Stroke
1 ☐ Cystic Fibrosis
1 ☐ Decubitus/Pressure Ulcer
1 ☐ Dementia
1 ☐ Diabetes
1 ☐ Hematologic Malignancy
1 ☐ Hemiplegia/Paraplegia
1 ☐ HIV
1 ☐ Influenza (within 10 days of initial culture)
1 ☐ IVDU
1 ☐ Metastatic Solid Tumor
1 ☐ Myocardial Infarct
1 ☐ Obesity
1 ☐ Other Drug Use
1 ☐ Peptic Ulcer Disease
1 ☐ Peripheral Vascular Disease (PVD)
1 ☐ Premature Birth
1 ☐ Solid Tumor (non metastatic)
1 ☐ Other: (specify only for cases ≤ 12 months of age) _____

17. 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: Date of discharge Mo. ☐☐ Day ☐☐ Year ☐☐☐☐ 1 ☐ Unknown

1 ☐ Surgery within year before initial culture date.
If yes, list the surgeries and dates of surgery that occurred within 90 days prior to the initial culture:

Surgery	Date
1. _____	____/____/____
2. _____	____/____/____
3. _____	____/____/____
4. _____	____/____/____

1 ☐ Dialysis within year before initial culture date. (Hemodialysis or Peritoneal dialysis)

1 ☐ Current chronic dialysis
Type ☐ Peritoneal ☐ Unknown
☐ 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 ☐ Admitted to a LTACH within year before initial culture date.

1 ☐ Central vascular catheter in place at any time in the 2 calendar days prior to initial culture.

18. SUPPLEMENTAL PNEUMONIA QUESTIONS. Please complete if the patient was determined to have pneumonia per question 15a (Timeframe of interest: within +/- 3 calendar days of initial culture).

a. 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) _____

b. 1 ☐ MRSA positive non-sterile respiratory specimens

– SURVEILLANCE OFFICE USE ONLY –

19. Was case first identified through audit?	20. CRF status:	21. Does this case have recurrent MRSA disease?	If YES, previous (1st) STATE I.D.:	22. Date reported to EIP site:	23. Initials of S.O:
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Complete 2 ☐ Incomplete 3 ☐ Edited & Correct 4 ☐ Chart unavailable after 3 requests	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	☐☐☐☐☐☐☐	Mo. ☐☐ Day ☐☐ Year ☐☐☐☐	_____

24 COMMENTS: _____