

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 – 2012



– 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 <input type="checkbox"/> Private Residence 1 <input type="checkbox"/> Incarcerated 1 <input type="checkbox"/> Long Term Care Facility 1 <input type="checkbox"/> Hospital Inpatient 1 <input type="checkbox"/> Long Term Acute Care Hospital 1 <input type="checkbox"/> Other _____ 1 <input type="checkbox"/> Homeless 1 <input type="checkbox"/> Unknown			6. DATE OF BIRTH: Mo. Day Year [][] [][] [][][][]	
8a. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female			8b. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown	
8c. RACE: (Check all that apply) 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Unknown			8d. WEIGHT: _____ lbs _____ oz OR _____ kg <input type="checkbox"/> Unknown	
9. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES: Date of admission Mo. Day Year [][] [][] [][][][] Date of discharge Mo. Day Year [][] [][] [][][][]			8e. HEIGHT: _____ ft _____ in OR _____ cm <input type="checkbox"/> Unknown	
10a. LOCATION OF CULTURE COLLECTION: (Check one) Hospital Inpatient Outpatient 1 <input type="checkbox"/> ICU 8 <input type="checkbox"/> Clinic/Doctors Office 5 <input type="checkbox"/> LTCF 6 <input type="checkbox"/> Surgery/OR 13 <input type="checkbox"/> LTACH 7 <input type="checkbox"/> Radiology 14 <input type="checkbox"/> Autopsy 2 <input type="checkbox"/> Other Unit 11 <input type="checkbox"/> Surgery 9 <input type="checkbox"/> Unknown 15 <input type="checkbox"/> Dialysis/Renal Clinic 10 <input type="checkbox"/> Other 4 <input type="checkbox"/> Other Outpatient 3 <input type="checkbox"/> Emergency Room 16 <input type="checkbox"/> Observational Unit/Clinical Decision Unit			8f. BMI: <input type="checkbox"/> Unknown _____	
11. PATIENT OUTCOME: 1 <input type="checkbox"/> Survived 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown – If survived, was the patient transferred to a LTCF? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – If survived, was the patient transferred to a LTACH? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Died, – Date of Death: Mo. Day Year [][] [][] [][][][] – Was MRSA cultured from a normally sterile site, < calendar day 7 before death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			10b. DATE OF INITIAL CULTURE: Mo. Day Year [][] [][] [][][][]	
12. At time of first positive culture, patient was: 1 <input type="checkbox"/> Pregnant 2 <input type="checkbox"/> Post-partum 3 <input type="checkbox"/> Neither 9 <input type="checkbox"/> Unknown			13. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED: (Check all that apply) 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Muscle 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Other sterile site (specify) _____	
14. Were cultures of the SAME or OTHER sterile site(s) positive within 30 days after initial culture date? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If yes, indicate site and date of last positive culture: 1 <input type="checkbox"/> Blood, Date: _____ 1 <input type="checkbox"/> Muscle, Date: _____ 1 <input type="checkbox"/> CSF, Date: _____ 1 <input type="checkbox"/> Internal body site Date: _____ 1 <input type="checkbox"/> Pleural fluid, Date: _____ 1 <input type="checkbox"/> Other sterile site (specify) _____ 1 <input type="checkbox"/> Peritoneal fluid, Date: _____ 1 <input type="checkbox"/> Other sterile site (specify) _____ 1 <input type="checkbox"/> Pericardial fluid, Date: _____ Date: _____ 1 <input type="checkbox"/> Joint/Synovial fluid, Date: _____ 1 <input type="checkbox"/> Bone, Date: _____			15. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply) 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Abscess (not skin) 1 <input type="checkbox"/> Empyema 1 <input type="checkbox"/> Septic Shock 1 <input type="checkbox"/> AV Fistula/Graft Infection 1 <input type="checkbox"/> Endocarditis 1 <input type="checkbox"/> Skin Abscess 1 <input type="checkbox"/> Bacteremia 1 <input type="checkbox"/> Meningitis 1 <input type="checkbox"/> Surgical Incision 1 <input type="checkbox"/> Bursitis 1 <input type="checkbox"/> Peritonitis 1 <input type="checkbox"/> Surgical Site (Internal) 1 <input type="checkbox"/> Catheter Site Infection 1 <input type="checkbox"/> Pneumonia 1 <input type="checkbox"/> Traumatic Wound 1 <input type="checkbox"/> Cellulitis 1 <input type="checkbox"/> Osteomyelitis 1 <input type="checkbox"/> Urinary Tract 1 <input type="checkbox"/> Chronic Ulcer/Wound (non-decubitus) 1 <input type="checkbox"/> Septic Arthritis 1 <input type="checkbox"/> Other: (specify) _____ 1 <input type="checkbox"/> Decubitus/Pressure Ulcer 1 <input type="checkbox"/> Septic Emboli	

16. UNDERLYING CONDITIONS: (Check all that apply) (if none or no chart available, check appropriate box) 1 None 1 Unknown

1 <input type="checkbox"/> Abscess/Boil	1 <input type="checkbox"/> Current Smoker	1 <input type="checkbox"/> HIV	1 <input type="checkbox"/> Peptic Ulcer Disease
1 <input type="checkbox"/> AIDS or CD4 count < 200	1 <input type="checkbox"/> CVA/Stroke	1 <input type="checkbox"/> Influenza (within 10 days of initial culture)	1 <input type="checkbox"/> Peripheral Vascular Disease (PVD)
1 <input type="checkbox"/> Chronic Liver Disease	1 <input type="checkbox"/> Cystic Fibrosis	1 <input type="checkbox"/> IVDU	1 <input type="checkbox"/> Premature Birth
1 <input type="checkbox"/> Chronic Pulmonary Disease	1 <input type="checkbox"/> Decubitus/Pressure Ulcer	1 <input type="checkbox"/> Metastatic Solid Tumor	1 <input type="checkbox"/> Solid Tumor (non metastatic)
1 <input type="checkbox"/> Chronic Renal Insufficiency	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> Myocardial Infarct	1 <input type="checkbox"/> Other: (specify only for cases ≤ 12 months of age) _____
1 <input type="checkbox"/> Chronic Skin Breakdown	1 <input type="checkbox"/> Diabetes	1 <input type="checkbox"/> Obesity	
1 <input type="checkbox"/> Congestive Heart Failure	1 <input type="checkbox"/> Hematologic Malignancy	1 <input type="checkbox"/> Other Drug Use	
1 <input type="checkbox"/> Connective Tissue Disease	1 <input type="checkbox"/> Hemiplegia/Paraplegia		

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.:
 If YES:

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1 Culture collected > 3 calendar days after hospital admission.

1 Hospitalized within year before initial culture date.

Date of discharge
 If YES: Mo. Day Year 1 Unknown
 If YES:

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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 Residence in a long-term care facility within year before initial culture date.

1 Current chronic dialysis
 Type Peritoneal Unknown
 Hemodialysis
 Type of vascular access
 AV fistula / graft
 Hemodialysis CVC
 Unknown

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 <input type="checkbox"/> Bronchopneumonia/pneumonia	1 <input type="checkbox"/> Consolidation
1 <input type="checkbox"/> Air space density/opacity	1 <input type="checkbox"/> No evidence of pneumonia
1 <input type="checkbox"/> Cavitation	1 <input type="checkbox"/> None listed
1 <input type="checkbox"/> Cannot rule out pneumonia	1 <input type="checkbox"/> Not available
1 <input type="checkbox"/> New or changed infiltrates	1 <input type="checkbox"/> Other: (specify) _____
1 <input type="checkbox"/> Pleural effusion	

b. 1 MRSA positive non-sterile respiratory specimens

- SURVEILLANCE OFFICE USE ONLY -

19. Was case first identified through audit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	20. CRF status: 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Incomplete 3 <input type="checkbox"/> Edited & Correct 4 <input type="checkbox"/> Chart unavailable after 3 requests	21. Does this case have recurrent MRSA disease? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, previous (1 st) STATE I.D.: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											22. Date reported to EIP site: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>									23. Initials of S.O: _____

24 COMMENTS: _____
