

2011 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: EIP TEAM ANTIMICROBIAL USE FORM

CDC ID: - Survey date: // Date form completed: // Initials: _____

Hospital discharge date: // OR check one: Still in hospital Unknown Not collected Patient outcome: Survive Unknown Died Not collected

** Check here if **no** antimicrobials were administered on the survey date or the calendar day prior to the survey date (*be sure to consider whether dialysis qualification applies—see Primary Team/EIP Team Data Collection Form). Otherwise, fill in information, complete pages 1 AND 2 of form.

** Check here if **>6** antimicrobial agents administered on the survey date or the calendar day prior to the survey date (*be sure to consider whether dialysis qualification applies—see Primary Team/EIP Team Data Collection Form), AND enter additional antimicrobial agents on another Antimicrobial Use Form.

This is Antimicrobial Use Form # _____ out of a total of _____ Antimicrobial Use Form(s) for this patient.

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	Route (check one):	Rationale (check all that apply):										
	<input type="checkbox"/> IV or IM <input type="checkbox"/> Oral/enteral <input type="checkbox"/> Inhaled	<input type="checkbox"/> Medical prophylaxis <input type="checkbox"/> Surgical prophylaxis <input type="checkbox"/> Treatment of active infection <input type="checkbox"/> Non-infectious <input type="checkbox"/> None documented	<p><i>If Rationale is "Treatment of active infection," then complete the following:</i></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="3">Clinician-defined therapeutic site (check all that apply):</th> <th rowspan="2" style="width:10%; text-align:center; vertical-align:middle;">AND</th> <th>Infection onset (check all that apply):</th> </tr> <tr> <td> <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> DIS <input type="checkbox"/> ENT </td> <td> <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> REP </td> <td> <input type="checkbox"/> SST <input type="checkbox"/> UTI <input type="checkbox"/> UND <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ </td> <td> <input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown </td> </tr> </table>	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
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Clinician-defined therapeutic site (check all that apply):	Infection onset (check all that apply):						

- IV or IM
- Oral/
enteral
- Inhaled

- Medical prophylaxis
- Surgical prophylaxis
- Treatment of active infection
- Non-infectious
- None documented

- BJI
- BSI
- CNS
- CVI
- DIS
- ENT

- GTI
- HEB
- IAB
- LRI
- REP

- SST
- UTI
- UND
- Unknown
- Other:

AND

- Your hospital
- Other healthcare facility
- Community
- Unknown

Continued on page 2 →

2011 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: EIP TEAM ANTIMICROBIAL USE FORM (continued)

CDC ID: -

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

If Rationale is "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"/> GTI <input type="checkbox"/> SST <input type="checkbox"/> BSI <input type="checkbox"/> HEB <input type="checkbox"/> UTI <input type="checkbox"/> CNS <input type="checkbox"/> IAB <input type="checkbox"/> UND <input type="checkbox"/> CVI <input type="checkbox"/> LRI <input type="checkbox"/> Unknown <input type="checkbox"/> DIS <input type="checkbox"/> REP <input type="checkbox"/> Other: <input type="checkbox"/> ENT _____	AND	<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown

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

If Rationale is "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"/> GTI <input type="checkbox"/> SST <input type="checkbox"/> BSI <input type="checkbox"/> HEB <input type="checkbox"/> UTI <input type="checkbox"/> CNS <input type="checkbox"/> IAB <input type="checkbox"/> UND <input type="checkbox"/> CVI <input type="checkbox"/> LRI <input type="checkbox"/> Unknown <input type="checkbox"/> DIS <input type="checkbox"/> REP <input type="checkbox"/> Other: <input type="checkbox"/> ENT _____	AND	<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown

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

If Rationale is "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"/> GTI <input type="checkbox"/> SST <input type="checkbox"/> BSI <input type="checkbox"/> HEB <input type="checkbox"/> UTI <input type="checkbox"/> CNS <input type="checkbox"/> IAB <input type="checkbox"/> UND <input type="checkbox"/> CVI <input type="checkbox"/> LRI <input type="checkbox"/> Unknown <input type="checkbox"/> DIS <input type="checkbox"/> REP <input type="checkbox"/> Other: <input type="checkbox"/> ENT _____	AND	<input type="checkbox"/> Your hospital <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown

Check one of the boxes below and follow the corresponding instructions:

If Rationale for ANY antimicrobial drug administered to the patient is “None documented” or “Treatment of active infection” → *GO TO HAI FORM.*

If Rationale for EVERY antimicrobial drug administered to the patient is “Medical prophylaxis,” “Surgical prophylaxis” or “Non-infectious” → *DON'T fill out HAI Form. Data collection complete.*

2011 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: EIP TEAM HAI FORM

CDC ID: -

Survey date: //

Date form completed: //

Data collector initials: _____

Does the patient have an HAI (check one)?

No → data collection complete Yes → complete the table and questions 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"/> PNE U	<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	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 : _____)	Operative procedure category code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<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"/> EEN T	<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"/> <input type="checkbox"/> GIT TRANS <input type="checkbox"/> HEP <input type="checkbox"/> NEC <input type="checkbox"/> <input type="checkbox"/> CDI		
<input type="checkbox"/> LRI	<input type="checkbox"/> BRON <input type="checkbox"/> LUNG		
<input type="checkbox"/> REP R	<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"/> DEC <input type="checkbox"/> PUST <input type="checkbox"/> ST U <input type="checkbox"/> CIRC <input type="checkbox"/> BURN <input type="checkbox"/> BRST <input type="checkbox"/> <input type="checkbox"/> UMB		
<input type="checkbox"/> SYS	<input type="checkbox"/> DI		

Enter the symptom/sign onset date for this HAI: // OR Unknown OR Not collected

Enter the therapy start date for this HAI: //

OR check one: Unknown Not collected No therapy given

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)

Continued on page 2 →

2011 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: EIP TEAM HAI FORM (continued)

CDC ID: -

Date form completed: //

Data collector initials: _____

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, NS=non-susceptible or not sensitive, N=not tested.
- 3) Antimicrobial agent abbreviations: AMK=amikacin, AMP=ampicillin, AMPSUL=ampicillin/sulbactam, CEFEP=cefepime, CEFOT=cefotaxime, CEFTAZ=ceftazidime, CEFTRX=ceftriaxone, CIPRO=ciprofloxacin, CLINDA=clindamycin, COL/PB=colistin or polymyxin B, DAPTO=daptomycin, DOXY=doxycycline, ERYTH=erythromycin, GENT=gentamicin, GENTHL=gentamicin-high level test (*Enterococcus* only), IMI=imipenem, LEVO=levofloxacin, LNZ=linezolid, MERO=meropenem, OX=oxacillin, PENG=penicillin G, PIP=piperacillin, PIPTAZ=piperacillin/tazobactam, QUIDAL=quinupristin/dalfopristin, RIF=rifampin, STREPHL=streptomycin-high level test (*Enterococcus* only), TETRA=tetracycline, TIG=tigecycline, TMZ=trimethoprim/sulfamethoxazole, VANC=vancomycin.

Check here if NONE of the organisms below are pathogens for this HAI (data collection is now complete).

<i>Acinetobacter</i> <input type="checkbox"/> <i>baumannii</i> <input type="checkbox"/> other	AMK	AMPSUL	CEFEP	CEFTAZ	CIPRO	COL/PB	GENT	IMI	LEVO	MERO	PIPTAZ	TOBRA	TIG
	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R
<i>E. coli</i>	AMK	AZT	CEFEP	CEFOT	CEFTAZ	CEFTRX	CIPRO	GENT	IMI	LEVO	MERO	TOBRA	
	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R
Positive test for extended-spectrum beta lactamase (ESBL) production? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							Positive test for carbapenemase production? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

<i>E. faecalis</i>	AMP	DAPTO	GENTHL	LNZ	PENG	STREPHL	TIG	VANC
	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R
Positive test for extended-spectrum beta lactamase (ESBL) production? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								

<i>E. faecium</i>	AMP	DAPTO	GENTHL	LNZ	PENG	QUIDAL	STREPHL	TIG	VANC
	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R
Positive test for extended-spectrum beta lactamase (ESBL) production? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									

<i>Klebsiella</i> <input type="checkbox"/> <i>pneumoniae</i> <input type="checkbox"/> <i>oxytoca</i> <input type="checkbox"/> other	AMK	AZT	CEFEP	CEFOT	CEFTAZ	CEFTRX	CIPRO	GENT	IMI	LEVO	MERO	TOBRA
	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R	<input type="checkbox"/> S <input type="checkbox"/> R
Positive test for extended-spectrum beta lactamase (ESBL) production? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						Positive test for carbapenemase production? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

AMK	AZT	CEFEP	CEFTAZ	CIPRO	GENT	IMI	LEVO	MERO	PIP	PIPTAZ	TOBRA
-----	-----	-------	--------	-------	------	-----	------	------	-----	--------	-------

<input type="checkbox"/> <i>P. aeruginosa</i>	<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"/> <i>S. aureus</i>	CLIND	DAPTO	DOXY	ERYTH	GENT	LNZ	OX	QUIDAL	RIF	TETRA	TIG	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	<input type="checkbox"/> S <input type="checkbox"/> I
	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N	<input type="checkbox"/> R <input type="checkbox"/> N
Enter the vancomycin MIC (in mcg/ml): _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not collected				Check vancomycin MIC test method: <input type="checkbox"/> E-test <input type="checkbox"/> Vitek 2 <input type="checkbox"/> Vitek Legacy <input type="checkbox"/> Phoenix <input type="checkbox"/> MicroScan dried overnight panels <input type="checkbox"/> Unknown <input type="checkbox"/> Not collected <input type="checkbox"/> Other: _____									

FORM IS COMPLETE

HAI & Antimicrobial Use Prevalence Survey 2010: HAI Criteria Worksheet

Surgical Site Infection (SSI)

CDC ID: _____

<p>* Specific Event:</p> <p><input type="checkbox"/> Superficial Incisional (SUP INC)</p>	<p>Organ/Space (specify site): _____</p> <p><input type="checkbox"/> Deep Incisional (DEEP INC)</p>
<p>Signs & Symptoms (check all that apply)</p> <p><input type="checkbox"/> Purulent drainage or material</p> <p><input type="checkbox"/> Pain or tenderness</p> <p><input type="checkbox"/> Localized swelling</p> <p><input type="checkbox"/> Redness</p> <p><input type="checkbox"/> Heat</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Incision deliberately opened by surgeon</p> <p><input type="checkbox"/> Wound spontaneously dehisces</p> <p><input type="checkbox"/> Abscess</p> <p><input type="checkbox"/> Hypothermia</p> <p><input type="checkbox"/> Apnea</p> <p><input type="checkbox"/> Bradycardia</p> <p><input type="checkbox"/> Lethargy</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Dysuria</p> <p><input type="checkbox"/> Other evidence of infection found on direct exam, during surgery, or by diagnostic tests²</p> <p><input type="checkbox"/> Other signs & symptoms²</p>	<p>Laboratory</p> <p><input type="checkbox"/> Positive culture</p> <p><input type="checkbox"/> Not cultured</p> <p><input type="checkbox"/> Positive blood culture</p> <p><input type="checkbox"/> Blood culture not done or no organisms detected in blood</p> <p><input type="checkbox"/> Positive Gram stain when culture is negative or not done</p> <p><input type="checkbox"/> Other positive laboratory tests²</p> <p><input type="checkbox"/> Radiographic evidence of infection</p> <p>Clinical Diagnosis</p> <p><input type="checkbox"/> Physician diagnosis of this event type</p> <p><input type="checkbox"/> Physician institutes appropriate antimicrobial therapy²</p> <p><small>²per organ/space specific site criteria</small></p>

Pneumonia (PNEU)

<p>* Specific Event: <input type="checkbox"/> PNU1 <input type="checkbox"/> PNU2 <input type="checkbox"/> PNU3</p>	<p>* Immuno-compromised: Yes No</p>
<p>* Specify Criteria Used: (check all that apply)</p>	
<p>X-Ray</p> <p><input type="checkbox"/> New or progressive and persistent infiltrate</p>	<p><input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pneumatoceles (in ≥ 1 y.o.)</p>
<p>Signs & Symptoms - A (check at least one)</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Leukopenia or leukocytosis</p> <p><input type="checkbox"/> Altered mental status (in ≥ 70 y.o.)</p>	<p>Laboratory</p> <p><input type="checkbox"/> Positive blood culture</p> <p><input type="checkbox"/> Positive pleural fluid culture</p> <p><input type="checkbox"/> Positive quantitative culture from LRT specimen</p> <p><input type="checkbox"/> $\geq 5\%$ BAL cells w/ bacteria</p> <p><input type="checkbox"/> Histopathologic exam w/ abscess formation, positive quantitative culture of lung parenchyma, or lung parenchyma invasion by fungal hyphae</p> <p><input type="checkbox"/> Positive culture of virus or <i>Chlamydia</i></p> <p><input type="checkbox"/> Positive detection of viral antigen or antibody</p> <p><input type="checkbox"/> 4-fold rise in paired sera for pathogen</p> <p><input type="checkbox"/> Positive PCR for <i>Chlamydia</i> or <i>Mycoplasma</i></p> <p><input type="checkbox"/> Positive micro-IF test for <i>Chlamydia</i></p> <p><input type="checkbox"/> Positive culture or micro-IF of <i>Legionella</i> spp</p> <p><input type="checkbox"/> <i>L. pneumophila</i> serogroup 1 antigens in urine</p> <p><input type="checkbox"/> 4-fold rise in <i>L. pneumophila</i> antibody titer</p> <p><input type="checkbox"/> Matching positive blood & sputum cultures w/ <i>Candida</i> spp</p> <p><input type="checkbox"/> Fungi or <i>Pneumocystis carinii</i> from LRT specimen</p>
<p>Signs & Symptoms - B</p> <p><input type="checkbox"/> New onset/change in sputum</p> <p><input type="checkbox"/> New onset/worsening cough, dyspnea, tachypnea</p> <p><input type="checkbox"/> Rales or bronchial breath sounds</p> <p><input type="checkbox"/> Worsening gas exchange</p> <p><input type="checkbox"/> Hemoptysis</p> <p><input type="checkbox"/> Pleuritic chest pain</p> <p><input type="checkbox"/> Temperature instability</p> <p><input type="checkbox"/> Apnea, tachycardia, nasal flaring with retraction of chest wall or grunting</p> <p><input type="checkbox"/> Hypothermia</p> <p><input type="checkbox"/> Wheezing, rales, or rhonchi</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Bradycardia or tachycardia</p>	

HAI & Antimicrobial Use Prevalence Survey 2011: HAI Criteria Worksheet

Custom Event

CDC ID: _____

Major Site:	Specific Site:																																		
<p>Signs & Symptoms (Check all that apply)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Abscess</td> <td><input type="checkbox"/> Heat</td> </tr> <tr> <td><input type="checkbox"/> Apnea</td> <td><input type="checkbox"/> Hypotension</td> </tr> <tr> <td><input type="checkbox"/> Vomiting</td> <td><input type="checkbox"/> Hypothermia</td> </tr> <tr> <td><input type="checkbox"/> Bradycardia</td> <td><input type="checkbox"/> Lethargy</td> </tr> <tr> <td><input type="checkbox"/> Redness</td> <td><input type="checkbox"/> Nausea</td> </tr> <tr> <td><input type="checkbox"/> Cough</td> <td><input type="checkbox"/> Suprapubic tenderness</td> </tr> <tr> <td><input type="checkbox"/> Dysuria</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fever</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Acute onset of diarrhea (liquid stools for > 12 hours)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Purulent drainage or material</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pain or tenderness</td> <td></td> </tr> <tr> <td><input type="checkbox"/> New onset/change in sputum, increased secretions or increased suctioning</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Localized swelling</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Persistent microscopic or gross blood in stools</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Wheezing, rales or rhonchi</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other evidence of infection found on direct exam, during surgery or by diagnostic testing+</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other signs and symptoms +</td> <td></td> </tr> </table>	<input type="checkbox"/> Abscess	<input type="checkbox"/> Heat	<input type="checkbox"/> Apnea	<input type="checkbox"/> Hypotension	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Redness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Cough	<input type="checkbox"/> Suprapubic tenderness	<input type="checkbox"/> Dysuria		<input type="checkbox"/> Fever		<input type="checkbox"/> Acute onset of diarrhea (liquid stools for > 12 hours)		<input type="checkbox"/> Purulent drainage or material		<input type="checkbox"/> Pain or tenderness		<input type="checkbox"/> New onset/change in sputum, increased secretions or increased suctioning		<input type="checkbox"/> Localized swelling		<input type="checkbox"/> Persistent microscopic or gross blood in stools		<input type="checkbox"/> Wheezing, rales or rhonchi		<input type="checkbox"/> Other evidence of infection found on direct exam, during surgery or by diagnostic testing+		<input type="checkbox"/> Other signs and symptoms +		<p>Laboratory or Diagnostic Testing</p> <ul style="list-style-type: none"> <input type="checkbox"/> Positive culture <input type="checkbox"/> Not cultured <input type="checkbox"/> Positive blood culture <input type="checkbox"/> Blood culture not done or no organisms detected in blood <input type="checkbox"/> Positive Gram stain when culture is negative or not done <input type="checkbox"/> >15 colonies cultured from IV cannula tip using semiquantitative culture method <input type="checkbox"/> Positive culture of pathogen <input type="checkbox"/> Positive culture of skin contaminant <input type="checkbox"/> Other positive laboratory tests <input type="checkbox"/> Radiographic evidence of infection <p>Clinical Diagnosis</p> <ul style="list-style-type: none"> <input type="checkbox"/> Physician diagnosis of this event type* <input type="checkbox"/> Physician institutes appropriate antimicrobial therapy* <p>+ Per specific event criteria</p>
<input type="checkbox"/> Abscess	<input type="checkbox"/> Heat																																		
<input type="checkbox"/> Apnea	<input type="checkbox"/> Hypotension																																		
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<input type="checkbox"/> Other signs and symptoms +																																			

Primary Bloodstream Infection (BSI)

* Specific Event: <input type="checkbox"/> Laboratory-confirmed											
<p>Signs & Symptoms:</p> <table style="width: 100%;"> <tr> <td style="width: 50%;"><u>Any patient</u></td> <td style="width: 50%;"><u>all year old</u></td> </tr> <tr> <td><input type="checkbox"/> Fever</td> <td><input type="checkbox"/> Fever</td> </tr> <tr> <td><input type="checkbox"/> Chills</td> <td><input type="checkbox"/> Hypothermia</td> </tr> <tr> <td><input type="checkbox"/> Hypotension</td> <td><input type="checkbox"/> Apnea</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Bradycardia</td> </tr> </table>	<u>Any patient</u>	<u>all year old</u>	<input type="checkbox"/> Fever	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Hypotension	<input type="checkbox"/> Apnea		<input type="checkbox"/> Bradycardia	<p>Laboratory (check one)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Recognized pathogen from one or more blood cultures <input type="checkbox"/> Common skin contaminant from ≥2 blood cultures
<u>Any patient</u>	<u>all year old</u>										
<input type="checkbox"/> Fever	<input type="checkbox"/> Fever										
<input type="checkbox"/> Chills	<input type="checkbox"/> Hypothermia										
<input type="checkbox"/> Hypotension	<input type="checkbox"/> Apnea										
	<input type="checkbox"/> Bradycardia										

Urinary Tract Infection (UTI)

* Specific Event: <input type="checkbox"/> Symptomatic UTI (SUTI) <input type="checkbox"/> Asymptomatic Bacteremic UTI (ABUTI) <input type="checkbox"/> Other UTI (OUTI)																							
<p>Signs & Symptoms (check all that apply)</p> <table style="width: 100%;"> <tr> <td style="width: 50%;"><u>Any patient</u></td> <td style="width: 50%;"><u>all year old</u></td> </tr> <tr> <td><input type="checkbox"/> Fever</td> <td><input type="checkbox"/> Fever</td> </tr> <tr> <td><input type="checkbox"/> Urgency</td> <td><input type="checkbox"/> Hypothermia</td> </tr> <tr> <td><input type="checkbox"/> Frequency</td> <td><input type="checkbox"/> Apnea</td> </tr> <tr> <td><input type="checkbox"/> Dysuria</td> <td><input type="checkbox"/> Bradycardia</td> </tr> <tr> <td><input type="checkbox"/> Suprapubic tenderness</td> <td><input type="checkbox"/> Dysuria</td> </tr> <tr> <td><input type="checkbox"/> Cost over tibial angle pain or tenderness</td> <td><input type="checkbox"/> Lethargy</td> </tr> <tr> <td><input type="checkbox"/> Abscess</td> <td><input type="checkbox"/> Vomiting</td> </tr> <tr> <td><input type="checkbox"/> Pain or tenderness</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Purulent drainage or material</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other evidence of infection found on direct exam, during surgery, or by diagnostic tests</td> <td></td> </tr> </table>	<u>Any patient</u>	<u>all year old</u>	<input type="checkbox"/> Fever	<input type="checkbox"/> Fever	<input type="checkbox"/> Urgency	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Frequency	<input type="checkbox"/> Apnea	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Suprapubic tenderness	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Cost over tibial angle pain or tenderness	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Abscess	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Pain or tenderness		<input type="checkbox"/> Purulent drainage or material		<input type="checkbox"/> Other evidence of infection found on direct exam, during surgery, or by diagnostic tests		<p>Laboratory & Diagnostic Testing</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 positive culture with ≥10⁵ CFU/ml with no more than 2 species of microorganisms <input type="checkbox"/> Positive dipstick for leukocyte esterase or nitrite <input type="checkbox"/> Pyuria <input type="checkbox"/> Microorganisms seen on Gram stain of unspun urine <input type="checkbox"/> 1 positive culture with ≥10³ CFU/ml and < 10⁵ CFU/ml with no more than 2 species of microorganisms <input type="checkbox"/> Positive culture <input type="checkbox"/> Positive blood culture <input type="checkbox"/> Radiographic evidence of infection
<u>Any patient</u>	<u>all year old</u>																						
<input type="checkbox"/> Fever	<input type="checkbox"/> Fever																						
<input type="checkbox"/> Urgency	<input type="checkbox"/> Hypothermia																						
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