

HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY PRIMARY TEAM / EIP TEAM DATA COLLECTION FORM

Form Approved
OMB No. 0920-0852
Exp. Date xx/xx/20xx
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CDC ID: - Survey date: // Data collector initials: _____

I. Identifiers (for Primary Team and EIP Team use only; identifiers are not transmitted to CDC)

Patient name: _____ Date of birth: //
(Last, First, MI)
Hospital name: _____ Hospital unit name: _____
Room number: _____ Medical record no.: _____

II. Demographics

Age: _____ ☐ years ☐ months ☐ days Admission date: //
Gender: ☐ M ☐ F ☐ Unknown CDC location code: _____
Race (check all that apply):
☐ American Indian or Alaska Native ☐ White
☐ Black or African American ☐ Other race
☐ Native Hawaiian or other Pacific Islander ☐ Unknown
☐ Asian Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

III. Risk factors (in place on the survey date)

Urinary catheter: ☐ No ☐ Yes ☐ Unknown
Ventilator: ☐ No ☐ Yes ☐ Unknown
Central line: ☐ No ☐ Yes → If "Yes," check all that apply:
☐ Unknown ☐ PICC ☐ Femoral line ☐ Other central line ☐ Unknown

IV. Antimicrobials

On antimicrobials on the survey date or the calendar day prior to the survey date: ☐ No ☐ Yes ☐ Unknown
Qualification for hemodialysis and peritoneal dialysis patients ONLY
On any of the following antimicrobials in the 4 calendar days prior to the survey date: vancomycin, amikacin, gentamicin, tobramycin, streptomycin, kanamycin → ☐ No ☐ Yes ☐ Unknown
☐ NA, not a dialysis patient

FORM IS COMPLETE

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