**HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY**

Form Approved

OMB No. **0920**-XXXX

Exp. Date xx/xx/20xx

Form Approved

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Exp. Date xx/xx/20xx

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Exp. Date xx/xx/20xx

**PRIMARY TEAM / EIP TEAM DATA COLLECTION FORM**

Form Approved

OMB No. **0920-0852**

Exp. Date 05/31/2013

**CDC ID:** **[ ] [ ]** -**[ ] [ ] [ ] [ ] [ ]  Survey date:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]  **Data collector** **initials: \_\_\_\_\_**

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| **I. Identifiers** *(for Primary Team and EIP Team use only; identifiers are not transmitted to CDC)* |
| **Patient name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last, First, MI) | **Date of birth:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]  |
| **Hospital name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Hospital unit name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Room number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Medical record no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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[ ] Black or African American[ ] Native Hawaiian or other Pacific Islander[ ] Asian | [ ] White[ ] Other race[ ] Unknown  | **Ethnicity:**[ ] Hispanic or Latino[ ] Not Hispanic or Latino[ ] Unknown |

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| **III. Risk factors** *(in place on the survey date)* |
| **Urinary catheter:** | [ ] No [ ] Yes [ ] Unknown  |
| **Ventilator:** | [ ] No [ ] Yes [ ] Unknown  |
| **Central line:** | [ ] No [ ] Yes 🡪 [ ] Unknown | *If “Yes,” check all that apply:*  [ ] PICC [ ] Femoral line [ ] Other central line [ ] Unknown |

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| **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 🡪** | [ ] NA, not a dialysis patient[ ] No [ ] Yes [ ] Unknown |

**FORM IS COMPLETE**

Public reporting burden of this collection of information is estimated **to average 15 minutes** per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-0852.

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