Form Approved
OMB No. 0920-0852
Exp. Date xx/xx/20xx

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

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: _____ (Last, First, MI)

Date of birth: ☐☐/☐☐/☐☐☐☐

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
- ☐Black or African American
- ☐Native Hawaiian or other Pacific Islander
- ☐Asian
- ☐White
- ☐Other race
- ☐Unknown

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 → ☐Unknown	*If "Yes," check all that apply:* ☐PICC ☐Femoral line ☐Other central line ☐Unknown

IV. Antimicrobials

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

FORM IS COMPLETE

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