

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

Form Approved  
OMB No. 0920-0852  
Date 09/20/13  
Exp. Date 09/20/20xx  
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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: _____ <input type="checkbox"/> years <input type="checkbox"/> months <input type="checkbox"/> days	Admission date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown	CDC location code: _____
<b>Race (check all that apply):</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Other race <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Asian	
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	

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

Urinary catheter:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Ventilator:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Central line:	<input type="checkbox"/> No <input type="checkbox"/> Yes → <i>If "Yes," check all that apply:</i> <input type="checkbox"/> Unknown <input type="checkbox"/> PICC <input type="checkbox"/> Femoral line <input type="checkbox"/> Other central line <input type="checkbox"/> Unknown

**IV. Antimicrobials**

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