

**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;"> <thead> <tr> <th colspan="3">Clinician-defined therapeutic site (check all that apply):</th> <th rowspan="2" style="width:10%; text-align:center;">AND</th> <th>Infection onset (check all that apply):</th> </tr> </thead> <tbody> <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> </tbody> </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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- 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: -

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**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	<b>Catheter-associated?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> PNE <b>U</b>	<input type="checkbox"/> PNU1 <input type="checkbox"/> PNU2 <input type="checkbox"/> PNU3	<b>Ventilator-associated?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> BSI	<input type="checkbox"/> LCBI	<b>Central line-associated?</b> <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 : _____)	<b>Operative procedure category code:</b> <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 <b>T</b>	<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 <b>R</b>	<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
<input type="checkbox"/> <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						

<input type="checkbox"/> <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
<input type="checkbox"/> I <input type="checkbox"/> N								

<input type="checkbox"/> <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
<input type="checkbox"/> I <input type="checkbox"/> N									

<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
<input type="checkbox"/> I <input type="checkbox"/> N												
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
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<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
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<input type="checkbox"/> <i>S. aureus</i>	<b>CLIND</b>	<b>DAPTO</b>	<b>DOXY</b>	<b>ERYTH</b>	<b>GENT</b>	<b>LNZ</b>	<b>OX</b>	<b>QUIDAL</b>	<b>RIF</b>	<b>TETRA</b>	<b>TIG</b>	<b>TMZ</b>	<b>VANC</b>	
	<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"/> 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	<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 &amp; 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 tests<sup>2</sup></p> <p><input type="checkbox"/> Other signs &amp; symptoms<sup>2</sup></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 tests<sup>2</sup></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 therapy<sup>2</sup></p> <p><small><sup>2</sup>per 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 <math>\geq 1</math> y.o.)</p>
<p>Signs &amp; 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 <math>\geq 70</math> 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"/> <math>\geq 5\%</math> 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 &amp; sputum cultures w/ <i>Candida</i> spp</p> <p><input type="checkbox"/> Fungi or <i>Pneumocystis carinii</i> from LRT specimen</p>
<p>Signs &amp; 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:
<b>Signs &amp; Symptoms (Check all that apply)</b> <input type="checkbox"/> Abscess <input type="checkbox"/> Apnea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bradycardia <input type="checkbox"/> Redness <input type="checkbox"/> Cough <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 +	<b>Laboratory or Diagnostic Testing</b> <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  <b>Clinical Diagnosis</b> <input type="checkbox"/> Physician diagnosis of this event type* <input type="checkbox"/> Physician institutes appropriate antimicrobial therapy* + Per specific event criteria

### Primary Bloodstream Infection (BSI)

* Specific Event: <input type="checkbox"/> Laboratory-confirmed		
<b>Signs &amp; Symptoms:</b> Any patient <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Hypotension	all year old <input type="checkbox"/> Fever <input type="checkbox"/> Hypothermia <input type="checkbox"/> Apnea <input type="checkbox"/> Bradycardia	<b>Laboratory (check one)</b> <input type="checkbox"/> Recognized pathogen from one or more blood cultures <input type="checkbox"/> Common skin contaminant from ≥2 blood cultures

### 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)		
<b>Signs &amp; Symptoms (check all that apply)</b> Any patient <input type="checkbox"/> Fever <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input type="checkbox"/> Dysuria <input type="checkbox"/> Suprapubic tenderness <input type="checkbox"/> Cost over tibial angle pain or tenderness <input type="checkbox"/> Abscess <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	all year old <input type="checkbox"/> Fever <input type="checkbox"/> Hypothermia <input type="checkbox"/> Apnea <input type="checkbox"/> Bradycardia <input type="checkbox"/> Dysuria <input type="checkbox"/> Lethargy <input type="checkbox"/> Vomiting	<b>Laboratory &amp; Diagnostic Testing</b> <input type="checkbox"/> ≥1 positive culture with ≥10 <sup>5</sup> 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 ≥10 <sup>3</sup> CFU/ml and < 10 <sup>5</sup> 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