

Patient ID: _____

- ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT -

Patient's Name: _____ Phone No.: () _____
(Last, First, M.I.)

Address: _____ Patient Chart No.: _____
(Number, Street, Apt. No.)

(City, State) (Zip Code) Hospital

- Patient identifier information is NOT transmitted to CDC -

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

INVASIVE METHICILLIN-RESISTANT • STAPHYLOCOCCUS AUREUS
ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT - 2012



Form Approved
OMB No. 0920-XXXX (for CDC)
Exp. Date xx/xx/20xx

- SHADED AREAS FOR OFFICE USE ONLY -

1. STATE: (Residence of patient)		2. COUNTY: (Residence of Patient)		3. STATE I.D.:		4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED:		4b. HOSPITAL I.D. WHERE PATIENT TREATED:			
[][]		_____		[][][][][][]		[][][][][]		[][][][][]			
5. Where was the patient a resident prior to the date of initial culture? (See CRF Instructions)					6. DATE OF BIRTH:			7a. AGE:		7b. Is age in day/mo/yr?	
1 <input type="checkbox"/> Private Residence 1 <input type="checkbox"/> Long Term Care Facility 1 <input type="checkbox"/> Long Term Acute Care Hospital 1 <input type="checkbox"/> Homeless 1 <input type="checkbox"/> Incarcerated 1 <input type="checkbox"/> Hospital Inpatient 1 <input type="checkbox"/> Other _____ 1 <input type="checkbox"/> Unknown					Mo. Day Year [][] [][] [][]			[][][]		1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.	
8a. SEX:		8b. ETHNIC ORIGIN:		8c. RACE: (Check all that apply)				8d. WEIGHT:		8e. HEIGHT:	
1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female		1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> Unknown				_____ lbs _____ oz OR _____ kg Unknown <input type="checkbox"/>		_____ ft _____ in OR _____ cm Unknown <input type="checkbox"/>	
9. WAS PATIENT HOSPITALIZED WITHIN 30 CALENDAR DAYS AFTER INITIAL CULTURE?			10a. LOCATION OF CULTURE COLLECTION: (Check one)						8f. BMI:		
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			Hospital Inpatient Outpatient 5 <input type="checkbox"/> LTCF 1 <input type="checkbox"/> ICU 8 <input type="checkbox"/> Clinic/Doctors Office 13 <input type="checkbox"/> LTACH 6 <input type="checkbox"/> Surgery/OR 11 <input type="checkbox"/> Surgery 14 <input type="checkbox"/> Autopsy 7 <input type="checkbox"/> Radiology 15 <input type="checkbox"/> Dialysis/Renal Clinic 9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Other Unit 4 <input type="checkbox"/> Other Outpatient 10 <input type="checkbox"/> Other						_____ Unknown <input type="checkbox"/>		
IF YES: Date of admission Mo. Day Year [][] [][] [][] Date of discharge Mo. Day Year [][] [][] [][]			3 <input type="checkbox"/> Emergency Room 16 <input type="checkbox"/> Observational Unit/Clinical Decision Unit						10b. DATE OF INITIAL CULTURE:		
									Mo. Day Year [][] [][] [][]		
11. PATIENT OUTCOME:					12. At time of first positive culture, patient was:			13. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED: (Check all that apply)			
1 <input type="checkbox"/> Survived 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown - If survived, was the patient transferred to a LTCF? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - If survived, was the patient transferred to a LTACH? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Died, - Date of Death: Mo. Day Year [][] [][] [][] - Was MRSA cultured from a normally sterile site, < calendar day 7 before death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					1 <input type="checkbox"/> Pregnant 2 <input type="checkbox"/> Post-partum 3 <input type="checkbox"/> Neither 9 <input type="checkbox"/> Unknown			1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Muscle 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Other sterile site (specify) _____			
14. Were cultures of the SAME or OTHER sterile site(s) positive within 30 days after initial culture?					15. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply)						
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown						
If yes, indicate site and date of last positive culture: 1 <input type="checkbox"/> Blood, Date: _____ 1 <input type="checkbox"/> Muscle, Date: _____ 1 <input type="checkbox"/> CSF, Date: _____ 1 <input type="checkbox"/> Internal body site Date: _____ 1 <input type="checkbox"/> Pleural fluid, Date: _____ 1 <input type="checkbox"/> Other sterile site (specify) _____ Date: _____ 1 <input type="checkbox"/> Peritoneal fluid, Date: _____ 1 <input type="checkbox"/> Pericardial fluid, Date: _____ 1 <input type="checkbox"/> Joint/Synovial fluid, Date: _____ 1 <input type="checkbox"/> Bone, Date: _____					1 <input type="checkbox"/> Abscess (not skin) 1 <input type="checkbox"/> Empyema 1 <input type="checkbox"/> Septic Shock 1 <input type="checkbox"/> AV Fistula/Graft Infection 1 <input type="checkbox"/> Endocarditis 1 <input type="checkbox"/> Skin Abscess 1 <input type="checkbox"/> Bacteremia 1 <input type="checkbox"/> Meningitis 1 <input type="checkbox"/> Surgical Incision 1 <input type="checkbox"/> Bursitis 1 <input type="checkbox"/> Peritonitis 1 <input type="checkbox"/> Surgical Site (Internal) 1 <input type="checkbox"/> Catheter Site Infection 1 <input type="checkbox"/> Pneumonia 1 <input type="checkbox"/> Traumatic Wound 1 <input type="checkbox"/> Cellulitis 1 <input type="checkbox"/> Osteomyelitis 1 <input type="checkbox"/> Urinary Tract 1 <input type="checkbox"/> Chronic Ulcer/Wound (non-decubitus) 1 <input type="checkbox"/> Septic Arthritis 1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Decubitus/Pressure Ulcer 1 <input type="checkbox"/> Septic Emboli						

Public reporting burden of this collection of information is estimated to average 20 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 E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

16. UNDERLYING CONDITIONS: (Check all that apply) (if none or no chart available, check appropriate box)

1 None 1 Unknown

- | | | | |
|--|---|---|---|
| 1 <input type="checkbox"/> Abscess/Boil | 1 <input type="checkbox"/> Current Smoker | 1 <input type="checkbox"/> HIV | 1 <input type="checkbox"/> Peptic Ulcer Disease |
| 1 <input type="checkbox"/> AIDS or CD4 count < 200 | 1 <input type="checkbox"/> CVA/Stroke | 1 <input type="checkbox"/> Influenza
(within 10 days of initial culture) | 1 <input type="checkbox"/> Peripheral Vascular Disease (PVD) |
| 1 <input type="checkbox"/> Chronic Liver Disease | 1 <input type="checkbox"/> Cystic Fibrosis | 1 <input type="checkbox"/> IVDU | 1 <input type="checkbox"/> Premature Birth |
| 1 <input type="checkbox"/> Chronic Pulmonary Disease | 1 <input type="checkbox"/> Decubitus/Pressure Ulcer | 1 <input type="checkbox"/> Metastatic Solid Tumor | 1 <input type="checkbox"/> Solid Tumor (non metastatic) |
| 1 <input type="checkbox"/> Chronic Renal Insufficiency | 1 <input type="checkbox"/> Dementia | 1 <input type="checkbox"/> Myocardial Infarct | 1 <input type="checkbox"/> Other: (specify only for cases ≤ 12 months of age) _____ |
| 1 <input type="checkbox"/> Chronic Skin Breakdown | 1 <input type="checkbox"/> Diabetes | 1 <input type="checkbox"/> Obesity | |
| 1 <input type="checkbox"/> Congestive Heart Failure | 1 <input type="checkbox"/> Hematologic Malignancy | 1 <input type="checkbox"/> Other Drug Use | |
| 1 <input type="checkbox"/> Connective Tissue Disease | 1 <input type="checkbox"/> Hemiplegia/Paraplegia | | |

17. CLASSIFICATION – Healthcare-associated and Community-associated: (Check all that apply)

1 None 1 Unknown

- | | |
|---|--|
| 1 <input type="checkbox"/> Previous documented MRSA infection or colonization
IF YES: Month Year OR previous STATE I.D.:
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 1 <input type="checkbox"/> Surgery within year before initial culture date.
If yes, list the surgeries and dates of surgery that occurred within <u>90 days</u> prior to the initial culture:
Surgery Date
1. _____ / _____ / _____
2. _____ / _____ / _____
3. _____ / _____ / _____
4. _____ / _____ / _____ |
| 1 <input type="checkbox"/> Culture collected >3 calendar days after hospital admission. | 1 <input type="checkbox"/> Dialysis within year before initial culture date.
(Hemodialysis or Peritoneal dialysis) |
| 1 <input type="checkbox"/> Hospitalized within year before initial culture date.
Date of discharge
IF YES: Mo. Day Year 1 <input type="checkbox"/> Unknown
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 1 <input type="checkbox"/> Residence in a long-term care facility within year before initial culture date. |
| | 1 <input type="checkbox"/> Current chronic dialysis
Type <input type="checkbox"/> Peritoneal <input type="checkbox"/> Unknown
<input type="checkbox"/> Hemodialysis
Type of vascular access
<input type="checkbox"/> AV fistula / graft
<input type="checkbox"/> Hemodialysis CVC
<input type="checkbox"/> Unknown |
| | 1 <input type="checkbox"/> Admitted to a LTACH within year before initial culture date. |
| | 1 <input type="checkbox"/> Central vascular catheter in place at any time in the 2 calendar days prior to initial culture. |

18. SUPPLEMENTAL PNEUMONIA QUESTIONS. Please complete if the patient was determined to have pneumonia per question 15a (Timeframe of interest: within +/- 3 calendar days of initial culture).

- a. Chest Radiology Results (Check all that apply) 1 Not done
- Type CT X-Ray
- | | |
|---|---|
| 1 <input type="checkbox"/> Bronchopneumonia/pneumonia | 1 <input type="checkbox"/> Consolidation |
| 1 <input type="checkbox"/> Air space density/opacity | 1 <input type="checkbox"/> No evidence of pneumonia |
| 1 <input type="checkbox"/> Cavitation | 1 <input type="checkbox"/> None listed |
| 1 <input type="checkbox"/> Cannot rule out pneumonia | 1 <input type="checkbox"/> Not available |
| 1 <input type="checkbox"/> New or changed infiltrates | 1 <input type="checkbox"/> Other: (specify) _____ |
| 1 <input type="checkbox"/> Pleural effusion | |
- b. 1 MRSA positive non-sterile respiratory specimens

- SURVEILLANCE OFFICE USE ONLY -

<p>19. Was case first identified through audit?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> Unknown</p>	<p>20. CRF status:</p> <p>1 <input type="checkbox"/> Complete</p> <p>2 <input type="checkbox"/> Incomplete</p> <p>3 <input type="checkbox"/> Edited & Correct</p> <p>4 <input type="checkbox"/> Chart unavailable after 3 requests</p>	<p>21. Does this case have recurrent MRSA disease?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> Unknown</p> <p>If YES, previous (1st) STATE I.D.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>22. Date reported to EIP site:</p> <p>Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>23. Initials of S.O:</p> <p>_____</p>
<p>24 COMMENTS: _____</p> <p>_____</p> <p>_____</p>				