

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY  
EIP HEALTHCARE FACILITY ASSESSMENT—FOR EIPT USE ONLY**

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

Hospital ID: \_\_\_\_\_

Survey date: //

1) Enter the date on which you are completing this form: //

2) Enter your initials: \_\_\_\_\_

3) Is the hospital located in an urban or rural area?

- Rural
- Urban
- Unknown

4) Does the hospital have an American Medical Association (AMA)-approved residency program?

- Yes
- No
- Unknown

5) Is the hospital a member of the Council of Teaching Hospitals (COTH)?

- Yes
- No
- Unknown

## HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL USE FORM

CDC ID: -

Survey date: //

Date form completed: //

Initials: \_\_\_\_\_

**\*\***  Check here if **no** antimicrobials were administered on the survey date or the calendar day prior to the survey date. If **no** antimicrobials were administered, data collection is complete. If one or more antimicrobials were administered, fill out pages 1 AND 2 of this form.

**\*\***  Check here if **>6** antimicrobial agents were administered on the survey date or the calendar day prior to the survey date, **AND** enter additional antimicrobial agents on another Antimicrobial Use Form (each form will accommodate 6 antimicrobial agent entries).

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.

<b>Enter drug name here:</b>  Start date: ___/___/___ <input type="checkbox"/> Survey date, total dose: _____  <input type="checkbox"/> Day prior to survey, total dose: _____	<b>Route (check one):</b>  <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	<b>Rationale (check all that apply):</b>  <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><b><i>If Rationale is "Treatment of active infection," then complete the following:</i></b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;"> <b>Clinician-defined therapeutic site (check all that apply):</b>   <input type="checkbox"/> BJI    <input type="checkbox"/> GTI    <input type="checkbox"/> SST  <input type="checkbox"/> BSI    <input type="checkbox"/> HEB    <input type="checkbox"/> UTI  <input type="checkbox"/> CNS    <input type="checkbox"/> IAB    <input type="checkbox"/> UND  <input type="checkbox"/> CVI    <input type="checkbox"/> LRI    <input type="checkbox"/> Unknown  <input type="checkbox"/> DIS    <input type="checkbox"/> REP    <input type="checkbox"/> Other: _____  <input type="checkbox"/> ENT                 </td> <td style="width: 5%; text-align: center; vertical-align: middle;"> <b>AND</b> </td> <td style="width: 35%; padding: 5px;"> <b>Infection onset (check all that apply):</b>   <input type="checkbox"/> Your hospital  <input type="checkbox"/> Nursing home/SNF  <input type="checkbox"/> Other healthcare facility  <input type="checkbox"/> Community  <input type="checkbox"/> Unknown                 </td> </tr> </table>	<b>Clinician-defined therapeutic site (check all that apply):</b>  <input type="checkbox"/> BJI <input type="checkbox"/> GTI <input type="checkbox"/> SST <input type="checkbox"/> BSI <input type="checkbox"/> HEB <input type="checkbox"/> UTI <input type="checkbox"/> CNS <input type="checkbox"/> IAB <input type="checkbox"/> UND <input type="checkbox"/> CVI <input type="checkbox"/> LRI <input type="checkbox"/> Unknown <input type="checkbox"/> DIS <input type="checkbox"/> REP <input type="checkbox"/> Other: _____ <input type="checkbox"/> ENT	<b>AND</b>	<b>Infection onset (check all that apply):</b>  <input type="checkbox"/> Your hospital <input type="checkbox"/> Nursing home/SNF <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown
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<input type="checkbox"/> Day prior to survey, total dose: _____	<input type="checkbox"/> INH	<input type="checkbox"/> Non-infectious <input type="checkbox"/> None documented
--------------------------------------------------------------------	------------------------------	-------------------------------------------------------------------------------------

<input type="checkbox"/> CVI <input type="checkbox"/> DIS <input type="checkbox"/> ENT	<input type="checkbox"/> LRI <input type="checkbox"/> REP	<input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	<input type="checkbox"/> Community <input type="checkbox"/> Unknown
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*Continued on page 2 →*

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL USE FORM (continued)**

CDC ID:   -

<b>Enter drug name here:</b>	<b>Route (check one):</b>	<b>Rationale (check all that apply):</b>	<i>If Rationale is "Treatment of active infection," then complete the following:</i>		
Start date: __/__/__ <input type="checkbox"/> Survey date, total dose: _____  <input type="checkbox"/> Day prior to survey, total dose: _____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	<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	<b>Clinician-defined therapeutic site (check all that apply):</b>	<b>AND</b>	<b>Infection onset (check all that apply):</b>
			<input type="checkbox"/> BJI <input type="checkbox"/> GTI <input type="checkbox"/> SST <input type="checkbox"/> BSI <input type="checkbox"/> HEB <input type="checkbox"/> UTI <input type="checkbox"/> CNS <input type="checkbox"/> IAB <input type="checkbox"/> UND <input type="checkbox"/> CVI <input type="checkbox"/> LRI <input type="checkbox"/> Unknown <input type="checkbox"/> DIS <input type="checkbox"/> REP <input type="checkbox"/> Other: _____ <input type="checkbox"/> ENT		<input type="checkbox"/> Your hospital <input type="checkbox"/> Nursing home/SNF <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown

<b>Enter drug name here:</b>	<b>Route (check one):</b>	<b>Rationale (check all that apply):</b>	<i>If Rationale is "Treatment of active infection," then complete the following:</i>		
Start date: __/__/__ <input type="checkbox"/> Survey date, total dose: _____  <input type="checkbox"/> Day prior to survey, total dose: _____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	<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	<b>Clinician-defined therapeutic site (check all that apply):</b>	<b>AND</b>	<b>Infection onset (check all that apply):</b>
			<input type="checkbox"/> BJI <input type="checkbox"/> GTI <input type="checkbox"/> SST <input type="checkbox"/> BSI <input type="checkbox"/> HEB <input type="checkbox"/> UTI <input type="checkbox"/> CNS <input type="checkbox"/> IAB <input type="checkbox"/> UND <input type="checkbox"/> CVI <input type="checkbox"/> LRI <input type="checkbox"/> Unknown <input type="checkbox"/> DIS <input type="checkbox"/> REP <input type="checkbox"/> Other: _____ <input type="checkbox"/> ENT		<input type="checkbox"/> Your hospital <input type="checkbox"/> Nursing home/SNF <input type="checkbox"/> Other healthcare facility <input type="checkbox"/> Community <input type="checkbox"/> Unknown

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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 only “Medical prophylaxis,” “Surgical prophylaxis” or “Non-infectious”  
→ *DON'T fill out HAI Form. Data collection is complete.*

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: HAI FORM**

CDC ID: -

Survey date: /

Data collector initials: \_\_\_\_\_

Date form completed: /

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"/> BSI	<input type="checkbox"/> LCBI <input type="checkbox"/> MBI-LCBI	<b>Central line-associated?</b> 2011 rule: <input type="checkbox"/> No <input type="checkbox"/> Yes      Current rule: <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> PNE U	<input type="checkbox"/> PNU1 <input type="checkbox"/> PNU <input type="checkbox"/> PNU2    3	<b>Ventilator-associated?</b> 2011 rule: <input type="checkbox"/> No <input type="checkbox"/> Yes      Current rule: <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> _____  <b>Procedure date:</b> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  <b>Implant?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <b>Incision closed primarily?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <b>If DEEP INC or ORGAN/SPACE, was physician diagnosis used to meet definition?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA	
<input type="checkbox"/> UTI	<input type="checkbox"/> SUTI <input type="checkbox"/> OUTI <input type="checkbox"/> ABUT I	<b>Catheter-associated?</b> 2011 rule: <input type="checkbox"/> No <input type="checkbox"/> Yes      Current rule: <input type="checkbox"/> No <input type="checkbox"/> Yes	

**Other Healthcare-Associated Events**

HAI	Specific Site	Comments
<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"/> END <input type="checkbox"/> MED O	
<input type="checkbox"/> EENT	<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"/> GIT <input type="checkbox"/> NEC <input type="checkbox"/> HEP <input type="checkbox"/> CDI	

HAI	Specific Site	Comments
<input type="checkbox"/> LRI	<input type="checkbox"/> BRON <input type="checkbox"/> LUNG	
<input type="checkbox"/> REPR	<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"/> PUST <input type="checkbox"/> ST <input type="checkbox"/> CIRC <input type="checkbox"/> BURN <input type="checkbox"/> BRST <input type="checkbox"/> DECU <input type="checkbox"/> UMB	
<input type="checkbox"/> SYS	<input type="checkbox"/> DI	
<input type="checkbox"/> VAE	<input type="checkbox"/> VAC <input type="checkbox"/> POVAP <input type="checkbox"/> IVAC <input type="checkbox"/> PRVAP	

Enter the symptom/sign onset date for this HAI: / OR  Unknown—prior to admit

Enter the therapy start date for this HAI: / OR  Unknown  No therapy given

Enter date on which all definition criteria were fully met: / OR  Unknown

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)

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: HAI FORM (continued)**

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

**Instructions:** 1) Check the appropriate box(es) to indicate which of the pathogen(s) below (if any) caused this HAI. 2) Circle the appropriate susceptibility test results for the antimicrobial agents listed: S=sensitive/susceptible, S-DD=susceptible dose-dependent, I=intermediate, R=resistant, NS=non-susceptible or not sensitive, N=not tested. 3) Where multiple antimicrobial agents are listed in a single column, circle the agent for which results are recorded. If susceptibility data are available for multiple agents listed in a single column, select and record results for the agent to which the organism is most resistant. 4) Abbreviations: AMK=amikacin, ANID=anidulafungin, CASPO=caspofungin, CEFEP=cefepime, CEFOT=cefotaxime, CEFOX/OX/METH=cefoxitin, oxacillin or methicillin, CEFTAZ=ceftazidime, CEFTRX=ceftriaxone, CEFROL=ceftriaxone, CIPRO/LEVO=ciprofloxacin or levofloxacin, COL/PB=colistin or polymyxin B, DAPTO=daptomycin, DORI=doripenem, ERTA=ertapenem, FLUCO=fluconazole, GENT=gentamicin, IMI=imipenem, LNZ=linezolid, MERO=meropenem, MICA=micafungin, PIP/PIPTAZO=piperacillin or piperacillin/tazobactam, POSA=posaconazole, TOBRA=tobramycin, VANC=vancomycin, VORI=voriconazole.

Check here  if NONE of the organisms below are pathogens for this HAI (data collection is now complete).

*Candida* spp. susceptibility data:

Organism	ANID	CASPO	FLUCO	MICA	POSA	VORI
<input type="checkbox"/> <i>Candida</i>						
<input type="checkbox"/> <i>albicans</i>	S I R NS N	S I R NS N	S S-DD I R NS N	S I R NS N	S S-DD I R NS N	S S-DD I R NS N
<input type="checkbox"/> <i>glabrata</i>	S I R NS N	S I R NS N	S S-DD I R NS N	S I R NS N	S S-DD I R NS N	S S-DD I R NS N
<input type="checkbox"/> <i>parapsilosis</i>	S I R NS N	S I R NS N	S S-DD I R NS N	S I R NS N	S S-DD I R NS N	S S-DD I R NS N
<input type="checkbox"/> other	S I R NS N	S I R NS N	S S-DD I R NS N	S I R NS N	S S-DD I R NS N	S S-DD I R NS N

Gram-positive bacteria susceptibility data:

Organism	CEFROL	CEFOX/OX/METH	DAPTO	LNZ	VANCO
<input type="checkbox"/> <i>Enterococcus</i>					
<input type="checkbox"/> <i>faecalis</i>			S I R NS N	S I R NS N	S I R N
<input type="checkbox"/> <i>faecium</i>			S I R NS N	S I R NS N	S I R N
<input type="checkbox"/> other			S I R NS N	S I R NS N	S I R N
<input type="checkbox"/> <i>Staphylococcus aureus</i>	S I R NS N	S I R N	S I R NS N	S I R NS N	S I R N

Enterobacteriaceae susceptibility data:

Organism	CEFEP	CEFOT	CEFTAZ	CEFTRX	COL/PB	DORI	ERTA	IMI	MERO
<input type="checkbox"/> <i>Enterobacter</i>									
<input type="checkbox"/> <i>aerogenes</i>	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N
<input type="checkbox"/> <i>cloacae</i>	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N
<input type="checkbox"/> other	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N
<input type="checkbox"/> <i>E. coli</i>	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N
<input type="checkbox"/> <i>Klebsiella</i>									
<input type="checkbox"/> <i>oxytoca</i>	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N
<input type="checkbox"/> <i>pneumoniae</i>	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N
<input type="checkbox"/> other	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N

*Pseudomonas aeruginosa* susceptibility data:

Organism	AMK	CEFEP	CEFTAZ	CIPRO/LEVO	COL/PB	DORI	GENT	IMI	MERO	PIPIPTAZ	TOBRA
<input type="checkbox"/> <i>P. aeruginosa</i>	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N	S I R N

**FORM IS COMPLETE**



## Appropriate Antimicrobial Use: Drug-Specific Form

Check the antimicrobial agent under evaluation (AUE) (only 1 AUE per form):

Vancomycin  Daptomycin  Linezolid  Piperacillin/tazobactam

### Demographics

CDC ID: -

Survey date: //

Date form completed: //

Data collector initials: \_\_\_\_\_

Hospital admission date: //

Hospital discharge date: //

### Patient Admission History

Date of symptom onset: //

Patient weight (in kg): \_\_\_\_\_

Was the patient a resident of a LTCF or LTACH prior to this hospital admission?  Yes  No  Unknown

Does this patient have any of the following drug allergies entered in the medical record?  None

Penicillin  TMP/Sulfa  Cephalosporins  Fluoroquinolones  Carbapenems  Other: \_\_\_\_\_

Primary admitting diagnosis: \_\_\_\_\_

Primary discharge diagnosis: \_\_\_\_\_

Did this patient have evidence of any of the following types of infection during the admission?  None

Skin or soft tissue infection  Prosthetic joint infection  Osteomyelitis  Septic arthritis  Abscess

Was this patient admitted on any antimicrobial therapy?  Yes  No  Unknown

If Yes, name of antimicrobial: \_\_\_\_\_

Did this patient have any of the following comorbidities present on admission or prior to antibiotic start? (check all that apply)  None

Leukemia or lymphoma

Prosthetic cardiac valve or pacemaker/AICD

History of solid organ transplant or stem cell transplant

Surgery in the 12 months prior to antibiotic start

Colonization with VRE in the 12 months prior to antibiotic start

Renal failure/Dialysis

Colonization with MRSA in the 12 months prior to antibiotic start

Cancer, solid tumor

Was this patient previously hospitalized in an acute care hospital for  $\geq 2$  days in the 12 weeks prior to this hospitalization?  Yes  No  Unknown

Was this patient admitted to an ICU  $\leq 5$  days after antibiotic start?  Yes  No  Unknown

If Yes, ICU admission date: //

ICU discharge date: //

If Yes, did the patient require ventilator support?  Yes  No

If Yes, did the patient require vasopressors?  Yes  No

Did the patient receive any of the following in the 7 days prior to antibiotic start?  None

IV antimicrobials  Chemotherapy  Wound care  Hemodialysis

Did this patient have a routine surveillance culture of the nares positive for MRSA on admission?

Yes  No  Not Tested  Unknown

**Antimicrobial Administration Table:** Complete the following table for all antimicrobials the patient received in the 7 days prior to and the 7 days after start of the AUE (i.e., vancomycin, daptomycin, linezolid or piperacillin/tazobactam):

- 1) Enter the names of all antimicrobials given IV, IM, po/enteral (PO), via inhalation (INH), or where route of administration is unknown (U).
- 2) Record the route of administration (IV, IM, PO, INH, or U).
- 3) Indicate the rationale: medical prophylaxis (MP), surgical prophylaxis (SP), empiric treatment (ET), targeted treatment (TT), non-infection-related (NI), or unknown rationale (U).
- 4) Enter the clinician-defined therapeutic site(s), or enter "NA" if MP, SP, NI or U. See operational manual for details.
- 5) Cells for dates on which an antimicrobial was not given should be left blank.

Date (mm/dd):									Date of AUE start:							
Drug Name		Day -7	Day -6	Day -5	Day -4	Day -3	Day -2	Day -1	Day 0	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
	Route															
	Rationale															
	Therapeutic site															
	Route															
	Rationale															
	Therapeutic site															
	Route															
	Rationale															
	Therapeutic site															
	Route															
	Rationale															
	Therapeutic site															
	Route															
	Rationale															
	Therapeutic site															
	Route															
	Rationale															
	Therapeutic site															
	Route															
	Rationale															
	Therapeutic site															

**Treatment**

Was the patient discharged on antimicrobials?  Yes  No  Unknown  NA (patient deceased)

**Diagnostic testing**

Were any of the following diagnostic or microbiology specimens sent in +/- 3 days of antibiotic start?  None

Cultures:  Blood  Respiratory  Urine  Wound  Deep surgical  Abscess drain  
 Ascitic fluid  Pleural fluid  Stool  Other (specify): \_\_\_\_\_

Diagnostics:  Urinalysis  *C. difficile* testing

If Yes, Complete the table below for each culture or diagnostic test:

Date Specimen Collected	Test Type	Date Final Result (with AST for cultures) Available	If Positive, Organism	Antimicrobial Sensitivities*	If positive, was repeat testing done for the same site ≤ 7 days after initial culture?	If yes, were any positive with same organism?

\*Record AST results on AST worksheets.

Did the patient have any of the following in ≤ 3 days after starting antibiotic therapy?  None

Received pressors  HR > 100 bpm  SBP < 99 mm Hg  RR ≥ 20 bpm  T ≥ 100°F (37.8°C)  
 Neutropenia (ANC < 500)

**COMMENTS:**



## Appropriate Antimicrobial Use: Urinary Tract Infection Form

Demographics															
CDC ID: <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Survey date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>														
Date form completed: <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Data collector initials: _____														
Hospital admission date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Hospital discharge date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>														
Patient Admission History															
Date of symptom onset: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>															
Was the patient a resident of a LTCF or LTACH prior to this hospital admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown															
Does this patient have any of the following drug allergies entered in the medical record? <input type="checkbox"/> None <input type="checkbox"/> Penicillin <input type="checkbox"/> TMP/Sulfa <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Fluoroquinolones <input type="checkbox"/> Carbapenems <input type="checkbox"/> Other: _____															
Primary admitting diagnosis: _____ Primary discharge diagnosis: _____															
Was this patient admitted on any antimicrobial therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, name of antimicrobial: _____															
Did this patient have any of the following comorbidities present on admission? (check all that apply) <input type="checkbox"/> None															
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Kidney stones</td> <td><input type="checkbox"/> Pregnancy</td> <td><input type="checkbox"/> Neutropenia (ANC &lt; 500)</td> </tr> <tr> <td><input type="checkbox"/> History of renal transplant</td> <td><input type="checkbox"/> Urologic procedure in last 3 months</td> <td><input type="checkbox"/> History of renal stents</td> </tr> <tr> <td><input type="checkbox"/> Spinal cord injury</td> <td><input type="checkbox"/> Chronic renal failure</td> <td><input type="checkbox"/> History of dialysis</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Urologic abnormality, specify: _____</td> </tr> </table>		<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Neutropenia (ANC < 500)	<input type="checkbox"/> History of renal transplant	<input type="checkbox"/> Urologic procedure in last 3 months	<input type="checkbox"/> History of renal stents	<input type="checkbox"/> Spinal cord injury	<input type="checkbox"/> Chronic renal failure	<input type="checkbox"/> History of dialysis	<input type="checkbox"/> Urologic abnormality, specify: _____				
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Neutropenia (ANC < 500)													
<input type="checkbox"/> History of renal transplant	<input type="checkbox"/> Urologic procedure in last 3 months	<input type="checkbox"/> History of renal stents													
<input type="checkbox"/> Spinal cord injury	<input type="checkbox"/> Chronic renal failure	<input type="checkbox"/> History of dialysis													
<input type="checkbox"/> Urologic abnormality, specify: _____															
Did the patient have any of the following signs or symptoms present on admission? (check all that apply) <input type="checkbox"/> None															
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Fever (Single temperature <math>\geq 37.8^{\circ}\text{C}</math> (100°F), or <math>&gt; 37.2^{\circ}\text{C}</math> (&gt;99°F) on repeated occasions, or an increase of <math>&gt;1.1^{\circ}\text{C}</math> (&gt;2°F) over baseline)</td> <td><input type="checkbox"/> Suprapubic pain, swelling, or tenderness</td> </tr> <tr> <td><input type="checkbox"/> New onset confusion/functional decline</td> <td><input type="checkbox"/> Purulent drainage at urinary catheter insertion site</td> </tr> <tr> <td><input type="checkbox"/> New onset hypotension</td> <td><input type="checkbox"/> Increased urgency</td> </tr> <tr> <td><input type="checkbox"/> Acute dysuria</td> <td><input type="checkbox"/> Increased incontinence</td> </tr> <tr> <td><input type="checkbox"/> Increased frequency</td> <td><input type="checkbox"/> Visible (gross) hematuria</td> </tr> <tr> <td><input type="checkbox"/> Costovertebral angle pain or tenderness</td> <td><input type="checkbox"/> Rigors</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Unknown</td> </tr> </table>		<input type="checkbox"/> Fever (Single temperature $\geq 37.8^{\circ}\text{C}$ (100°F), or $> 37.2^{\circ}\text{C}$ (>99°F) on repeated occasions, or an increase of $>1.1^{\circ}\text{C}$ (>2°F) over baseline)	<input type="checkbox"/> Suprapubic pain, swelling, or tenderness	<input type="checkbox"/> New onset confusion/functional decline	<input type="checkbox"/> Purulent drainage at urinary catheter insertion site	<input type="checkbox"/> New onset hypotension	<input type="checkbox"/> Increased urgency	<input type="checkbox"/> Acute dysuria	<input type="checkbox"/> Increased incontinence	<input type="checkbox"/> Increased frequency	<input type="checkbox"/> Visible (gross) hematuria	<input type="checkbox"/> Costovertebral angle pain or tenderness	<input type="checkbox"/> Rigors		<input type="checkbox"/> Unknown
<input type="checkbox"/> Fever (Single temperature $\geq 37.8^{\circ}\text{C}$ (100°F), or $> 37.2^{\circ}\text{C}$ (>99°F) on repeated occasions, or an increase of $>1.1^{\circ}\text{C}$ (>2°F) over baseline)	<input type="checkbox"/> Suprapubic pain, swelling, or tenderness														
<input type="checkbox"/> New onset confusion/functional decline	<input type="checkbox"/> Purulent drainage at urinary catheter insertion site														
<input type="checkbox"/> New onset hypotension	<input type="checkbox"/> Increased urgency														
<input type="checkbox"/> Acute dysuria	<input type="checkbox"/> Increased incontinence														
<input type="checkbox"/> Increased frequency	<input type="checkbox"/> Visible (gross) hematuria														
<input type="checkbox"/> Costovertebral angle pain or tenderness	<input type="checkbox"/> Rigors														
	<input type="checkbox"/> Unknown														
Did the patient have any of the following urinary catheters in place at the time of or in the $\leq 2$ calendar days prior to symptom onset? <input type="checkbox"/> None															
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Indwelling catheter</td> <td><input type="checkbox"/> Suprapubic catheter</td> <td><input type="checkbox"/> Condom catheter (males only)</td> </tr> <tr> <td><input type="checkbox"/> Intermittent Catheterization</td> <td colspan="2"><input type="checkbox"/> In place, type unknown</td> </tr> </table>		<input type="checkbox"/> Indwelling catheter	<input type="checkbox"/> Suprapubic catheter	<input type="checkbox"/> Condom catheter (males only)	<input type="checkbox"/> Intermittent Catheterization	<input type="checkbox"/> In place, type unknown									
<input type="checkbox"/> Indwelling catheter	<input type="checkbox"/> Suprapubic catheter	<input type="checkbox"/> Condom catheter (males only)													
<input type="checkbox"/> Intermittent Catheterization	<input type="checkbox"/> In place, type unknown														
If urinary catheter in place at the time of or $\leq 2$ calendar days, was it changed or removed after the diagnosis of UTI? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown															

**Antimicrobial Administration Table:** Complete the following table for all antimicrobials the patient received in the 3 days prior to and the 7 days after symptom onset date:

- 1) Enter the names of all antimicrobials given IV, IM, po/enteral (PO), via inhalation (INH), or where route of administration is unknown (U).
- 2) Record the route of administration (IV, IM, PO, INH, or U).
- 3) Indicate the rationale: medical prophylaxis (MP), surgical prophylaxis (SP), empiric treatment (ET), targeted treatment (TT), non-infection-related (NI), or unknown rationale (U).
- 4) Enter the clinician-defined therapeutic site(s), or enter "NA" if MP, SP, NI or U. See operational manual for details.
- 5) Cells for dates on which an antimicrobial was not given should be left blank.

Date (mm/dd):					Symptom onset:								
Drug Name		Day -3	Day -2	Day -1	Day 0	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Was the patient discharged on this drug?
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												

**Diagnostic testing**

**Was a urinalysis sent  $\leq$  3 days of first antibiotic start with UTI rationale?** Yes No Unknown  
 If **Yes**, was there evidence of pyuria ( $\geq$  5-10 WBCs/high power field)? Yes No Unknown

**Was a urine culture sent within  $\leq$  3 days of first antibiotic start with UTI rationale?** Yes No Unknown

If **Yes**, date of specimen collection: / /

If **Yes**, date final result was available: / /

If **Yes**, was the urine culture positive? Yes No Unknown

If culture was **positive**, document organism, colony count, and antimicrobial sensitivity results:

Organism	Colony forming unit count	Antimicrobial sensitivities*

\*Record AST results on the AST worksheet

**Did the patient have any blood cultures positive for the same organisms listed above within  $\leq$  3 days of the urine culture specimen collection date?** Yes No Unknown

**Were other urinary cultures collected  $>$ 3 days after first antibiotic start with UTI rationale?** Yes No Unknown  
 If **Yes**, indicate # of days after first antibiotic start with UTI rationale: \_\_\_\_\_ days

**COMMENTS:**

## Appropriate Antimicrobial Use: Community-Onset Lower Respiratory Infection Form

Demographics													
CDC ID: <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Survey date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>												
Date form completed: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Data collector initials: _____												
Hospital admission date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Hospital discharge date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>												
Patient Admission History													
Date of symptom onset: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>													
Was the patient a resident of a LTCF or LTACH prior to this hospital admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
Does this patient have any of the following drug allergies entered in the medical record? <input type="checkbox"/> None <input type="checkbox"/> Penicillin <input type="checkbox"/> TMP/Sulfa <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Fluoroquinolones <input type="checkbox"/> Carbapenems <input type="checkbox"/> Other: _____													
Primary admitting diagnosis: _____ Primary discharge diagnosis: _____													
Was this patient admitted on any antimicrobial therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, name of antimicrobial: _____													
Did this patient have any of the following comorbidities present on admission? (check all that apply) <input type="checkbox"/> None  <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> HIV+ with CD4 cell count &lt; 200 cells/mm<sup>3</sup> or 14%</td> <td style="width: 33%;"><input type="checkbox"/> Cancer w/ Neutropenia (ANC &lt; 500)</td> <td style="width: 33%;"><input type="checkbox"/> Asthma</td> </tr> <tr> <td><input type="checkbox"/> History of solid organ transplant or stem cell transplant</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Asplenia</td> </tr> <tr> <td><input type="checkbox"/> COPD/Emphysema</td> <td><input type="checkbox"/> Alcohol Abuse</td> <td><input type="checkbox"/> Liver Failure</td> </tr> <tr> <td><input type="checkbox"/> Renal failure/Dialysis</td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> HIV+ with CD4 cell count < 200 cells/mm <sup>3</sup> or 14%	<input type="checkbox"/> Cancer w/ Neutropenia (ANC < 500)	<input type="checkbox"/> Asthma	<input type="checkbox"/> History of solid organ transplant or stem cell transplant	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asplenia	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Liver Failure	<input type="checkbox"/> Renal failure/Dialysis		
<input type="checkbox"/> HIV+ with CD4 cell count < 200 cells/mm <sup>3</sup> or 14%	<input type="checkbox"/> Cancer w/ Neutropenia (ANC < 500)	<input type="checkbox"/> Asthma											
<input type="checkbox"/> History of solid organ transplant or stem cell transplant	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asplenia											
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Liver Failure											
<input type="checkbox"/> Renal failure/Dialysis													
Was this patient previously hospitalized in an acute care hospital for ≥ 2 days with a diagnosis of pneumonia in the 12 weeks prior to this CO-LRI diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
Was this patient admitted to an ICU within ≤ 5 days of hospital admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, ICU admission date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ICU discharge date: <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> If Yes, did the patient require ventilator support? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, did the patient require vasopressors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
Did the patient receive any of the following in the 7 days prior to this CO-LRI diagnosis? <input type="checkbox"/> None <input type="checkbox"/> IV antimicrobials <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Wound care <input type="checkbox"/> Hemodialysis													



**Antimicrobial Administration Table:** Complete the following table for all antimicrobials the patient received on the day of admission and the 10 days after admission:

- 1) Enter the names of all antimicrobials given IV, IM, po/enteral (PO), via inhalation (INH), or where route of administration is unknown (U).
- 2) Record the route of administration (IV, IM, PO, INH, or U).
- 3) Indicate the rationale: medical prophylaxis (MP), surgical prophylaxis (SP), empiric treatment (ET), targeted treatment (TT), non-infection-related (NI), or unknown rationale (U).
- 4) Enter the clinician-defined therapeutic site(s), or enter "NA" if MP, SP, NI or U. See operational manual for details.
- 5) Cells for dates on which an antimicrobial was not given should be left blank.

Date (mm/dd):		Admit date:											
Drug Name		Day 0	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Was the patient discharged on this drug?
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												
	Route												
	Rationale												
	Therapeutic site												

**Diagnostic testing**

Was a blood culture sent ≤ 3 days of admission?  Yes  No  Unknown

If Yes, Complete the table below for each blood culture collected:

Cult. No.	Date Specimen Collected	Date Final Result (with AST) Available	If Positive, Organism	Antimicrobial sensitivities*	If positive, were repeat cultures taken ≤ 7 days after initial culture?	If yes, were any positive for same organism?
1						
2						
3						
4						
5						
6						

Was a sputum, ET aspirate, or BAL sent for gram stain and culture sent ≤ 3 days of admission?

Yes  No  Unknown

If Yes, Complete the table below for each specimen collected:

Cult. No.	Specimen Source	Date Specimen Collected	Date Final Result (with AST) Available	If Positive, Organism	Antimicrobial sensitivities*
7					
8					
9					
10					
11					
12					

\*Record the AST results on an AST worksheet.

Urinary antigen test for *Streptococcus pneumoniae*:  Pos.  Neg.  NT  U  
 Urinary antigen test for *Legionella pneumophila*:  Pos.  Neg.  NT  U

Influenza testing:  Pos.  Neg.  NT  U  
 Other respiratory virus testing:  Pos.  Neg.  NT  U

Did this patient have a chest x-ray or CT scan performed ≤ 3 days of admission?  Yes  No  Unknown

If Yes, did the patient have any of the following documented in the final interpretation radiology report?  None listed

Bronchopneumonia/pneumonia  Consolidation  Air space density/opacity  
 No evidence of pneumonia  Cavitation  New or changed infiltrates  
 Pleural effusion  Cannot rule out pneumonia  
 Not available

**COMMENTS:**

# Appropriate Antimicrobial Use: Antimicrobial Susceptibility Testing (AST) Worksheet

CDCID:   -

Date form completed:   /   /

Culture collection date:   /   /

Culture No. \_\_\_\_\_

Source: \_\_\_\_\_

Organism #1: \_\_\_\_\_

Organism #2: \_\_\_\_\_

Organism #3: \_\_\_\_\_

AAU Event Type (*circle only one*): UTI    CO-LRI    VANC    DAPTO    LNZ    PIP/TAZO

**Antimicrobial Susceptibility Testing Results**

Instructions: Write the appropriate susceptibility test results for the antimicrobial agents listed using the following indications:  
 S=sensitive/susceptible, I=intermediate, NS=not susceptible, R=resistant, N=not tested.

Antimicrobial Abbreviation (Full Name)	Organism #1	Organism #2	Organism #3
AMK (Amikacin)			
AMP (Ampicillin)			
AMPSUL (Ampicillin/sulbactam)			
CEFEP (Cefepime)			
CEFOT (Cefotaxime)			
CEFOX (Cefoxitin)			
CEFROL (Ceftaroline)			
CEFTAZ (Ceftazidime)			
CEFTRX (Ceftriaxone)			
CIPRO (Ciprofloxacin)			
CLINDA (Clindamycin)			
COL/PB (Colistin or Polymyxin B)			
DAPTO (Daptomycin)			
DORI (Doripenem)			
DOXY (Doxycycline)			
ERYTH (Erythromycin)			
ERTA (Ertapenem)			
GENT (Gentamicin)			
IMI (Imipenem)			
LEVO (Levofloxacin)			
LNZ (Linezolid)			
MERO (Meropenem)			
METH (Methicillin)			
OX (Oxacillin)			
PENG (Penicillin G)			
PIP (Piperacillin)			
PIPTAZ (Piperacillin/tazobactam)			
QUIDAL (Quinupristin/dalfopristin)			
RIF (Rifampin)			
TETRA (Tetracycline)			
TIG (Tigecycline)			
TMZ (Trimethoprim/sulfamethoxazole)			
VANC (Vancomycin)			
TOBRA (Tobramycin)			
Other, specify: _____			
Other, specify: _____			

**FORM IS COMPLETE**