

**2011 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY
PRIMARY TEAM / EIP TEAM DATA COLLECTION FORM**

Form Approved
OMB No. 0920-0852
Exp. Date 05/31/2013
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

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"/> <input type="text"/>
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown	CDC location code: _____
Race (check all that apply): <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	
Ethnicity: <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
Qualification for hemodialysis and peritoneal dialysis patients ONLY	<input type="checkbox"/> NA, not a dialysis patient
On <u>any</u> of the following antimicrobials in the 4 calendar days prior to the survey date : 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 7 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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