

**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.

Enter drug name here: Start date: ___/___/___ <input type="checkbox"/> Survey date, total dose: _____ <input type="checkbox"/> Day prior to survey, total dose: _____	Route (check one): <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	Rationale (check all that apply): <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>If Rationale is "Treatment of active infection," then complete the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; padding: 5px;"> Clinician-defined therapeutic site (check all that apply): <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; font-weight: bold;"> AND </td> <td style="width: 35%; padding: 5px;"> Infection onset (check all that apply): <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>	Clinician-defined therapeutic site (check all that apply): <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	AND	Infection onset (check all that apply): <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
Clinician-defined therapeutic site (check all that apply): <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	AND	Infection onset (check all that apply): <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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Clinician-defined therapeutic site (check all that apply): <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	AND	Infection onset (check all that apply): <input type="checkbox"/> Your hospital <input type="checkbox"/> Nursing home/SNF <input type="checkbox"/> Other healthcare facility					

<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: -

Enter drug name here:	Route (check one):	Rationale (check all that apply):	If Rationale is "Treatment of active infection," then complete the following:	
Start date: __/__/__ <input type="checkbox"/> Survey date, total dose: _____ <hr/> <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	Clinician-defined therapeutic site (check all that apply):	Infection onset (check all that apply):
			<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
			AND	

Enter drug name here:	Route (check one):	Rationale (check all that apply):	If Rationale is "Treatment of active infection," then complete the following:	
Start date: __/__/__ <input type="checkbox"/> Survey date, total dose: _____ <hr/> <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	Clinician-defined therapeutic site (check all that apply):	Infection onset (check all that apply):
			<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
			AND	

Enter drug name here:	Route (check one):	Rationale (check all that apply):	If Rationale is "Treatment of active infection," then complete the following:	
Start date: __/__/__ <input type="checkbox"/> Survey date, total dose: _____ <hr/> <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	Clinician-defined therapeutic site (check all that apply):	Infection onset (check all that apply):
			<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
			AND	

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	Central line-associated? 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	Ventilator-associated? 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 <i>(for ORGAN/SPACE, specify site : _____)</i>	Operative procedure category code: _____ Procedure date: <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Implant? <input type="checkbox"/> No <input type="checkbox"/> Yes Incision closed primarily? <input type="checkbox"/> No <input type="checkbox"/> Yes If DEEP INC or ORGAN/SPACE, was physician diagnosis used to meet definition? <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	Catheter-associated? 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: <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"/>	Patient weight (in kg): _____
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: _____	
Did this patient have evidence of any of the following types of infection during the admission? <input type="checkbox"/> None <input type="checkbox"/> Skin or soft tissue infection <input type="checkbox"/> Prosthetic joint infection <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Septic arthritis <input type="checkbox"/> Abscess	
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 or prior to antibiotic start? (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Leukemia or lymphoma <input type="checkbox"/> Prosthetic cardiac valve or pacemaker/AICD <input type="checkbox"/> History of solid organ transplant or stem cell transplant <input type="checkbox"/> Surgery in the 12 months prior to antibiotic start <input type="checkbox"/> Colonization with VRE in the 12 months prior to antibiotic start <input type="checkbox"/> Renal failure/Dialysis <input type="checkbox"/> Colonization with MRSA in the 12 months prior to antibiotic start <input type="checkbox"/> Cancer, solid tumor	
Was this patient previously hospitalized in an acute care hospital for ≥ 2 days in the 12 weeks prior to this hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Was this patient admitted to an ICU ≤ 5 days after antibiotic start? <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 If Yes, did the patient require vasopressors? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the patient receive any of the following in the 7 days prior to antibiotic start? <input type="checkbox"/> None <input type="checkbox"/> IV antimicrobials <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Wound care <input type="checkbox"/> Hemodialysis	
Did this patient have a routine surveillance culture of the nares positive for MRSA on admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Tested <input type="checkbox"/> 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 style="width: 33%;"><input type="checkbox"/> Kidney stones</td> <td style="width: 33%;"><input type="checkbox"/> Pregnancy</td> <td style="width: 33%;"><input type="checkbox"/> Neutropenia (ANC < 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: _____								
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<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 style="width: 33%;"><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)</td> <td colspan="2"><input type="checkbox"/> Suprapubic pain, swelling, or tenderness</td> </tr> <tr> <td><input type="checkbox"/> New onset confusion/functional decline</td> <td colspan="2"><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> <td><input type="checkbox"/> Visible (gross) hematuria</td> </tr> <tr> <td><input type="checkbox"/> Acute dysuria</td> <td><input type="checkbox"/> Increased incontinence</td> <td><input type="checkbox"/> Rigors</td> </tr> <tr> <td><input type="checkbox"/> Increased frequency</td> <td colspan="2"><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Costovertebral angle pain or tenderness</td> <td colspan="2"></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"/> Visible (gross) hematuria	<input type="checkbox"/> Acute dysuria	<input type="checkbox"/> Increased incontinence	<input type="checkbox"/> Rigors	<input type="checkbox"/> Increased frequency	<input type="checkbox"/> Unknown		<input type="checkbox"/> Costovertebral angle pain or tenderness		
<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"/> Visible (gross) hematuria																	
<input type="checkbox"/> Acute dysuria	<input type="checkbox"/> Increased incontinence	<input type="checkbox"/> Rigors																	
<input type="checkbox"/> Increased frequency	<input type="checkbox"/> Unknown																		
<input type="checkbox"/> Costovertebral angle pain or tenderness																			
Did the patient have any of the following urinary catheters in place at the time of or in the ≤ 2 calendar days prior to symptom onset? <input type="checkbox"/> None <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 ≤ 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 < 200 cells/mm³ or 14%</td> <td style="width: 33%;"><input type="checkbox"/> Cancer w/ Neutropenia (ANC < 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 ³ 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 ³ 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