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

2014 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY

PATIENT INFORMATION FORM

CDC ID: ☐☐-☐☐☐☐☐ **Survey date:** ☐☐/☐☐/☐☐☐☐ **Data collector initials:** _____

If data collected <u>on survey date</u>, enter data collection time: ☐☐:☐☐ ☐am ☐pm

OR ☐Data collection done retrospectively

I. Identifiers *(for Primary Team and EIP Team use only; identifiers are not transmitted to CDC)*

Patient name: _____ (Last, First, MI) **Date of birth:** ☐☐/☐☐/☐☐☐☐

Hospital name: _____ **Hospital unit name:** _____

Room number: _____ **Medical record no.:** _____

II. Demographic information

Age: _____ ☐yrs ☐mos ☐dys ☐Unknown **Admission date:** ☐☐/☐☐/☐☐☐☐

Gender: ☐M ☐F ☐Unknown **CDC location code:** _____

Race *(check all that apply)*:
☐American Indian or Alaska Native
☐Black or African American
☐Native Hawaiian/other Pacific Islander
☐Asian
☐White
☐Other race
☐Unknown

Ethnicity:
☐Hispanic or Latino
☐Not Hispanic or Latino
☐Unknown

Primary Payer:
☐Medicare
☐Medicaid
☐Private insurance
☐Self-pay
☐No charge
☐Other
☐Unknown

III. Weight and height

For infants in neonatal locations (e.g., CC-NURS, CCS-NURS, S-NURS, W-NURS, W-LDRP):
Birthweight: _____ pounds _____ ounces OR _____ grams OR ☐Birthweight unknown

For other patients:
BMI: _____ OR ☐Unknown *(if BMI unknown, enter Height and Weight below)*
Height: _____ feet _____ inches OR _____ cm OR ☐Height unknown
Weight: _____ pounds _____ ounces OR _____ grams OR ☐Weight unknown

IV. Devices

Urinary catheter: ☐No ☐Yes ☐Unknown **Ventilator:** ☐No ☐Yes ☐Unknown

Central line: ☐No ☐Yes ☐Unknown *If "Yes," indicate how many lines: ☐1 line ☐>1 line ☐ Unknown*

V. Antimicrobials

Antimicrobials administered <u>or</u> scheduled to be administered:
On the survey date: ☐No ☐Yes ☐Unknown
On the day before the survey date: ☐No ☐Yes ☐Unknown

Public reporting burden of this collection of information is estimated to average 17 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 Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

2011 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: EIP TEAM ANTIMICROBIAL USE FORM

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VI. Follow-up information
Enter date of follow-up data collection: ☐☐/☐☐/☐☐☐☐
Hospital discharge date: ☐☐/☐☐/☐☐☐☐ **OR** check one: ☐Unknown ☐Still in hospital
Patient outcome at time of hospital discharge: ☐Survived ☐Died ☐Unknown ☐Still in hospital

FORM IS COMPLETE