Form Approved
OMB 0920-xxxx
Exp. Date xx/xx/20xx
www.cdc.gov/nhsn

Outpatient Procedure Component Event

*required for saving

Facility ID:	Event #:
*Patient ID:	Social Security #:
Secondary ID #:	Medicare #:
Patient Name, Last:	First: Middle:
*Gender: F M Other	*Date of Birth:
Ethnicity (Specify):	Race (Specify):
*Date admitted to facility where procedure occurred (MM/DD/YYYY):	

Four Same Day Outcome Measures

*Specify event: (check all that apply)

☐ Patient burn ☐ Patient fall ☐ Hospital transfer/admission

☐ Wrong site ☐ Wrong side ☐ Wrong patient ☐ Wrong procedure ☐ Wrong implant

Prophylactic IV Antibiotic Timing

☐ Had an order for a prophylactic IV antibiotic that was NOT administered on time

Surgical Site Infection (SSI)

*Date of SSI: ____/____/_____ *Primary CPT Code:_____ NHSN Procedure Code:_____

*Specific event (type of SSI): ☐ Superficial incisional ☐ Deep incisional ☐ Organ/space

*How infection was first reported: (Check all that apply):

☐ Surgeon ☐ Attending physician other than surgeon

☐ Admitting inpatient facility ☐ Routine follow-up at outpatient facility ☐ Patient or family member

*Specify SSI criteria used (check all that apply):

Signs & Symptoms

☐ Purulent drainage ☐ Redness

☐ Incision deliberately opened/drained ☐ Heat

☐ Pain or tenderness ☐ Abscess

☐ Localized swelling ☐ Fever (>38˚C)

☐ Wound spontaneously dehisces

Laboratory

☐ Positive culture

☐ Not cultured

☐ Imaging test evidence of infection

☐ Histopathologic evidence of infection

Other

☐ Diagnosis of superficial SSI by surgeon or attending physician

☐ Other evidence of infection on direct exam or during invasive procedure

*Pathogens identified: ☐ Yes ☐ No

If Yes, indicate up to 3 pathogens: _____ _____ _____

Custom Fields

Label _____ ____/____/____	Label _____ _____

Comments