Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Laboratory-identified MDRO or CDI Event

Instructions for this form are available at: http://www.cdc.gov/nhsn/forms/instr/57_128.pdf

*required for saving

Facility ID:	Event #:
*Patient ID:	Social Security #:
Secondary ID:	Medicare #:
Patient Name, Last: First: Middle:	
*Gender: M F	*Date of Birth:
Ethnicity (Specify):	Race (Specify):

Event Details

*Event Type: LabID	*Date Specimen Collected:

*Specific Organism Type: (Check one)

☐ MRSA ☐ MSSA ☐ VRE ☐ *C. difficile* ☐ CephR-*Klebsiella*

☐ CRE-*E. coli* ☐ CRE-*Enterobacter* ☐ CRE-*Klebsiella* ☐ MDR-*Acinetobacter*

*Outpatient: Yes No	*Specimen Body Site/System:	*Specimen Source:
*Date Admitted to Facility: _____	*Location:	*Date Admitted to Location: _____

Last physical overnight location of patient immediately prior to arriving into facility (applies to specimen(s) collected in outpatient setting or <4 days after inpatient admission) (Check one):

☐ Nursing Home/Skilled Nursing Facility ☐ Personal residence/Residential care

☐ Other Inpatient Healthcare Setting (i.e., acute care hospital, IRF, LTAC, etc.) ☐ Unknown

*Has patient been discharged from <u>your</u> facility in the past 3 months? ☐ Yes ☐ No

If Yes, date of last discharge from your facility:_____

Has patient been discharged from <u>another</u> facility in the past 4 weeks? ☐ Yes ☐ No

If Yes, from where (Check one):

☐ Nursing Home/Skilled Nursing Facility ☐ Other Inpatient Healthcare Setting (i.e., acute care hospital, IRF, LTAC, etc.)

☐ Unknown

Custom Fields

Label		Label	
_____	____/____/____	_____	____/____/____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments