HAI & ANTIMICROBIAL USE PREVALENCE SURVEY
EIP HEALTHCARE FACILITY ASSESSMENT—FOR EIPT USE ONLY

Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx
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:	**Route** ***(check one)*****:**	**Rationale** ***(check all that apply)*****:**	***If Rationale is "Treatment of active infection," then complete the following:*** **Clinician-defined therapeutic site** ***(check all that apply)*****:**	**AND**	**Infection onset** ***(check all that apply)*****:**
Start date: ___/___/___ ☐Survey date, total dose: _____ ☐Day prior to survey, total dose: _____	☐IV ☐IM ☐PO ☐INH	☐Medical prophylaxis ☐Surgical prophylaxis ☐Treatment of active infection ☐Non-infectious ☐None documented	☐BJI ☐GTI ☐SST ☐BSI ☐HEB ☐UTI ☐CNS ☐IAB ☐UND ☐CVI ☐LRI ☐Unknown ☐DIS ☐REP ☐Other: _____ ☐ENT		☐Your hospital ☐Nursing home/SNF ☐Other healthcare facility ☐Community ☐Unknown

Enter drug name here:	**Route** ***(check one)*****:**	**Rationale** ***(check all that apply)*****:**	***If Rationale is "Treatment of active infection," then complete the following:*** **Clinician-defined therapeutic site** ***(check all that apply)*****:**	**AND**	**Infection onset** ***(check all that apply)*****:**
Start date: ___/___/___ ☐Survey date, total dose: _____ ☐Day prior to survey, total dose: _____	☐IV ☐IM ☐PO ☐INH	☐Medical prophylaxis ☐Surgical prophylaxis ☐Treatment of active infection ☐Non-infectious ☐None documented	☐BJI ☐GTI ☐SST ☐BSI ☐HEB ☐UTI ☐CNS ☐IAB ☐UND ☐CVI ☐LRI ☐Unknown ☐DIS ☐REP ☐Other: _____ ☐ENT		☐Your hospital ☐Nursing home/SNF ☐Other healthcare facility ☐Community ☐Unknown

Enter drug name here:	**Route** ***(check one)*****:**	**Rationale** ***(check all that apply)*****:**	***If Rationale is "Treatment of active infection," then complete the following:*** **Clinician-defined therapeutic site** ***(check all that apply)*****:**	**AND**	**Infection onset** ***(check all that apply)*****:**
Start date: ___/___/___ ☐Survey date, total dose: _____	☐IV ☐IM ☐PO	☐Medical prophylaxis ☐Surgical prophylaxis ☐Treatment of active infection	☐BJI ☐GTI ☐SST ☐BSI ☐HEB ☐UTI ☐CNS ☐IAB ☐UND		☐Your hospital ☐Nursing home/SNF ☐Other healthcare facility

☐ Day prior to survey, total dose: _____	☐ INH	☐ Non-infectious ☐ None documented	☐ CVI ☐ DIS ☐ ENT	☐ LRI ☐ REP	☐ Unknown ☐ Other: _____		☐ Community ☐ Unknown

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:* **Clinician-defined therapeutic site *(check all that apply)*:**				**Infection onset *(check all that apply)*:**
Start date: ___/___/___ ☐ Survey date, total dose: ______ ☐ Day prior to survey, total dose: ______	☐ IV ☐ IM ☐ PO ☐ INH	☐ Medical prophylaxis ☐ Surgical prophylaxis ☐ Treatment of active infection → ☐ Non-infectious ☐ None documented	☐ BJI ☐ BSI ☐ CNS ☐ CVI ☐ DIS ☐ ENT	☐ GTI ☐ HEB ☐ IAB ☐ LRI ☐ REP	☐ SST ☐ UTI ☐ UND ☐ Unknown ☐ Other: ______	**AND**	☐ Your hospital ☐ Nursing home/SNF ☐ Other healthcare facility ☐ Community ☐ Unknown

Enter drug name here:	**Route *(check one)*:**	**Rationale *(check all that apply)*:**	*If Rationale is "Treatment of active infection," then complete the following:* **Clinician-defined therapeutic site *(check all that apply)*:**				**Infection onset *(check all that apply)*:**
Start date: ___/___/___ ☐ Survey date, total dose: ______ ☐ Day prior to survey, total dose: ______	☐ IV ☐ IM ☐ PO ☐ INH	☐ Medical prophylaxis ☐ Surgical prophylaxis ☐ Treatment of active infection → ☐ Non-infectious ☐ None documented	☐ BJI ☐ BSI ☐ CNS ☐ CVI ☐ DIS ☐ ENT	☐ GTI ☐ HEB ☐ IAB ☐ LRI ☐ REP	☐ SST ☐ UTI ☐ UND ☐ Unknown ☐ Other: ______	**AND**	☐ Your hospital ☐ Nursing home/SNF ☐ Other healthcare facility ☐ Community ☐ Unknown

Enter drug name here:	**Route *(check one)*:**	**Rationale *(check all that apply)*:**	*If Rationale is "Treatment of active infection," then complete the following:* **Clinician-defined therapeutic site *(check all that apply)*:**				**Infection onset *(check all that apply)*:**
Start date: ___/___/___ ☐ Survey date, total dose: ______ ☐ Day prior to survey, total dose: ______	☐ IV ☐ IM ☐ PO ☐ INH	☐ Medical prophylaxis ☐ Surgical prophylaxis ☐ Treatment of active infection → ☐ Non-infectious ☐ None documented	☐ BJI ☐ BSI ☐ CNS ☐ CVI ☐ DIS ☐ ENT	☐ GTI ☐ HEB ☐ IAB ☐ LRI ☐ REP	☐ SST ☐ UTI ☐ UND ☐ Unknown ☐ Other: ______	**AND**	☐ Your hospital ☐ Nursing home/SNF ☐ Other healthcare facility ☐ Community ☐ Unknown

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*
☐ **BSI**	☐ LCBI ☐ MBI-LCBI	**Central line-associated?** 2011 rule: ☐ No ☐ Yes Current rule: ☐ No ☐ Yes	
☐ **PNEU**	☐ PNU1 ☐ PNU3 ☐ PNU2	**Ventilator-associated?** 2011 rule: ☐ No ☐ Yes Current rule: ☐ No ☐ Yes	
☐ **SSI**	☐ SUP INC ☐ DEEP INC ☐ ORGAN/SPACE *(for ORGAN/SPACE, specify site : _____)*	**Operative procedure category code:** _____ **Procedure date:** ☐☐/☐☐/☐☐☐☐ **Implant?** ☐ No ☐ Yes **Incision closed primarily?** ☐ No ☐ Yes **If DEEP INC or ORGAN/SPACE, was physician diagnosis used to meet definition?** ☐ No ☐ Yes ☐ NA	
☐ **UTI**	☐ SUTI ☐ OUTI ☐ ABUTI	**Catheter-associated?** 2011 rule: ☐ No ☐ Yes Current rule: ☐ No ☐ Yes	

Other Healthcare-Associated Events

HAI	*Specific Site*	*Comments*
☐ **BJ**	☐ BONE ☐ JNT ☐ DISC	
☐ **CNS**	☐ IC ☐ MEN ☐ SA	
☐ **CVS**	☐ VASC ☐ CARD ☐ END ☐ MEDO	
☐ **EENT**	☐ CONJ ☐ ORAL ☐ EYE ☐ SINU ☐ EAR ☐ UR	
☐ **GI**	☐ GE ☐ IAB ☐ GIT ☐ NEC ☐ HEP ☐ CDI	

HAI	*Specific Site*	*Comments*
☐ **LRI**	☐ BRON ☐ LUNG	
☐ **REPR**	☐ EMET ☐ VCUF ☐ EPIS ☐ OREP	
☐ **SST**	☐ SKIN ☐ PUST ☐ ST ☐ CIRC ☐ BURN ☐ BRST ☐ DECU ☐ UMB	
☐ **SYS**	☐ DI	
☐ **VAE**	☐ VAC ☐ POVAP ☐ IVAC ☐ 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

 Continued on page 2→

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=ceftaroline, 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*
☐ *Candida*						
☐ *albicans*	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
☐ *glabrata*	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
☐ *parapsilosis*	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
☐ 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*
☐ *Enterococcus*					
☐ *faecalis*			S I R NS N	S I R NS N	S I R N
☐ *faecium*			S I R NS N	S I R NS N	S I R N
☐ other			S I R NS N	S I R NS N	S I R N
☐ *Staphylococcus aureus*	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*
☐ *Enterobacter*									
☐ *aerogenes*	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
☐ *cloacae*	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
☐ 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
☐ *E. coli*	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
☐ *Klebsiella*									
☐ *oxytoca*	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
☐ *pneumoniae*	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
☐ 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*	*PIP/PIPTAZ*	*TOBRA*
☐ *P. aeruginosa*	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: ☐☐-☐☐☐☐☐ | **Survey date:** ☐☐/☐☐/☐☐☐☐

Date form completed: ☐☐/☐☐/☐☐☐☐ | **Data collector initials:** _____

Hospital admission date: ☐☐/☐☐/☐☐☐☐ **Hospital discharge date:** ☐☐/☐☐/☐☐☐☐

Patient Admission History

Date of symptom onset: ☐☐/☐☐/☐☐☐☐ | **Patient weight (in kg):** _____

Was the patient a resident of a LTCF or LTACH prior to this hospital admission? ☐Yes ☐No ☐Unknown

Does this patient have any of the following drug allergies entered in the medical record? ☐None
☐Penicillin ☐TMP/Sulfa ☐Cephalosporins ☐Fluoroquinolones ☐Carbapenems ☐Other:_____

Primary admitting diagnosis:_____
Primary discharge diagnosis:_____

Did this patient have evidence of any of the following types of infection during the admission? ☐None
☐Skin or soft tissue infection ☐Prosthetic joint infection ☐Osteomyelitis ☐Septic arthritis ☐Abscess

Was this patient admitted on any antimicrobial therapy? ☐Yes ☐No ☐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) ☐None

☐Leukemia or lymphoma
☐History of solid organ transplant or stem cell transplant
☐Colonization with VRE in the 12 months prior to antibiotic start
☐Colonization with MRSA in the 12 months prior to antibiotic start
☐Prosthetic cardiac valve or pacemaker/AICD
☐Surgery in the 12 months prior to antibiotic start
☐Renal failure/Dialysis
☐Cancer, solid tumor

Was this patient previously hospitalized in an acute care hospital for ≥ 2 days in the 12 weeks prior to this hospitalization? ☐Yes ☐No ☐Unknown

Was this patient admitted to an ICU ≤ 5 days after antibiotic start? ☐Yes ☐No ☐Unknown
If **Yes**, ICU admission date**:** ☐☐/☐☐/☐☐☐☐ ICU discharge date**:** ☐☐/☐☐/☐☐☐☐
If **Yes**, did the patient require ventilator support? ☐Yes ☐No
If **Yes**, did the patient require vasopressors? ☐Yes ☐No

Did the patient receive any of the following in the 7 days prior to antibiotic start? ☐None
☐IV antimicrobials ☐Chemotherapy ☐Wound care ☐Hemodialysis

Did this patient have a routine surveillance culture of the nares positive for MRSA on admission?
☐Yes ☐No ☐Not Tested ☐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															
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	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: ☐☐-☐☐☐☐☐ | **Survey date:** ☐☐/☐☐/☐☐☐☐

Date form completed: ☐☐/☐☐/☐☐☐☐ | **Data collector initials:** _____

Hospital admission date: ☐☐/☐☐/☐☐☐☐ **Hospital discharge date:** ☐☐/☐☐/☐☐☐☐

Patient Admission History

Date of symptom onset: ☐☐/☐☐/☐☐☐☐

Was the patient a resident of a LTCF or LTACH prior to this hospital admission? ☐Yes ☐No ☐Unknown

Does this patient have any of the following drug allergies entered in the medical record? ☐None
☐Penicillin ☐TMP/Sulfa ☐Cephalosporins ☐Fluoroquinolones ☐Carbapenems ☐Other:_____

Primary admitting diagnosis:_____
Primary discharge diagnosis:_____

Was this patient admitted on any antimicrobial therapy? ☐Yes ☐No ☐Unknown
If **Yes**, name of antimicrobial:_____

Did this patient have any of the following comorbities present on admission? (check all that apply) ☐None

☐Kidney stones ☐Pregnancy ☐Neutropenia (ANC < 500)
☐History of renal transplant ☐Urologic procedure in last 3 months ☐History of renal stents
☐Spinal cord injury ☐Chronic renal failure ☐History of dialysis
☐Urologic abnormality, specify:_____

Did the patient have any of the following signs or symptoms present on admission? (check all that apply) ☐None

☐Fever (Single temperature ≥ 37.8°C (100°F), or > 37.2°C (>99°F) on repeated occasions, or an increase of >1.1°C (>2°F) over baseline)
☐New onset confusion/functional decline ☐Suprapubic pain, swelling, or tenderness
☐New onset hypotension ☐Purulent drainage at urinary catheter insertion site
☐Acute dysuria ☐Increased urgency ☐Visible (gross) hematuria
☐Increased frequency ☐Increased incontinence ☐Rigors
☐Costovertebral angle pain or tenderness ☐Unknown

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? ☐None
☐Indwelling catheter ☐Suprapubic catheter ☐Condom catheter (males only)
☐Intermittent Catheterization ☐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?
☐Yes ☐No ☐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												
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	Therapeutic site												

Diagnostic testing

Was a urinalysis sent ≤ 3 days of first antibiotic start with UTI rationale? ☐Yes ☐No ☐Unknown
If **Yes**, was there evidence of pyuria (≥ 5-10 WBCs/high power field)? ☐Yes ☐No ☐Unknown

Was a urine culture sent within ≤ 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 ≤ 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: ☐☐-☐☐☐☐☐ | **Survey date:** ☐☐/☐☐/☐☐☐☐

Date form completed: ☐☐/☐☐/☐☐☐☐ | **Data collector initials:** _____

Hospital admission date: ☐☐/☐☐/☐☐☐☐ **Hospital discharge date:** ☐☐/☐☐/☐☐☐☐

Patient Admission History

Date of symptom onset: ☐☐/☐☐/☐☐☐☐

Was the patient a resident of a LTCF or LTACH prior to this hospital admission? ☐Yes ☐No ☐Unknown

Does this patient have any of the following drug allergies entered in the medical record? ☐None
☐Penicillin ☐TMP/Sulfa ☐Cephalosporins ☐Fluoroquinolones ☐Carbapenems ☐Other:_____

Primary admitting diagnosis:_____
Primary discharge diagnosis:_____

Was this patient admitted on any antimicrobial therapy? ☐Yes ☐No ☐Unknown
If **Yes**, name of antimicrobial:_____

Did this patient have any of the following comorbidities present on admission? (check all that apply) ☐None

☐HIV+ with CD4 cell count < 200 cells/mm^3 or 14%
☐History of solid organ transplant or stem cell transplant
☐COPD/Emphysema
☐Renal failure/Dialysis
☐Cancer w/ Neutropenia (ANC < 500)
☐Diabetes
☐Alcohol Abuse
☐Asthma
☐Asplenia
☐Liver Failure

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? ☐Yes ☐No ☐Unknown

Was this patient admitted to an ICU within ≤ 5 days of hospital admission? ☐Yes ☐No ☐Unknown
If **Yes**, ICU admission date**:** ☐☐/☐☐/☐☐☐☐ ICU discharge date**:** ☐☐/☐☐/☐☐☐☐
If **Yes**, did the patient require ventilator support? ☐Yes ☐No ☐Unknown
If **Yes**, did the patient require vasopressors? ☐Yes ☐No ☐Unknown

Did the patient receive any of the following in the 7 days prior to this CO-LRI diagnosis? ☐None
☐IV antimicrobials ☐Chemotherapy ☐Wound care ☐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												
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	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