**2014 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY**

Form Approved

OMB No. **0920**-XXXX

Exp. Date xx/xx/20xx

Form Approved

OMB No. **0920**-XXXX

Exp. Date xx/xx/20xx

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OMB No. **0920**-XXXX

Exp. Date xx/xx/20xx

**PATIENT INFORMATION FORM**

Form Approved

OMB No. **0920-XXX**

Exp. Date xx/xx/20xx

**CDC ID:** **[ ] [ ]** -**[ ] [ ] [ ] [ ] [ ]  Survey date:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]  **Data collector** **initials: \_\_\_\_\_**

**If data collected on survey date, enter data collection time:** [ ] [ ] :[ ] [ ]  [ ] am [ ] pm

**OR** [ ] Data collection done retrospectively

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| **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.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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 |

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| **III. Weight and height** |
| **For infants in neonatal locations (e.g., CC-NURS, CCS-NURS, S-NURS, W-NURS, W-LDRP):** **Birthweight: \_\_\_\_\_\_\_** pounds **\_\_\_\_\_\_\_** ouncesOR **\_\_\_\_\_\_\_** 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 |

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| **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* |

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| **V. Antimicrobials** |
| **Antimicrobials administered or scheduled to be administered:** **On the survey date:** **On the day before the survey date:** | [ ] No [ ] Yes [ ] Unknown[ ] 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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**Page 2**

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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**