

2014 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY

PATIENT INFORMATION FORM

Form Approved
OMB No. 0920-0044
Exp. Date xx/xx/20xx
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CDC ID: - Survey date: // Data collector initials: _____

If data collected on survey date, 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: _____ Date of birth: //
(Last, First, MI)

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):

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other race |
| <input type="checkbox"/> Native Hawaiian/other Pacific Islander | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Asian | |

Ethnicity:

- Hispanic or Latino
 Not Hispanic or Latino
 Unknown

Primary Payer:

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Self-pay |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> No charge |
| <input type="checkbox"/> Private insurance | <input type="checkbox"/> Other |
| | <input type="checkbox"/> 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 or scheduled to be administered:

On the survey date:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
On the day before the survey date:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

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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