**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY**

Form Approved

OMB No. **0920**-XXXX

Exp. Date xx/xx/20xx

Form Approved

OMB No. **0920**-XXXX

Exp. Date xx/xx/20xx

**EIP HEALTHCARE FACILITY ASSESSMENT—FOR EIPT USE ONLY**

**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

1. Does the hospital have an American Medical Association (AMA)-approved residency program?

Yes

No

Unknown

1. 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)*:** | | |  | **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 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |

***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 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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  PNU2 | PNU3 | **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  ABUTI | OUTI | **Catheter-associated?**  2011 rule: No Yes Current rule: No Yes |  |

**Other Healthcare-Associated Events**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***HAI*** | ***Specific Site*** | | ***Comments*** |  | ***HAI*** | ***Specific Site*** | | | ***Comments*** |
| **BJ** | BONE  JNT  DISC | |  |  | **LRI** | BRON  LUNG | | |  |
| **CNS** | IC  MEN  SA | |  |  | **REPR** | EMET  EPIS | | VCUF  OREP |  |
| **CVS** | VASC  ENDO | CARD  MED |  |  | **SST** | SKIN  ST  BURN  DECU | | PUST  CIRC  BRST  UMB |  |
| **EENT** | CONJ  EYE  EAR | ORAL  SINU  UR |  |  | **SYS** | DI | | |  |
| **GI** | GE  GIT  HEP | IAB  NEC  CDI |  |  | **VAE** | VAC  IVAC | POVAP  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

**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)***

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| --- | --- |
| **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*  *glabrata*  *parapsilosis*  other | S I R NS N  S I R NS N  S I R NS N  S I R NS N | S I R NS N  S I R NS N  S I R NS N  S I R NS N | S S-DD I R NS N  S S-DD I R NS N  S S-DD I R NS N  S S-DD I R NS N | S I R NS N  S I R NS N  S I R NS N  S I R NS N | S S-DD I R NS N  S S-DD I R NS N  S S-DD I R NS N  S S-DD I R NS N | S S-DD I R NS N  S S-DD I R NS N  S S-DD I R NS N  S S-DD I R NS N |

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| ***Gram-positive bacteria susceptibility data:*** | | | | | |
| ***Organism*** | ***CEFROL*** | ***CEFOX/OX/METH*** | ***DAPTO*** | ***LNZ*** | ***VANCO*** |
| *Enterococcus*  *faecalis*  *faecium*  other |  |  | S I R NS N  S I R NS N  S I R NS N | S I R NS N  S I R NS N  S I R NS N | S I R N  S I R 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*  *cloacae*  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 | 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  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*  *pneumoniae*  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 | 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  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 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***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 Prosthetic cardiac valve or pacemaker/AICD  History of solid organ transplant or stem cell transplant Surgery in the 12 months prior to antibiotic start Colonization with VRE in the 12 months prior to antibiotic start Renal failure/Dialysis Colonization with MRSA in the 12 months prior to antibiotic start 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.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 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 ≥100oF (37.8oC)  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 |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| 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/mm3 or 14% Cancer w/ Neutropenia (ANC < 500) Asthma  History of solid organ transplant or stem cell transplant Diabetes Asplenia  COPD/Emphysema Alcohol Abuse Liver Failure  Renal failure/Dialysis | |
| **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 |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| Rationale |  |  |  |  |  |  |  |  |  |  |  |  |
| Therapeutic site |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Route |  |  |  |  |  |  |  |  |  |  |  |  |
| 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**