**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 |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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)***

|  |  |
| --- | --- |
| **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 NS I R NS NS I R NS NS I R NS N | S I R NS NS I R NS NS I R NS NS I R NS N | S S-DD I R NS NS S-DD I R NS NS S-DD I R NS NS S-DD I R NS N | S I R NS NS I R NS NS I R NS NS I R NS N | S S-DD I R NS NS S-DD I R NS NS S-DD I R NS NS S-DD I R NS N | S S-DD I R NS NS S-DD I R NS NS S-DD I R NS NS S-DD I R NS N |

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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?** [ ] NoneCultures: [ ] 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 [ ]  UnknownIf **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 [ ] UnknownIf **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**