Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

2014 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY

PATIENT INFORMATION FORM

CDC ID: ☐☐-☐☐☐☐☐ **Survey date:** ☐☐/☐☐/☐☐☐☐ **Data collector initials:** _____

If data collected <u>on survey date</u>, 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: _____ (Last, First, MI) **Date of birth:** ☐☐/☐☐/☐☐☐☐

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)*:
☐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

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 <u>or</u> scheduled to be administered:
On the survey date: ☐No ☐Yes ☐Unknown
On the day before the survey date: ☐No ☐Yes ☐Unknown

2011 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY: EIP TEAM ANTIMICROBIAL USE FORM

2014 HAI & ANTIMICROBIAL USE POINT PREVALENCE SURVEY

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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