

**ANTIMICROBIAL PRESCRIBING QUALITY EVALUATION:
COMMUNITY ACQUIRED PNEUMONIA EVENT FORM**

CDCID: - Date: // Data collector initials: _____

Identifiers (for EIP Team use only; do not transmit to CDC)

Hospital code: _____

Name: _____ **Date of birth:** ___/___/___ **Medical record no.:** _____

Case identification and eligibility

A. Eligible ICD-9 codes recorded for this patient (check all that apply):

- 480.0 480.1 480.2 480.3 480.8 480.9 481 482.0 482.1 482.2 482.30
482.31 482.32 482.39 482.40 482.41 482.49 482.81 482.82 482.83 482.84 482.89
482.9 483.0 483.1 483.2 483.8 485 486 487.0 487.1 487.8
None → If "None," stop here. This patient is NOT eligible for inclusion.

B. Present on Admission? Yes No Unknown

If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.

C. Is there documentation in the medical record that ≥1 antibiotic was given for an indication of CAP?

Yes No Unknown

If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.

D. Age ≥1 year? Yes No Unknown

If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.

E. Is there documentation in the medical record of any of the following?

- Nursing home or long term care facility residence prior to admission
Hospitalized ≥2 days in the 90 days prior to admission
Received IV antibiotic therapy in the 30 days prior to admission
Received cancer chemotherapy in the 30 days prior to admission
Received wound care in the 30 days prior to admission
Chronic hemodialysis
Home mechanical ventilation
AIDS
Solid organ, bone marrow, or stem cell transplant
Long-term (>30 days) high-dose corticosteroid treatment
Other congenital or acquired immunodeficiency
Cystic fibrosis

If **any** of these is indicated as present, stop here. This patient is NOT eligible for inclusion.

F. Based on A thru E above, confirm patient eligibility: Not eligible → stop. Eligible → complete rest of form.

Demographic characteristics, hospitalization dates and outcome

1. Admission date: ___/___/___

2. Discharge date: ___/___/___ or Unknown

3. Age: _____ years or Unknown

4. Sex: M F Unknown

5. Race (check all that apply):

- American Indian or Alaska Native Native Hawaiian/other Pacific Islander
Asian White
Black or African American Unknown

6. Ethnicity:

- Hispanic or Latino
Not Hispanic or Latino
Unknown

8. Patient outcome at time of hospital discharge: Survived Died Unknown

9. Where did the patient reside the day prior to this admission? Private residence Another acute care hospital
Homeless Incarcerated Other _____ Unknown

Antimicrobial allergies

12. Is an antimicrobial drug allergy recorded in the medical record? Yes No Unknown

12b. If yes, specify drug class or classes to which patient is allergic, and reaction(s):

Drug class	Nausea, vomiting and/or diarrhea	Hives or urticaria	Other skin rash	Wheezing, throat tightness, trouble breathing	Angio-edema or face swelling	Anaphylaxis	Not specified	Other (specify)
<input type="checkbox"/> Penicillins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Macrolides	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Fluoroquinolones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Vancomycin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____

13. Underlying conditions: check all that apply.

If none or no chart available, check appropriate box: None or Unknown

- | | |
|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> HIV without AIDS |
| <input type="checkbox"/> Asplenia | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lymphoma or multiple myeloma |
| <input type="checkbox"/> Cerebrovascular disease/stroke (except hemiplegia) | <input type="checkbox"/> Previous documented MRSA colonization or infection |
| <input type="checkbox"/> Chronic cognitive deficit | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Chronic obstructive pulmonary disease or emphysema | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Chronic lung disease (other than COPD/emphysema) | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Solid tumor malignancy, metastatic |
| <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Solid tumor malignancy, not metastatic |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Vaccination, pneumococcal |
| <input type="checkbox"/> Diabetes mellitus with complications | <input type="checkbox"/> Vaccination for influenza in past year |
| <input type="checkbox"/> Diabetes mellitus without complications | <input type="checkbox"/> Vaccinations "up to date" (pediatric only) |
| <input type="checkbox"/> Hemiplegia | |

Pneumonia signs and symptoms

14. CAP onset date (mm/dd/yy): ___ / ___ / ___ or Prior to hospitalization but specific date unknown

15. CAP signs and symptoms (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Increased secretions/sputum production | <input type="checkbox"/> Grunting |
| <input type="checkbox"/> Chills or rigors | <input type="checkbox"/> Hemoptysis | <input type="checkbox"/> Nasal flaring |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Head bobbing |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Mental status changes or functional decline | <input type="checkbox"/> Chest wall retractions |
| <input type="checkbox"/> Increased oxygen requirements | <input type="checkbox"/> Apnea | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Rhinorrhea | <input type="checkbox"/> Muscle aches |
| | | <input type="checkbox"/> None documented |

16. Did the patient require mechanical ventilation at any time during hospitalization? Yes No Unknown

16b. If yes, was the patient extubated/removed from mechanical ventilation before discharge? Yes No Unknown

17. Chest imaging: complete table below or check None or Unknown
 If multiple chest imaging tests on a single date, make one entry for that date that summarizes any findings that are present among the multiple imaging tests. If

No.	Date	Findings on radiograph or CT scan			
1	___/___/___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation	<input type="checkbox"/> Pleural effusion <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
2	___/___/___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation	<input type="checkbox"/> Pleural effusion <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
3	___/___/___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation	<input type="checkbox"/> Pleural effusion <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
4	___/___/___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation	<input type="checkbox"/> Pleural effusion <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
5	___/___/___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation	<input type="checkbox"/> Pleural effusion <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these

18. Infections present during the hospitalization: complete table, or check None or Unknown
 If more than 4, enter the first 4 that were present.

No.	Infection (code)	Onset date	Signs and symptoms documented in medical record (check all that apply)			Was infection treated with antimicrobials?
1		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Infection codes: BJI, BSI, CNS, CVI, ENT, GTI, HEB, IAB, LRI, Other (specify), PNEU, REP, SSI (specify site), SST, UND (includes empiric therapy), UTI

Severity of illness

19. Was the patient in an ICU at any time during the hospitalization? Yes No Unknown

If **Yes**, enter the dates of the first ICU admission during the hospitalization:

ICU admission date: ____ / ____ / ____ ICU discharge date: ____ / ____ / ____

20. Complete the table below for the specified dates (for all events regardless of response to Q.19)::			
SIRS parameter category	Hospital admission: ____ / ____ / ____	Hospital day 3: ____ / ____ / ____	Discharge: ____ / ____ / ____
Temperature:			
Highest temperature recorded:	____ °C or ____ °F or <input type="checkbox"/> Unk	____ °C or ____ °F or <input type="checkbox"/> Unk	____ °C or ____ °F or <input type="checkbox"/> Unk
Lowest temperature recorded:	____ °C or ____ °F or <input type="checkbox"/> Unk	____ °C or ____ °F or <input type="checkbox"/> Unk	____ °C or ____ °F or <input type="checkbox"/> Unk
Heart rate:			
Highest heart rate recorded:	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk
Lowest heart rate recorded:	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk
Respiratory:			
Highest respiratory rate recorded:	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk
Lowest arterial PaCO ₂ recorded:	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk
Mechanically ventilated:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
White blood cells:			
Highest WBC count recorded:	____ cells/mm ³ or <input type="checkbox"/> Unk	____ cells/mm ³ or <input type="checkbox"/> Unk	____ cells/mm ³ or <input type="checkbox"/> Unk
Lowest WBC count recorded:	____ cells/mm ³ or <input type="checkbox"/> Unk	____ cells/mm ³ or <input type="checkbox"/> Unk	____ cells/mm ³ or <input type="checkbox"/> Unk
Highest %bands recorded:	____ % or <input type="checkbox"/> Unk	____ % or <input type="checkbox"/> Unk	____ % or <input type="checkbox"/> Unk
Blood pressure:			
Lowest systolic blood pressure:	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk
Lowest mean arterial pressure:	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk
On vasopressors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Serum lactate (lactic acid)	____ mg/dL or <input type="checkbox"/> Unk	____ mg/dL or <input type="checkbox"/> Unk	<i>Intentionally left blank</i>

21. Antimicrobial administration: complete the table for all antimicrobials administered during the hospitalization.

Drug name	Start date (mm/dd/yy) and route	End date (mm/dd/yy) and route	Indication		
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____

Discharge CAP prescribing

22. Was an antibiotic prescribed at discharge to treat CAP? Yes No Unknown

22b. If yes, enter antibiotic #1 name: _____ No. days prescribed: _____ or Unknown

enter antibiotic #2 name: _____ No. days prescribed: _____ or Unknown

23. Microbiology data: record cultures or other microbiology tests collected during the hospitalization.

No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Positive or negative	Pathogens identified (insert code) and culture colony count (CFU/ml, where applicable)	If SA was identified, is SA susceptible (S) to methicillin, oxacillin, or ceftaxitin?	Are all pathogens susceptible (S) to ≥1 antimicrobial the patient was getting THE DAY AFTER THE TEST RESULT WAS FINAL?
1	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
2	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
3	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
4	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
5	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
6	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
7	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
8	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
9	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
10	<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> ETA <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

**ANTIMICROBIAL PRESCRIBING QUALITY EVALUATION:
URINARY TRACT INFECTION EVENT FORM**

CDCID: - Date: // Data collector initials: _____

Identifiers (for EIP Team use only; do not transmit to CDC)		Hospital code: _____
Name: _____	Date of birth: ___ / ___ / ___	Medical record no.: _____

Case identification and eligibility	
A. Eligible ICD-9 codes recorded for this patient (check all that apply): <input type="checkbox"/> 590.10 <input type="checkbox"/> 590.11 <input type="checkbox"/> 590.2 <input type="checkbox"/> 590.3 <input type="checkbox"/> 590.80 <input type="checkbox"/> 590.81 <input type="checkbox"/> 590.9 <input type="checkbox"/> 595.0 <input type="checkbox"/> 597.0 <input type="checkbox"/> 597.80 <input type="checkbox"/> 599.0 <input type="checkbox"/> None → If "None," stop here. This patient is NOT eligible for inclusion.	
B. Present on Admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.	
C. Is there documentation in the medical record that ≥1 antibiotic was given for an indication of UTI? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.	
D. Age ≥1 year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.	
E. Based on A thru D above, confirm patient eligibility: <input type="checkbox"/> Not eligible → stop. <input type="checkbox"/> Eligible → complete rest of form.	

Demographic characteristics, hospitalization dates and outcome	
1. Admission date: ___ / ___ / ___	2. Discharge date: ___ / ___ / ___ or <input type="checkbox"/> Unknown
3. Age: _____ <input type="checkbox"/> years or <input type="checkbox"/> Unknown	4. Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown
5. Race (check all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Unknown	
6. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
8. Patient outcome at time of hospital discharge: <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown	

Healthcare exposures
9. Where did the patient reside the day prior to this admission? <input type="checkbox"/> Private residence <input type="checkbox"/> Long term care/SNF <input type="checkbox"/> LTACH <input type="checkbox"/> Another acute care hospital <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown
10. In the 30 days prior to admission, did the patient receive: <input type="checkbox"/> IV antimicrobials <input type="checkbox"/> Cancer chemotherapy <input type="checkbox"/> Wound care <input type="checkbox"/> Dialysis <input type="checkbox"/> Surgery <input type="checkbox"/> None <input type="checkbox"/> Unknown
11. Was the patient hospitalized in an acute care hospital for ≥2 days in the 90 days prior to this admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Antimicrobial allergies

12. Is an antimicrobial drug allergy recorded in the medical record? Yes No Unknown

12b. If yes, specify drug class or classes to which patient is allergic, and reaction(s):

Drug class	Nausea, vomiting and/or diarrhea	Hives or urticaria	Other skin rash	Wheezing, throat tightness, trouble breathing	Angio-edema or face swelling	Anaphylaxis	Not specified	Other (specify)
<input type="checkbox"/> Penicillins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Macrolides	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Fluoroquinolones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Vancomycin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____

13. Underlying conditions: check all that apply.

If none or no chart available, check appropriate box: None or Unknown

- | | |
|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Kidney stones/nephrolithiasis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asplenia | <input type="checkbox"/> Lymphoma or multiple myeloma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Cerebrovascular disease/stroke (except hemiplegia) | <input type="checkbox"/> Neutropenia (absolute neutrophil count <500 cells / μ L) |
| <input type="checkbox"/> Chronic cognitive deficit | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Chronic obstructive pulmonary disease or emphysema | <input type="checkbox"/> Recurrent cystitis or urinary tract infection |
| <input type="checkbox"/> Chronic lung disease (other than COPD/emphysema) | <input type="checkbox"/> Renal stents |
| <input type="checkbox"/> Chronic steroid or other immunosuppressive therapy | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Congenital urinary tract abnormality (not VUR) | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Solid tumor malignancy, metastatic (not urologic/renal) |
| <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Solid tumor malignancy, not metastatic (not urologic/renal) |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Spinal cord injury or paraplegia or quadriplegia |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Transplant, hematopoietic stem cell or bone marrow |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Transplant, solid organ |
| <input type="checkbox"/> Diabetes mellitus with complications | <input type="checkbox"/> Urostomy or nephrostomy |
| <input type="checkbox"/> Diabetes mellitus without complications | <input type="checkbox"/> Urologic or renal malignancy |
| <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Vesicoureteral reflux (VUR) |
| <input type="checkbox"/> HIV without AIDS | |

Urinary tract infection signs and symptoms

14. Date of UTI onset (mm/dd/yy): ____ / ____ / ____ or Prior to hospitalization but specific date unknown

15. Signs and symptoms (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Frequency | <input type="checkbox"/> Costovertebral angle (CVA) pain or tenderness |
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Visible blood in urine | <input type="checkbox"/> Suprapubic pain, swelling or tenderness |
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Mental status changes or functional decline |
| <input type="checkbox"/> Rigors | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Pain or burning with urination |
| | | <input type="checkbox"/> None documented |

16. Indwelling urinary catheter in place at the time of or \leq 2 calendar days prior to UTI symptom onset:

Yes No Unknown

16b. If yes, was it changed or removed after the diagnosis of UTI? Yes No Unknown

17. Urinalysis: complete table below or check None done or Unknown if urinalysis done

No.	Urinalysis Date (mm/dd/yy)	Pyuria (>5 WBCs / hpf)	Positive nitrites	Positive leukocyte esterase	Positive bacteria	Positive yeast
1	___/___/___	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
2	___/___/___	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
3	___/___/___	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
4	___/___/___	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
5	___/___/___	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

18. Infections present during the hospitalization: complete table, or check None or Unknown

If more than 4, enter the first 4 that were present.

No.	Infection (code)	Onset date	Signs and symptoms documented in medical record (check all that apply)			Was infection treated with antimicrobials?
1		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Infection codes: BJI, BSI, CNS, CVI, ENT, GTI, HEB, IAB, LRI, Other (specify), PNEU, REP, SSI (specify site), SST, UND (includes empiric therapy), UTI

Severity of illness

19. Was the patient in an ICU at any time during the hospitalization? Yes No Unknown

If **Yes**, enter the dates of the first ICU admission during the hospitalization:

ICU admission date: ____ / ____ / ____ ICU discharge date: ____ / ____ / ____

20. Complete the table below for the specified dates (for all events regardless of response to Q. 19):::

SIRS parameter category	Admission: ____ / ____ / ____	Hospital day 3: ____ / ____ / ____	Discharge: ____ / ____ / ____
Temperature:			
Highest temperature recorded:	____ °C or ____ °F or <input type="checkbox"/> Unk	____ °C or ____ °F or <input type="checkbox"/> Unk	____ °C or ____ °F or <input type="checkbox"/> Unk
Lowest temperature recorded:	____ °C or ____ °F or <input type="checkbox"/> Unk	____ °C or ____ °F or <input type="checkbox"/> Unk	____ °C or ____ °F or <input type="checkbox"/> Unk
Heart rate:			
Highest heart rate recorded:	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk
Lowest heart rate recorded:	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk
Respiratory:			
Highest respiratory rate recorded:	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk	____ bpm or <input type="checkbox"/> Unk
Lowest arterial PaCO ₂ recorded:	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk
Mechanically ventilated:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
White blood cells:			
Highest WBC count recorded:	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk
Lowest WBC count recorded:	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk
Highest %bands recorded:	____ % or <input type="checkbox"/> Unk	____ % or <input type="checkbox"/> Unk	____ % or <input type="checkbox"/> Unk
Blood pressure:			
Lowest systolic blood pressure:	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk
Lowest mean arterial pressure:	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk	____ mmHg or <input type="checkbox"/> Unk
On vasopressors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Serum lactate (lactic acid)	_____ mg/dL or <input type="checkbox"/> Unk	_____ mg/dL or <input type="checkbox"/> Unk	<i>Intentionally left blank</i>

21. Antimicrobial administration: complete the table for all antimicrobials administered during the hospitalization.

Drug name	Start date (mm/dd/yy) and route	End date (mm/dd/yy) and route	Indication		
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___ / ___ / ___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____

Discharge UTI prescribing

22. Was an antibiotic prescribed at discharge to treat UTI? Yes No Unknown

22b. If yes, enter antibiotic #1 name: _____ No. days prescribed: _____ or Unknown

enter antibiotic #2 name: _____ No. days prescribed: _____ or Unknown

23. Microbiology data: record cultures or other microbiology tests collected during the hospitalization.

No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Positive or negative	Pathogens identified (insert code) and culture colony count (CFU/ml, where applicable)	Are all pathogens susceptible (S) to ≥1 antimicrobial the patient was getting THE DAY AFTER THE TEST RESULT WAS FINAL?
1	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
2	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
3	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
4	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
5	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
6	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
7	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
8	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
9	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
10	<input type="checkbox"/> Blood <input type="checkbox"/> Resp <input type="checkbox"/> Urine,cc <input type="checkbox"/> Urine,cath <input type="checkbox"/> Urine,other <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path2_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA Path3_____ <input type="checkbox"/> <10K <input type="checkbox"/> 10-49.9K <input type="checkbox"/> 50-100K <input type="checkbox"/> >100K <input type="checkbox"/> U <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

**ANTIMICROBIAL PRESCRIBING QUALITY EVALUATION:
INTRAVENOUS VANCOMYCIN EVENT FORM**

CDCID: - Date: / / Data collector initials: _____

Identifiers (for EIP Team use only; do not transmit to CDC)

Hospital code: _____

Name: _____

Date of birth: ___ / ___ / ___

Medical record no.: _____

Case identification and eligibility

A. Did the patient receive at least 1 dose of intravenous vancomycin during the hospitalization, per the Medication Administration Record?

Yes No Unknown → If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.

B. Was vancomycin administered solely for surgical prophylaxis?

Yes No Unknown → If "Yes" or "Unknown," stop here. This patient is NOT eligible for inclusion.

C. Age >=1 year? Yes No Unknown

If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.

D. Based on A thru C above, confirm patient eligibility: Not eligible → stop. Eligible → complete rest of form.

Demographic characteristics, hospitalization dates and outcome

1. Admission date: ___ / ___ / ___

2. Discharge date: ___ / ___ / ___ or Unknown

3. Age: _____ or Unknown

4. Sex: M F Unknown

5. Race (check all that apply):

American Indian or Alaska Native

Native Hawaiian/other Pacific Islander

Asian

White

Black or African American

Unknown

6. Ethnicity:

Hispanic or Latino

Not Hispanic or Latino

Unknown

8. Patient outcome at time of hospital discharge: Survived Died Unknown

Healthcare exposures

9. Where did the patient reside the day prior to this admission?

Private residence Long term care/SNF LTACH Another acute care hospital Homeless Incarcerated

Other _____ Unknown

10. In the 30 days prior to admission, did the patient receive:

IV antimicrobials Cancer chemotherapy Wound care Dialysis Surgery None Unknown

11. Was the patient hospitalized in an acute care hospital for >=2 days in the 90 days prior to this admission?

Yes No Unknown

Antimicrobial allergies

12. Is an antimicrobial drug allergy recorded in the medical record? Yes No Unknown

12b. If yes, specify drug class or classes to which patient is allergic, and reaction(s):

Drug class	Nausea, vomiting and/or diarrhea	Hives or urticaria	Other skin rash	Wheezing, throat tightness, trouble breathing	Angio-edema or face swelling	Anaphylaxis	Not specified	Other (specify)
<input type="checkbox"/> Penicillins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Macrolides	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Fluoroquinolones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Vancomycin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____

13. Underlying conditions: check all that apply.

If none or no chart available, check appropriate box: None or Unknown

- | | |
|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> HIV without AIDS |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> IVDU |
| <input type="checkbox"/> Asplenia | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lymphoma or multiple myeloma |
| <input type="checkbox"/> Cerebrovascular disease/stroke (except hemiplegia) | <input type="checkbox"/> Previous documented MRSA colonization or infection |
| <input type="checkbox"/> Chronic cognitive deficit | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Neutropenia (absolute neutrophil count <500 cells / μ L) |
| <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Chronic obstructive pulmonary disease or emphysema | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Chronic lung disease (other than COPD/emphysema) | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Chronic steroid or other immunosuppressive therapy | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Solid tumor malignancy, metastatic |
| <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Solid tumor malignancy, not metastatic |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Transplant, hematopoietic stem cell or bone marrow |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Transplant, solid organ |
| <input type="checkbox"/> Diabetes mellitus with complications | <input type="checkbox"/> Vaccination, pneumococcal |
| <input type="checkbox"/> Diabetes mellitus without complications | <input type="checkbox"/> Vaccination for influenza in past year |
| <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Vaccinations "up to date" (pediatric only) |

15. Infections present during the hospitalization: complete table, or check None or Unknown
 If more than 4, enter the first 4 that were present.

No.	Infection (code)	Onset date	Signs and symptoms documented in medical record (check all that apply)			Was infection treated with IV vancomycin?
1		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Infection codes: BJI, BSI, CNS, CVI, ENT, GTI, HEB, IAB, LRI, Other (specify), PNEU, REP, SSI (specify site), SST, UND (includes empiric therapy), UTI

Severity of illness

16. Was the patient in an ICU at any time during the hospitalization? Yes No Unknown

If Yes, enter the dates of the first ICU admission during the hospitalization:

ICU admission date: ___ / ___ / ___ ICU discharge date: ___ / ___ / ___

17. Complete the table below for the specified dates (for all events regardless of response to Q. 16):

SIRS parameter category	Hospital admission: ___ / ___ / ___	First day of vancomycin: ___ / ___ / ___	Discharge: ___ / ___ / ___
Temperature:			
Highest temperature recorded:	___ °C or ___ °F or <input type="checkbox"/> Unk	___ °C or ___ °F or <input type="checkbox"/> Unk	___ °C or ___ °F or <input type="checkbox"/> Unk
Lowest temperature recorded:	___ °C or ___ °F or <input type="checkbox"/> Unk	___ °C or ___ °F or <input type="checkbox"/> Unk	___ °C or ___ °F or <input type="checkbox"/> Unk
Heart rate:			
Highest heart rate recorded:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Lowest heart rate recorded:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Respiratory:			
Highest respiratory rate recorded:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Lowest arterial PaCO ₂ recorded:	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
Mechanically ventilated:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
White blood cells:			
Highest WBC count recorded:	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk
Lowest WBC count recorded:	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk
Highest %bands recorded:	___ % or <input type="checkbox"/> Unk	___ % or <input type="checkbox"/> Unk	___ % or <input type="checkbox"/> Unk
Blood pressure:			
Lowest systolic blood pressure:	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
Lowest mean arterial pressure:	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
On vasopressors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Serum lactate (lactic acid)	_____ mg/dL or <input type="checkbox"/> Unk	_____ mg/dL or <input type="checkbox"/> Unk	<i>Intentionally left blank</i>

18. Antimicrobial administration: complete the table for all antimicrobials administered during the hospitalization.

Drug name	Start date (mm/dd/yy) and route	End date (mm/dd/yy) and route	Indication		
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____

Discharge IV vancomycin prescribing

19. Was IV vancomycin prescribed at discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge)?

Yes No Unknown

19b. If yes, enter the duration of the prescription in no. of days: _____ Unknown

20. Microbiology data during hospitalization: Record tests/cultures collected within 4 days before vancomycin start date through the vancomycin end date. Do NOT record screening nares cultures for MRSA in the table. 4 days before vancomycin start date: ___/___/___ Vancomycin end date: ___/___/___

20b. MRSA nares surveillance culture done during this admission? Yes No Unknown *If yes, indicate result:* Negative Positive Unknown

No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Positive or negative	Pathogens identified (insert code)	Pathogen susceptible to oxacillin, methicillin or ceftioxin?	Pathogen susceptible to penicillin or ampicillin?	Pathogen susceptible to vancomycin?	Are all pathogens susceptible (S) to ≥1 antimicrobial the patient was getting THE DAY AFTER THE DATE THE TEST RESULT WAS FINAL?
1	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
2	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
3	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
4	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
5	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
6	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
7	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
8	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
9	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
10	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1_____ Path2_____ Path3_____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

**ANTIMICROBIAL PRESCRIBING QUALITY EVALUATION:
FLUOROQUINOLONE EVENT FORM**

CDCID: - Date: / / Data collector initials: _____

Identifiers (for EIP Team use only; do not transmit to CDC)

Hospital code: _____

Name: _____ **Date of birth:** ___ / ___ / ___ **Medical record no.:** _____

Case identification and eligibility

A. Did the patient receive at least 1 dose of a fluoroquinolone (IV or oral/enteral) during the hospitalization, per the Medication Administration Record?

Yes No Unknown → If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion.

B. Which fluoroquinolones were administered?

Ciprofloxacin Levofloxacin Moxifloxacin None of these → If "None of these" is checked, stop here. This patient is NOT eligible for inclusion.

C. Age >=18 years? Yes No Unknown

If "No" or "Unknown," stop here. This patient is NOT eligible for inclusion Note that the age cutoff is different than the other events because children are not included in the fluoroquinolone event.

D. Based on A and C above, confirm patient eligibility: Not eligible → stop. Eligible → complete rest of form.

Demographic characteristics, hospitalization dates and outcome

1. Admission date: ___ / ___ / ___

2. Discharge date: ___ / ___ / ___ or Unknown

3. Age: _____ years or Unknown

4. Sex: M F Unknown

5. Race (check all that apply):

American Indian or Alaska Native Native Hawaiian/other Pacific Islander
 Asian White
 Black or African American Unknown

6. Ethnicity:

Hispanic or Latino
 Not Hispanic or Latino
 Unknown

8. Patient outcome at time of hospital discharge: Survived Died Unknown

Healthcare exposures

9. Where did the patient reside the day prior to this admission?

Private residence Long term care/SNF LTACH Another acute care hospital Homeless Incarcerated
 Other _____ Unknown

10. In the 30 days prior to admission, did the patient receive:

IV antimicrobials Cancer chemotherapy Wound care Dialysis Surgery None Unknown

11. Was the patient hospitalized in an acute care hospital for >=2 days in the 90 days prior to this admission?

Yes No Unknown

Antimicrobial allergies

12. Is an antimicrobial drug allergy recorded in the medical record? Yes No Unknown

12b. If yes, specify drug class or classes to which patient is allergic, and reaction(s):

Drug class	Nausea, vomiting and/or diarrhea	Hives or urticaria	Other skin rash	Wheezing, throat tightness, trouble breathing	Angio-edema or face swelling	Anaphylaxis	Not specified	Other (specify)
<input type="checkbox"/> Penicillins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Macrolides	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Fluoroquinolones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Vancomycin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____

13. Underlying conditions: check all that apply.

If none or no chart available, check appropriate box: None or Unknown

- | | |
|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> HIV without AIDS |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> IVDU |
| <input type="checkbox"/> Asplenia | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lymphoma or multiple myeloma |
| <input type="checkbox"/> Cerebrovascular disease/stroke (except hemiplegia) | <input type="checkbox"/> Previous documented MRSA colonization or infection |
| <input type="checkbox"/> Chronic cognitive deficit | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Neutropenia (absolute neutrophil count <500 cells / μ L) |
| <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Chronic obstructive pulmonary disease or emphysema | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Chronic lung disease (other than COPD/emphysema) | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Chronic steroid or other immunosuppressive therapy | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Solid tumor malignancy, metastatic |
| <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Solid tumor malignancy, not metastatic |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Transplant, hematopoietic stem cell or bone marrow |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Transplant, solid organ |
| <input type="checkbox"/> Diabetes mellitus with complications | <input type="checkbox"/> Vaccination, pneumococcal |
| <input type="checkbox"/> Diabetes mellitus without complications | <input type="checkbox"/> Vaccination for influenza in past year |
| <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Vaccinations "up to date" (pediatric only) |

15. Infections present during the hospitalization: complete table, or check None or Unknown

If more than 4, enter the first 4 that were present.

No.	Infection (code)	Onset date	Signs and symptoms documented in medical record (check all that apply)			Was infection treated with fluoro-quinolones?
1		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4		<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hospital day 3 <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Mental status change	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> None of these <input type="checkbox"/> Other _____ <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Infection codes: BJI, BSI, CNS, CVI, ENT, GTI, HEB, IAB, LRI, Other (specify), PNEU, REP, SSI (specify site), SST, UND (includes empiric therapy), UTI

Severity of illness

16. Was the patient in an ICU at any time during the hospitalization? Yes No Unknown

If Yes, enter the dates of the first ICU admission during the hospitalization:

ICU admission date: ___ / ___ / ___ ICU discharge date: ___ / ___ / ___

17. Complete the table below for the specified dates (for all events regardless of response to Q.16):

SIRS parameter category	Hospital admission: ___ / ___ / ___	First day of vancomycin: ___ / ___ / ___	Discharge: ___ / ___ / ___
Temperature:			
Highest temperature recorded:	___ °C or ___ °F or <input type="checkbox"/> Unk	___ °C or ___ °F or <input type="checkbox"/> Unk	___ °C or ___ °F or <input type="checkbox"/> Unk
Lowest temperature recorded:	___ °C or ___ °F or <input type="checkbox"/> Unk	___ °C or ___ °F or <input type="checkbox"/> Unk	___ °C or ___ °F or <input type="checkbox"/> Unk
Heart rate:			
Highest heart rate recorded:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Lowest heart rate recorded:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Respiratory:			
Highest respiratory rate recorded:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Lowest arterial PaCO ₂ recorded:	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
Mechanically ventilated:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
White blood cells:			
Highest WBC count recorded:	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk
Lowest WBC count recorded:	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk	_____ cells/mm ³ or <input type="checkbox"/> Unk
Highest %bands recorded:	___ % or <input type="checkbox"/> Unk	___ % or <input type="checkbox"/> Unk	___ % or <input type="checkbox"/> Unk
Blood pressure:			
Lowest systolic blood pressure:	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
Lowest mean arterial pressure:	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
On vasopressors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Serum lactate (lactic acid)	_____ mg/dL or <input type="checkbox"/> Unk	_____ mg/dL or <input type="checkbox"/> Unk	Intentionally left blank

18. Antimicrobial administration: complete the table for all antimicrobials administered during the hospitalization.

Drug name	Start date (mm/dd/yy) and route	End date (mm/dd/yy) and route	Indication		
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____
	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	___/___/___ <input type="checkbox"/> IV <input type="checkbox"/> Oral/enteral <input type="checkbox"/> IM <input type="checkbox"/> Inhaled	<input type="checkbox"/> MedProph <input type="checkbox"/> SurProph <input type="checkbox"/> NonInfect	<input type="checkbox"/> Treatment → <input type="checkbox"/> Unknown	If treatment: <input type="checkbox"/> BJI <input type="checkbox"/> BSI <input type="checkbox"/> CNS <input type="checkbox"/> CVI <input type="checkbox"/> ENT <input type="checkbox"/> GTI <input type="checkbox"/> HEB <input type="checkbox"/> IAB <input type="checkbox"/> LRI <input type="checkbox"/> PNEU <input type="checkbox"/> REP <input type="checkbox"/> SST <input type="checkbox"/> UND <input type="checkbox"/> UTI <input type="checkbox"/> SSI (site): _____ <input type="checkbox"/> Other: _____

Discharge fluoroquinolone prescribing

19. Was a fluoroquinolone prescribed at discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge)?

Yes--ciprofloxacin Yes—levofloxacin Yes--moxifloxacin No Unknown

19b. If yes, what was the route of administration? IV Oral/enteral Unknown

19c. If yes, enter the duration of the prescription in no. of days: _____ Unknown

20. Microbiology data during hospitalization: Record tests/cultures collected within 4 days before fluoroquinolone start date through the end date.
 4 days before fluoroquinolone start date: ___/___/___ Fluoroquinolone end date: ___/___/___

No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Positive or negative	Pathogens identified (insert code)	Pathogen susceptible to ciprofloxacin?	Pathogen susceptible to levofloxacin?	Pathogen susceptible to moxifloxacin?	Are all pathogens susceptible (S) to ≥1 antimicrobial the patient was getting THE DAY AFTER THE TEST RESULT WAS FINAL?
1	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
2	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
3	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
4	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
5	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
6	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
7	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
8	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
9	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
10	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

FORM IS COMPLETE