Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CDC ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chart Abstraction Form**

Name of Person Completing Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_

Case  Control: Matched to case (CDC ID): \_\_\_\_\_\_\_

Date of onset/positive culture (for case or matched control): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

30day window period: \_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_ 7day window period: \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_

1. **Demographic Information**

Sex:  Male  Female Age (specify years or months if <2 years):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race:  White  Black  Asian  American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander  Other\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino

1. **Birth History**

Gestational age: \_\_\_\_ wks \_\_\_\_ days Birth weight: \_\_\_\_\_\_ grams or \_\_\_\_\_lbs.\_\_\_\_oz.

Birth:  C-section  Vaginal delivery  Multiple birth APGAR: 1min\_\_\_\_ 5 min\_\_\_\_

1. **Maternal/ Obstetric History:**  G\_\_\_\_P\_\_\_\_

Chorioamnionitis

Cigarette smoking

Drug use:\_\_\_\_\_\_\_\_\_\_\_\_\_

Fetal distress

Gestational diabetes

IUGR

Maternal infection

Preeclampsia

Premature delivery

PROM

Unknown

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Medical History**

1. Comorbidities:  Unknown

Aspiration

Gastric residual >30%

Intracran. hemorrhage

Patent ductus arteriosis

Perinatal asphyxia

Reflux/ Regurgitation

Sepsis

Cardiac abnormalities (e.g., congenital heart disease): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulmonary disease (e.g., BPD, HMD/RDS, meconium aspiration): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastointestinal disease (e.g., NEC, gastroschisis, omphalocele): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Did infant have any of the following *7 days* prior to positive culture?  Unknown

GI surgery  Non GI surgery  Retinopathy of prematurity (ROP) treatment

Mechanical ventilation  Umbilical catheter  Other central venous catheter

Oro/nasogastric tube  G-tube  Jejunal tube

RBC transf: (Date: \_\_\_\_\_\_\_\_, # units:\_\_\_\_)  Supplemental O2

Other devices (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Medication History**
2. Was infant treated with antimicrobial 30 days before onset/positive culture?

Yes  No  Unk.

|  |  |  |  |
| --- | --- | --- | --- |
| **Antimicrobial** | **Route** | **Start Date** | **Stop Date** |
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1. Other medications received 7 days prior to onset or positive culture?

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| --- | --- | --- | --- |
| **Medication** | **Route** | **Start Date(s)** | **Stop Date(s)** |
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1. Other injectables received in the 7 days before onset or positive culture?

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| **Product** | **Start Date(s)** | **Stop Date(s)** |
| TPN  Yes No Unk |  |  |
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1. **Illness History:** *Please fill out for case-patients only*

1. Date of onset/positive culture: \_\_\_\_/\_\_\_ /\_\_\_\_

2. Outcome (include date):

Ongoing illness  Symptoms resolved\_\_\_\_\_\_\_\_\_\_  Colonization only \_\_\_\_\_\_\_\_\_\_\_\_  Death\_\_\_\_\_\_\_\_\_\_\_\_  Unknown

If death, attributed to *Pseudomonas*? Yes  No Autopsy performed? Yes  No

3. Pathology results from surgery or autopsy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Pathology samples from surgery or autopsy available? Yes No

**H. Clinical Information:** *Please fill out for case-patients only*

1. Signs and Symptoms within 48 hours of onset or positive culture (check all that apply):

Unk.

Fever

Sepsis

Tachycardia/ Rapid heart rate

Tachypnea/Rapid breathing

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Abnormal laboratory findings within 48 hours of onset or positive culture (check all that apply):

Unk.

Anemia: Hb\_\_\_\_\_\_, Hct\_\_\_\_\_\_

Coagulopathy: INR\_\_\_\_\_\_\_, PTT\_\_\_\_\_

Leukocytosis: WBC\_\_\_\_\_\_

Metabolic acidosis: pH\_\_\_\_\_, HCO3\_\_\_

Neutropenia: WBC\_\_\_\_\_\_, ANC\_\_\_\_\_\_

Thrombocytopenia: Plt \_\_\_\_\_\_

3. Microbiology findings: List all positive cultures from sterile sites (blood, urine, etc.) and surveillance culture sites

*(Date range: 1 week prior to illness onset until resolution of illness)*

No cultures drawn  All cultures negative  Unknown

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| --- | --- | --- | --- | --- |
| **Date** | **Source** | **Organism** | **# Positive Bottles (x/y)** | **Surveillance culture?(Y/N)** |
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1. **Bathing/skin care history**

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| **Skin care products used** | **Brand/Manufacturer** | **Dates** |
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1. **Oral care products**

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| --- | --- | --- |
| **Oral care products used** | **Brand/Manufacturer** | **Dates** |
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1. **Staff exposures**

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| **Staff** | **Role** | **Dates** |
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**L. Notes/Remarks** (Anything unusual about hospital course not included above, including patterns of medication/thickener use, patient course at home, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**K. Medical Chart Abstraction Form Complete?**

Yes---- date of completion \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

No