

Appendix 1: Chart Abstraction Form

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Patient Name: _____

CDC ID#: _____

DRAFT

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

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 _____

A. 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

B. Birth History

Gestational age: ____ wks ____ days Birth weight: _____ grams or ____ lbs. ____ oz.
 Birth: C-section Vaginal delivery Multiple birth APGAR: 1min ____ 5 min ____

C. Maternal/ Obstetric History:

G ____ P ____

<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Premature delivery
<input type="checkbox"/> Cigarette smoking	<input type="checkbox"/> IUGR	<input type="checkbox"/> PROM
<input type="checkbox"/> Drug use: _____	<input type="checkbox"/> Maternal infection	<input type="checkbox"/> Unknown
<input type="checkbox"/> Fetal distress	<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> Other _____

D. Medical History

1. Comorbidities:

<input type="checkbox"/> Aspiration	<input type="checkbox"/> Patent ductus arteriosus	<input type="checkbox"/> Unknown
<input type="checkbox"/> Gastric residual >30%	<input type="checkbox"/> Perinatal asphyxia	<input type="checkbox"/> Reflux/ Regurgitation
<input type="checkbox"/> Intracran. hemorrhage		<input type="checkbox"/> Sepsis
<input type="checkbox"/> Cardiac abnormalities (e.g., congenital heart disease): _____		
<input type="checkbox"/> Pulmonary disease (e.g., BPD, HMD/RDS, meconium aspiration): _____		
<input type="checkbox"/> Gastrointestinal disease (e.g., NEC, gastroschisis, omphalocele): _____		
<input type="checkbox"/> Other: _____		

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

<input type="checkbox"/> GI surgery	<input type="checkbox"/> Non GI surgery	<input type="checkbox"/> Retinopathy of prematurity (ROP) treatment
<input type="checkbox"/> Mechanical ventilation	<input type="checkbox"/> Umbilical catheter	<input type="checkbox"/> Other central venous catheter
<input type="checkbox"/> Oro/nasogastric tube	<input type="checkbox"/> G-tube	<input type="checkbox"/> Jejunal tube
<input type="checkbox"/> RBC transf: (Date: _____, # units: ____)	<input type="checkbox"/> Supplemental O2	
<input type="checkbox"/> Other devices (describe): _____		

E. Medication History

1. Was infant treated with antimicrobial 30 days before onset/positive culture?

Yes No Unk.

Antimicrobial	Route	Start Date	Stop Date
---------------	-------	------------	-----------

2. Other medications received 7 days prior to onset or positive culture?

Medication	Route	Start Date(s)	Stop Date(s)

3. Other injectables received in the 7 days before onset or positive culture?

Product	Start Date(s)	Stop Date(s)
TPN <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		

F. 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.
 Tachypnea/Rapid breathing
 Other _____
 Fever
 Sepsis

 Tachycardia/ Rapid heart rate

2. Abnormal laboratory findings within 48 hours of onset or positive culture (check all that apply):
- Coagulopathy: INR _____, PTT _____
 - Leukocytosis: WBC _____
 - 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

Date	Source	Organism	# Positive Bottles (x/y)	Surveillance culture? (Y/N)

I. Bathing/skin care history

Skin care products used	Brand/Manufacturer	Dates

J. Oral care products

Oral care products used	Brand/Manufacturer	Dates

K. Staff exposures

Staff	Role	Dates

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

K. Medical Chart Abstraction Form Complete?

- Yes---- date of completion ____ / ____ / ____
- No