APPENDIX 2 – MEDICAL CHART ABSTRACTION FORM – PA NTM INFECTIONS

Abstractor: Date of abstraction: ____ / ____ / ____

Case ID:_____

This patient is a: 1 [ ] Case 2 [ ] Control

Pathogen	Infection site	Specimen	Date specimen obtained	Test performed
[ ] M. abscessus [ ] M. chelonae [ ] M. fortuitum [ ] M. something	[ ] BSI [ ] SSI [ ] Respiratory [ ] CAUTI [ ] Skin/soft tissues [ ] Other_____	[ ] Blood [ ] Tissue/Biopsy [ ] BAL/BW [ ] Urine [ ] Swab [ ] Other_____	_ _/_ _/_ _	[ ] Culture [ ] PCR [ ] Histopath [ ] Other_____

A. Patient information

Sex: 1 [ ] Male 2 [ ] Female 9 [ ] N/A

Year of birth/Age:_____

Race/Ethnicity:
1 [ ] White 2 [ ] Afr Am 3 [ ] Hispanic 4 [ ] Asian/PI 5 [ ] AI/AN
7 [ ] Other, specify:_____ 9 [ ] Unknown

Hospital/clinic admission date: __ __/__ __/__ __ (mm/dd/yy)

Admission diagnosis_____

Onset date: __ __/__ __/__ __ (mm/dd/yy)

Chief complaints_____

B. **History and Physical**

Secondary Diagnoses (patient medical history):
[ ] CAD [ ] Rheumatoid Arthritis [ ] Solid tumor (non-metastatic) [ ]
CHF [ ] Connective tissue disease [ ] Metastatic solid tumor

[ ] PVD [ ] Mild liver disease [ ] Lymphoma

[ ] Dementia [ ] Moderate-to-severe liver disease [ ] PUD

[ ] Chronic pulmonary disease [ ] Diabetes w/o complications [ ] AIDS (CD4≤200 or OI)

[ ] Hemiplegia [ ] Diabetes w/end organ disease [ ] Inflammatory bowel disease

[ ] Moderate to severe renal disease (Cr>=3.0, h/o uremia, transplant) [ ] Ulcer disease

[ ] Leukemia [ ] Obesity [ ] Hypertension

Other:_____

Current alcohol use 1 [ ] Yes, amount (drinks/week): _____ 2 [ ] No 9 [ ] Unknown
Smoking status (at admission) 1 [ ] Yes, amount (pack-years):___2 [ ] No 9 [ ] Unknown
Any prior history of smoking? 1 [ ]Yes, pack-year history ___ [ ] No 9 [ ] Unknown

Other history related to this hospitalization

_____
_____
_____
_____
_____

Any medications used prior to admission

_____
_____
_____

C. Hospital course

Patient location/procedures/movements in the hospital … days before first positive culture:

(procedures may include central line insertion/care, catheter insertion, ultrasound, endoscopy…)

Building	Tower	Unit	Room	Dates	Procedure	Staff encounter
_____	_____	_____ _	_____	_____	_____	_____
_____	_____	_____ _	_____	_____	_____	_____
_____	_____	_____ _	_____	_____	_____	_____
_____	_____	_____ _	_____	_____	_____	_____

D. If BSI, consider the following

Central line is present: [ ] Yes [ ] No
If Yes, then

Date inserted	Type	Active during 1 week before culture
__ __/__ __/__ __	[ ] CVC [ ] PICC [ ] Port [ ] Swan-Ganz [ ] Other_____	[ ] Yes [ ] No
__ __/__ __/__ __	[ ] CVC [ ] PICC [ ] Port [ ] Swan-Ganz [ ] Other_____	[ ] Yes [ ] No

Central line access (within 1 week of positive culture)

Date accessed	Staff	Procedure	Saline flush	Medications administered
_ _/_ _/_ _	_____	[ ] Flush [ ] Dressing change [ ] Med administration [ ] Other____	[ ] Yes [ ] No	_____ (note if something is multi-dose vial)
_ _/_ _/_ _	_____	[ ] Flush [ ] Dressing change [ ] Med administration [ ] Other____	[ ] Yes [ ] No	_____ (note if something is multi-dose vial)

Other medications administered parenterally (not via central line)

Date	Staff	Route/site	Medications administered
_ _/_ _/_ _	_____	[ ] IV_____ [ ] IM_____ [ ] SC_____	_____ (note if something is multi-dose vial)
_ _/_ _/_ _	_____	[ ] IV_____ [ ] IM_____ [ ] SC_____	_____ (note if something is multi-dose vial)

Did patient have a shower/bath during the week before positive culture [ ] Yes [ ] No

Date shower 1: __ __/__ __/__ __
Date shower 2: __ __/__ __/__ __
Date shower 3: __ __/__ __/__ __

E. If SSI, consider the following

Weight_____lbs/kg Height_____in/cm on admission date

Highest glucose in 48 hours prior to surgery:_____Date: __ __/__ __/__ __ Time: __:__

HgbA1c value within 3 months of surgery (take most recent value):_____Date: __ __/__ __/__ __

Pre-op albumin level:_____ Date: __ __/__ __/__ __ Time: __:__

ASA Score: _____ NYHA Score:_____ Preop EF:_____

Date of surgery __ __/__ __/__ __

Antibiotics used

Pre-op Abx use [ ] Yes [ ] No

Name	Route	Dose	Date	Time start
_____	[ ] IV [ ] IM	_____	_ _/_ _/_ _	__:__
_____	[ ] IV [ ] IM	_____	_ _/_ _/_ _	__:__

Intra-op Abx use [ ] Yes [ ] No

Name	Route	Dose	Date	Time start
_____	[ ] IV [ ] IM	_____	_ _/_ _/_ _	__:__
_____	[ ] IV [ ] IM	_____	_ _/_ _/_ _	__:__

Intra-op Abx use [ ] Yes [ ] No

Name	Route	Dose	Date	Time start
_____	[ ] IV [ ] IM	_____	_ _/_ _/_ _	__:__
_____	[ ] IV [ ] IM	_____	_ _/_ _/_ _	__:__

Antiseptic showering □ Yes, type and date given: _____ □ No
Pre-op hair removal: □ none □ razor □ clipper □ Other _____
Pre-op prep: □ CHG □ Betadine □ Other _____

Any special skin preparation: _____
_____

Surgical procedures (briefly, e.g., CABGx2, LIMA harvest…):
_____

If this is a CABG, what is the harvest site_____

Surgery start time:_____
Surgery stop time:_____

OR Room #: _____

Surgeon _____ Anesthesiologist _____

RFNA_____ CRNA _____

RFNA_____ Perfusionist _____

Scrub Nurse(s)_____ Personal Scrub _____

Circulator 1 _____ Circulator 2_____

Other (name/title)_____ Other (name/title)_____

Did patient have Cardiopulmonary Bypass (CBP)? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

Intraoperative US (e.g., TEE) performed: 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
If yes, by whom? _____

Cardioplegia or similar intervention 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
If yes, what was used for the procedure_____

Other IV drugs during surgery?

Type	Dose	Route	Time start	Time stop
		[ ] IV [ ] IM		
		[ ] IV [ ] IM		
		[ ] IV [ ] IM		
		[ ] IV [ ] IM		
		[ ] IV [ ] IM		

Transfusions during surgery?

Type	Dose	Time start	Time stop

Highest glucose during procedure:_____ Time: __:__

List all the devices or equipment that were inserted into patient's body (valve, grafts, drains, staple/suture, wound dressing…)

Instrument type	Name	Catalog #	Serial #	Check if left in place	Date removed
Grafts					
Staples/sutures					
Drains					

Other intra-operative findings (including cooling methods, drugs in/on chest, dressing, ointment…):
_____
_____
_____
_____
_____

Post operation

ICU recovery room _____ Admission date: __ __ /__ __/__ __ Time:__ __:__ __

Did patient have warmers (forced air warming blanket, etc)…1 [ ] Yes 2 [ ] No 9 [ ] Unknown

Medications (suppressors, immunosuppressant) after surgery?

Type	Dose	Route	Date and time start	Date and time stop
		[ ] IV [ ] IM		
		[ ] IV [ ] IM		
		[ ] IV [ ] IM		
		[ ] IV [ ] IM		

Transfusions after surgery?

Type	Dose	Date and time start	Date and time stop

Highest glucose within 24 hours post operation:_____ Date: __ __/__ __/__ __ Time: __:__

Wound care after surgery:

Dressing change (one change per line, regardless of products used) or wound cleansing

Dressing/cleansing product	Date change	Time change	Staff name	Note

Date of dressing removal __ __ /__ __/__ __ [ ] N/A

Date of staple/suture removal __ __ /__ __/__ __ [ ] N/A

Date of drain removal __ __ /__ __/__ __ [ ] N/A

Other interventions in or around the wound (date) _____

Did patient have a shower/bath during hospitalization after surgery [ ] Yes [ ] No

Date shower 1: __ __/__ __/__ __
Date shower 2: __ __/__ __/__ __
Date shower 3: __ __/__ __/__ __

If SSI is related to endoscopy/laparoscopy

Date	Type and site	Interpretation	Meds used during	Location (Bedside,

	of endoscopy		bronchoscopy	Radiology) and staff
__ __ /__ __/__ __	_____	_____	_____	_____
__ __ /__ __/__ __	_____	_____	_____	_____
__ __ /__ __/__ __	_____	_____	_____	_____

Abx used before admission for SSI 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
If Yes, start date__ __/__ __/__ __ and drug name_____

SSI symptoms:

Fever 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

Wound findings: 1 [ ] Superficial 2 [ ] Deep 3 [ ] Organ space

Site of the wound _____ 9 [ ] Unknown

Drainage 1 [ ] Yes 2 [ ] No

Swelling 1 [ ] Yes 2 [ ] No

Erythema 1 [ ] Yes 2 [ ] No

Pain 1 [ ] Yes 2 [ ] No

Other symptoms:_____

Wound Classification: □ Clean □ Clean-Contaminated □ Contaminated □ Dirty

Wound treatment:

Surgical Debridement 1 [ ] Yes 2 [ ] No Date __ __ /__ __/__ __

Wound Vac 1 [ ] Yes 2 [ ] No Date __ __ /__ __/__ __

Flap 1 [ ] Yes 2 [ ] No Date __ __ /__ __/__ __

Antibiotics 1 [ ] Yes 2 [ ] No start date __ __ /__ __/__ __
Specify agent/dose/route:_____

Other medications 1 [ ] Yes 2 [ ] No Date __ __ /__ __/__ __
Specify:_____

F. If respiratory infections, consider the following

List RTs who had contact with the patient before first positive culture date:

Name	Date
_____	__ __ /__ __/__ __
_____	__ __ /__ __/__ __
_____	__ __ /__ __/__ __
_____	__ __ /__ __/__ __

Respiratory Meds received before first positive culture? □ YES □NO
Include O2, NO or other inhaled agents (e.g. albuterol, anesthesia meds, inhaled antibiotics, inhaled asthma meds) in this section

Name (use generic name)	Type/Route (eg MDI, Neb, nasal canula)	Date administered
_____	_____	__ __ /__ __/__ __
_____	_____	__ __ /__ __/__ __
_____	_____	__ __ /__ __/__ __
_____	_____	__ __ /__ __/__ __

Antibiotics received before first positive culture? □YES □NO

Name	Dose	Route	Dates administered
_____	_____	[ ] IV [ ] IM [ ] PO	__ __ /__ __/__ __
_____	_____	[ ] IV [ ] IM [ ] PO	__ __ /__ __/__ __
_____	_____	[ ] IV [ ] IM [ ] PO	__ __ /__ __/__ __
_____	_____	[ ] IV [ ] IM [ ] PO	__ __ /__ __/__ __

Routine care items/treatments/nutrition received before first positive culture

Mouthwash: Yes No If yes, brand_____
Lip balm: Yes No If yes, brand_____
Nasal spray: Yea No If yes, brand_____
Deodorant: Yes No If yes, brand_____
Chlorhexidine: Yes No If yes, brand_____
Antiseptics: Yes No If yes, name_____
Tube feeds: Yes No If yes, tube type_____
Feed fluid name_____
Shaving gel: Yes No If yes, brand_____
Other products:
Name_____ Brand_____
Name_____ Brand_____
Name_____ Brand_____
Name_____ Brand_____

Were steroids administered before first positive culture? □Yes □No
If yes, dose _____ dates administered__/__/____-__/__/____
__/__/____-__/__/____

Was suctioning done: □Yes □No
If yes, dates __/__/____-__/__/____
How many times did the patient receive suctioning within the exposure window: _____
Any solutions/fluid used during the procedure_____

Was bronchoscopy done: □Yes □ No
If yes fill the table below:

Date	Interpretation	Meds used during bronchoscopy	Location (Bedside, Radiology) and staff	Specimen obtained
__ __ /__ __/__ __	_____	_____	_____	1 [ ] Yes 2 [ ] No
__ __ /__ __/__ __	_____	_____	_____	1 [ ] Yes 2 [ ] No
__ __ /__ __/__ __	_____	_____	_____	1 [ ] Yes 2 [ ] No

Ventilation
Did patient require mechanical ventilation before first positive culture date? □YES □ NO

Vent brand/serial number_____
If yes, date intubated __/__/____
Location where intubated_____
Date extubated __/__/____

Did the patient have or receive a tracheostomy during the exposure window? □YES □NO
If yes, date procedure performed __/__/____
Location where tracheotomy done_____

Did patient require CPAP? □YES □NO
If yes, # of days on CPAP before first positive culture_____

Did patient require BIPAP? □YES □ NO
If yes, # of days on BIPAP before first positive culture _____

G. If CAUTI, consider

Is patient incontinence 1 [ ] Yes 2 [ ] No

Catheter information

Date inserted	Date withdrawn	Type

__ __/__ __/__ __	__ __/__ __/__ __	[ ] Urinary catheter [ ] Suprapubic catheter [ ] Temporary relief [ ] Other_____
__ __/__ __/__ __	__ __/__ __/__ __	[ ] Urinary catheter [ ] Suprapubic catheter [ ] Temporary relief [ ] Other_____

If catheter was accessed or maneuvered, provide information

Date accessed	Staff	Procedure	Bag drain
_ _/_ _/_ _	_____	_____	[ ] Yes [ ] No
_ _/_ _/_ _	_____	_____	[ ] Yes [ ] No

H. Patient symptoms and other laboratory data

[ ] Fever
[ ] Chills
[ ] Abdominal pain
[ ] Cough
[ ] Hemoptysis
[ ] Dyspnea
[ ] Respiratory failure
[ ] Shock

CBC and chemistry

Date specimen obtained	WBC	ALT	AST	…
_ _/_ _/_ _	_____	_____	_____	_____
_ _/_ _/_ _	_____	_____	_____	_____

Urinalysis

Date specimen obtained	WBC	RBC	…	…
_ _/_ _/_ _	_____	_____	_____	_____
_ _/_ _/_ _	_____	_____	_____	_____

Other culture

Date specimen obtained	Source of specimen	Test	Result	…
_ _/_ _/_ _	_____	[ ] Culture	_____	_____

		[ ] PCR [ ] Histopath [ ] Other_____		
_ _/_ _/_ _	_____	[ ] Culture [ ] PCR [ ] Histopath [ ] Other_____	_____	_____

I. Patient treatment and outcome

Antibiotic received

Name	Route	Dose	Date start	Date stop
_____	[ ] IV [ ] IM [ ] PO	_____	_ _/_ _/_ _	_ _/_ _/_ _
_____	[ ] IV [ ] IM [ ] PO	_____	_ _/_ _/_ _	_ _/_ _/_ _

Patient outcome of this hospitalization?

1 [ ] Recover and discharged 2 [ ] Died 3 [ ] Still in hospital
4 [ ] Other_____ 9 [ ] Unknown