

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
<input type="checkbox"/> M. abscessus <input type="checkbox"/> M. chelonae <input type="checkbox"/> M. fortuitum <input type="checkbox"/> M. something	<input type="checkbox"/> BSI <input type="checkbox"/> SSI <input type="checkbox"/> Respiratory <input type="checkbox"/> CAUTI <input type="checkbox"/> Skin/soft tissues <input type="checkbox"/> Other_____	<input type="checkbox"/> Blood <input type="checkbox"/> Tissue/Biopsy <input type="checkbox"/> BAL/BW <input type="checkbox"/> Urine <input type="checkbox"/> Swab <input type="checkbox"/> Other_____	__/__/__	<input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> Histopath <input type="checkbox"/> 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 \leq 200 or OI)
 Hemiplegia Diabetes w/end organ disease Inflammatory bowel disease
 Moderate to severe renal disease (Cr \geq 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
__ __/__ __/__ __	<input type="checkbox"/> CVC <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Swan-Ganz <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
__ __/__ __/__ __	<input type="checkbox"/> CVC <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Swan-Ganz <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Central line access (within 1 week of positive culture)

Date accessed	Staff	Procedure	Saline flush	Medications administered
--/--/--	_____	<input type="checkbox"/> Flush <input type="checkbox"/> Dressing change <input type="checkbox"/> Med administration <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ (note if something is multi-dose vial)
--/--/--	_____	<input type="checkbox"/> Flush <input type="checkbox"/> Dressing change <input type="checkbox"/> Med administration <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ (note if something is multi-dose vial)

Other medications administered parenterally (not via central line)

Date	Staff	Route/site	Medications administered
--/--/--	_____	<input type="checkbox"/> IV _____ <input type="checkbox"/> IM _____ <input type="checkbox"/> SC _____	_____ (note if something is multi-dose vial)
--/--/--	_____	<input type="checkbox"/> IV _____ <input type="checkbox"/> IM _____ <input type="checkbox"/> 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
_____	<input type="checkbox"/> IV <input type="checkbox"/> IM	_____	__ / __ / __	__ : __
_____	<input type="checkbox"/> IV <input type="checkbox"/> IM	_____	__ / __ / __	__ : __

Intra-op Abx use Yes No

Name	Route	Dose	Date	Time start
_____	<input type="checkbox"/> IV <input type="checkbox"/> IM	_____	__ / __ / __	__ : __
_____	<input type="checkbox"/> IV <input type="checkbox"/> IM	_____	__ / __ / __	__ : __

Intra-op Abx use Yes No

Name	Route	Dose	Date	Time start
_____	<input type="checkbox"/> IV <input type="checkbox"/> IM	_____	__ / __ / __	__ : __
_____	<input type="checkbox"/> IV <input type="checkbox"/> 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
		<input type="checkbox"/> IV <input type="checkbox"/> IM		
		<input type="checkbox"/> IV <input type="checkbox"/> IM		
		<input type="checkbox"/> IV <input type="checkbox"/> IM		
		<input type="checkbox"/> IV <input type="checkbox"/> IM		
		<input type="checkbox"/> IV <input type="checkbox"/> IM		

Transfusions during surgery?

Type	Dose	Type	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
		<input type="checkbox"/> IV <input type="checkbox"/> IM		
		<input type="checkbox"/> IV <input type="checkbox"/> IM		
		<input type="checkbox"/> IV <input type="checkbox"/> IM		
		<input type="checkbox"/> IV <input type="checkbox"/> 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
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO	___/___/___
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO	___/___/___
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO	___/___/___
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
___/___/___	_____	_____	_____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
___/___/___	_____	_____	_____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> 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

__/__/__	__/__/__	<input type="checkbox"/> Urinary catheter <input type="checkbox"/> Suprapubic catheter <input type="checkbox"/> Temporary relief <input type="checkbox"/> Other _____
__/__/__	__/__/__	<input type="checkbox"/> Urinary catheter <input type="checkbox"/> Suprapubic catheter <input type="checkbox"/> Temporary relief <input type="checkbox"/> Other _____

If catheter was accessed or maneuvered, provide information

Date accessed	Staff	Procedure	Bag drain
__/__/__	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
__/__/__	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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	...
__/__/__	_____	<input type="checkbox"/> Culture	_____	_____

		<input type="checkbox"/> PCR <input type="checkbox"/> Histopath <input type="checkbox"/> Other_____		
-- / - / - -	_____	<input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> Histopath <input type="checkbox"/> Other_____	_____	_____

I. Patient treatment and outcome

Antibiotic received

Name	Route	Dose	Date start	Date stop
_____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO	_____	-- / - / - -	-- / - / - -
_____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO	_____	-- / - / - -	-- / - / - -

Patient outcome of this hospitalization?

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