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?

|  |  |  |  |
| --- | --- | --- | --- |
| **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?

|  |  |  |
| --- | --- | --- |
| **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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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**

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

|  |  |  |
| --- | --- | --- |
| **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