Undetermined source for *Salmonella* Infantis infections among detention center inmates — South Carolina, 2016

*Chart abstraction form to be used by federal employees*

**MEDICAL RECORD ABSTRACTION FORM**

**CDC ID:** **[ ] [ ] [ ] [ ]  Date:** [ ] [ ] /[ ] [ ] /[ ] [ ]   **Data collector** **initials: \_\_\_\_\_**

1. **Patient’s Name:**
2. **Unit:**
3. **DOB:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]
4. **When was the first documented episode of diarrhea:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]
5. **Admission date:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]
6. **Discharge date:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]

**MEDICAL RECORD ABSTRACTION FORM**

**CDC ID:** **[ ] [ ] [ ] [ ]  Date:** [ ] [ ] /[ ] [ ] /[ ] [ ]   **Data collector** **initials: \_\_\_\_\_**

|  |
| --- |
|  |
| **Part 1. Demographic Information** |
| **1. Gender:** [ ] M [ ] F  [ ] Unknown | 1. **Race** *(check all that apply)*

[ ] American Indian or Alaska Native [ ] Asian[ ] Black or African American [ ] White[ ] Native Hawaiian/other Pacific Islander [ ] Unknown[ ] Other race |
| 1. **Ethnicity**

[ ] Hispanic or Latino[ ] Not Hispanic or Latino[ ] Unknown | 1. **Unit of residence:** \_\_\_\_\_\_\_\_\_\_\_\_ [ ] Unknown
 |
| 1. **Underlying conditions** *(check all that apply)* [ ] None [ ] Unknown

|  |  |
| --- | --- |
| [ ] Asplenia[ ] Autoimmune disease[ ] Cancer, any (incl. leukemia/lymphoma)[ ] Chronic kidney disease (with or without dialysis)[ ] Chronic liver disease (incl. cirrhosis)[ ] Chronic pulmonary disease (incl. COPD/emphysema, asthma)[ ] Congestive heart failure[ ] Connective tissue disease[ ] Diabetes mellitus[ ] Gastroesophageal reflux disease (GERD)[ ] HIV/AIDS | [ ] Ischemic heart disease/Myocardial infarction/Peripheral vascular dz[ ] IVDU in past year[ ] Peptic ulcer disease[ ] Pregnancy (current)[ ] Prosthetic device or vascular graft[ ] Recurrent cystitis or urinary tract infection[ ] Sickle cell disease[ ] Smoking in past year[ ] Transplant (incl. solid organ, hematopoietic stem cell, bone marrow)[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 |
| 1. **How long did the patient remain in the medical unit?**

**\_\_\_\_\_\_\_\_\_** [ ] Hours [ ] Days [ ] Did not go to medical unit [ ] Unknown  |
| 1. **In the 30 days prior to illness onset, did the patient receive any form of antacid?:** *(check all that apply)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Y** | **N** | **Unk** |  |  |
| [ ]  | [ ]  | [ ]  | a. Calcium carbonate (may be taken for heartburn/indigestion)? *[Common medication names include Tums, Maalox, Mylanta, Rolaids]* | Name(s): \_\_\_\_\_\_\_\_\_ |
| [ ]  | [ ]  | [ ]  | b. H2 receptor blocker (may be taken for peptic ulcer disease)? [Common medication names include cimetidine (Tagamet), ranitidine (Zantac), famotidine (Pepcid), nizatidine (Axid)] | Name(s): \_\_\_\_\_\_\_\_\_ |
| [ ]  | [ ]  | [ ]  | c. Proton pump inhibitor (may be taken for peptic ulcer disease or gastroesophageal reflux disease [GERD])? *[Common medication names include omeprazole (Prilosec), pantoprazole (Protonix), lansoprazole (Prevacid), esomeprazole (Nexium)]*d.Other                                                                                               | Name(s): \_\_\_\_\_\_\_\_\_Name(s): \_\_\_\_\_\_\_\_\_ |

1. **In the 30 days prior to illness onset, did the patient receive any of the following?:** *(check all that apply)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | [ ]  | [ ]  | a. Any form of radiation therapy? |  |
| [ ]  | [ ]  | [ ]  | b. Abdominal surgery (e.g. removal of appendix, removal of gallbladder, any surgery of the stomach, small intestine or large intestine) | Notes: \_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  | [ ]  | [ ]  | c. Any oral or intravenous (IV) steroid? *[Common steroids include prednisone, prednisolone, methylprednisolone, hydrocortisone, dexamethasone]* | Name(s): \_\_\_\_\_\_\_\_\_ |
| [ ]  | [ ]  | [ ]  | d. Any other oral, intravenous (IV), or injectable immune-suppressing medication? *[Common medication names include azathioprine, cyclosporine, methotrexate, tacrolimus (FK 506), sirolimus, rituximab, infliximab, etanercept, or other chemotherapy]* | Name(s): \_\_\_\_\_\_\_\_\_ |
| [ ]  | [ ]  | [ ]  | e. Probiotics | Name(s): \_\_\_\_\_\_\_\_\_ |

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**MEDICAL RECORD ABSTRACTION FORM**

**CDC ID:** **[ ] [ ] [ ] [ ]  Date:** [ ] [ ] /[ ] [ ] /[ ] [ ]   **Data collector** **initials: \_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **In the 30 days prior to illness onset, did the patient receive any antimicrobial medication(s)?**

[ ]  No antimicrobial medication was given[ ]  Yes antimicrobial medication was given (please list them below)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug no.** | **Drug name** | **Route** | **Start date** *(mm/dd/yy)* | **End date** *(mm/dd/yy)* | **Other Comments** |
| 1  |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 2 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 3 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 4 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 5 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 6 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 7 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |

  |

**CDC ID:** **[ ] [ ] [ ] [ ]  Date:** [ ] [ ] /[ ] [ ] /[ ] [ ]   **Data collector** **initials: \_\_\_\_\_**

|  |
| --- |
| **Part 2. Medical unit Information** |
| 1. **When was the first documented episode of diarrhea?** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]
2. **When was the patient first seen in the medical unit:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]
3. **What was the highest documented temperature at the time of medical unit visit?** \_\_\_\_\_\_°C ­­­\_\_\_\_\_\_\_°F [ ] Unknown
4. **What were the documented clinical signs and symptoms?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptom | Yes/No/Don’t Know | Onset Date | Resolution Date (only applicable for highlighted symptoms, V/D/F) | Notes |
| Nausea | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |
| Vomiting | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Diarrhea | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Bloody diarrhea | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |
| Abdominal pain/cramping | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |
| Fever | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Chills | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |
| Headache | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |
| Body aches | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |
| Fatigue/Tiredness | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |
| Dizziness | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Yes | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |  |

**MEDICAL RECORD ABSTRACTION FORM****CDC ID:** **[ ] [ ] [ ] [ ]  Date:** [ ] [ ] /[ ] [ ] /[ ] [ ]   **Data collector** **initials: \_\_\_\_\_**1. **Was any treatment given to the patient in the medical unit?** [ ] Yes [ ] No [ ] Unknown
	1. If yes, please select all that apply:

 [ ] Probiotics (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Analgesic/antipyretic medication (specify: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Antidiarrheal medication (specify: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Antiemetic medication (specify: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Antimicrobial medication (specify: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Oral fluids for rehydration (specify: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Intravenous fluids for rehydration (specify: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. **If any antimicrobial medication(s) were given to treat the gastrointestinal illness, please list them below. If none were given, please mark that none were given.**

[ ]  No antimicrobial medication was ever given

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug no.** | **Drug name** | **Route** | **First date** *(mm/dd/yy)* | **Last date** *(mm/dd/yy)* | **Other Comments** |
| 1  |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 2 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 3 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 4 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 5 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 6 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |
| 7 |  | [ ] IV [ ] IM[ ] PO [ ] INH | \_\_\_/\_\_\_/\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |  |

1. **What diagnoses were given to the patient in the medical unit?**

|  |  |
| --- | --- |
| **No.** | **Diagnoses** |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| 6 |  |
| 7 |  |

1. **Was this patient ever hospitalized?** [ ] Yes [ ] No [ ] Unknown
	1. *If yes, on what day was he/she admitted?* [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]
	2. *When was he/she discharged?* [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]
	3. *What were the discharge diagnoses?*

|  |  |
| --- | --- |
| **No.** | **Discharge diagnoses** |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| 6 |  |
| 7 |  |

1. **Were any specimens collected for laboratory testing at the medical unit?** [ ] Yes [ ] No [ ] Unknown
	1. *If yes, please proceed to Part 3 of this form.*
	2. *If no,* ***end of survey.***
 |

**MEDICAL RECORD ABSTRACTION FORM**

**CDC ID:** **[ ] [ ] [ ] [ ]  Date:** [ ] [ ] /[ ] [ ] /[ ] [ ]   **Data collector** **initials: \_\_\_\_\_**

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| --- |
| **Part 3. Laboratory testing – Positive Culture Data** |
| 1. **Were cultures done?** [ ] Yes [ ] No [ ] Unknown

*If “Yes,” complete the table below.***Positive Cultures**

| **Culture No.** | **Specimen ID****--------------------****Alternate ID** | **Specimen** | **Collect date (mm/dd/yy)** | **Positive for any pathogen?** | **Pathogens identified**  | **AST data recorded in AST Table?** |
| --- | --- | --- | --- | --- | --- | --- |
| 1 |  | [ ] Stool [ ] Blood [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ / \_\_\_ / \_\_\_ | [ ] Y [ ] N [ ] Unk | Path1 \_\_\_\_\_\_\_\_Path2 \_\_\_\_\_\_\_\_Path3 \_\_\_\_\_\_\_\_ | Path1: [ ] Y [ ] NPath2: [ ] Y [ ] NPath3: [ ] Y [ ] N |
|  |
| 2 |  | [ ] Stool [ ] Blood [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ / \_\_\_ / \_\_\_ | [ ] Y [ ] N [ ] Unk | Path1 \_\_\_\_\_\_\_\_Path2 \_\_\_\_\_\_\_\_Path3 \_\_\_\_\_\_\_\_ | Path1: [ ] Y [ ] NPath2: [ ] Y [ ] NPath3: [ ] Y [ ] N |
|  |
| 3 |  | [ ] Stool [ ] Blood [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ / \_\_\_ / \_\_\_ | [ ] Y [ ] N [ ] Unk | Path1 \_\_\_\_\_\_\_\_Path2 \_\_\_\_\_\_\_\_Path3 \_\_\_\_\_\_\_\_ | Path1: [ ] Y [ ] NPath2: [ ] Y [ ] NPath3: [ ] Y [ ] N |
|  |
| 4 |  | [ ] Stool [ ] Blood [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ / \_\_\_ / \_\_\_ | [ ] Y [ ] N [ ] Unk | Path1 \_\_\_\_\_\_\_\_Path2 \_\_\_\_\_\_\_\_Path3 \_\_\_\_\_\_\_\_ | Path1: [ ] Y [ ] NPath2: [ ] Y [ ] NPath3: [ ] Y [ ] N |
|  |
| 5 |  | [ ] Stool [ ] Blood [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ / \_\_\_ / \_\_\_ | [ ] Y [ ] N [ ] Unk | Path1 \_\_\_\_\_\_\_\_Path2 \_\_\_\_\_\_\_\_Path3 \_\_\_\_\_\_\_\_ | Path1: [ ] Y [ ] NPath2: [ ] Y [ ] NPath3: [ ] Y [ ] N |
|  |
| 6 |  | [ ] Stool [ ] Blood [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ / \_\_\_ / \_\_\_ | [ ] Y [ ] N [ ] Unk | Path1 \_\_\_\_\_\_\_\_Path2 \_\_\_\_\_\_\_\_Path3 \_\_\_\_\_\_\_\_ | Path1: [ ] Y [ ] NPath2: [ ] Y [ ] NPath3: [ ] Y [ ] N |
|  |
| 7 |  | [ ] Stool [ ] Blood [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ / \_\_\_ / \_\_\_ | [ ] Y [ ] N [ ] Unk | Path1 \_\_\_\_\_\_\_\_Path2 \_\_\_\_\_\_\_\_Path3 \_\_\_\_\_\_\_\_ | Path1: [ ] Y [ ] NPath2: [ ] Y [ ] NPath3: [ ] Y [ ] N |
|  |
| 8 |  | [ ] Stool [ ] Blood [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ / \_\_\_ / \_\_\_ | [ ] Y [ ] N [ ] Unk | Path1 \_\_\_\_\_\_\_\_Path2 \_\_\_\_\_\_\_\_Path3 \_\_\_\_\_\_\_\_ | Path1: [ ] Y [ ] NPath2: [ ] Y [ ] NPath3: [ ] Y [ ] N |
|  |

 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEDICAL RECORD ABSTRACTION FORM****CDC ID:** **[ ] [ ] [ ] [ ]  Date:** [ ] [ ] /[ ] [ ] /[ ] [ ]   **Data collector** **initials: \_\_\_\_\_**1. **Table 4: Antimicrobial Sensitivity**

**Complete the AST table below by filling in the culture no. from the positive culture table, checking the appropriate pathogen, and circling the corresponding AST results.**

|  |  |  |  |
| --- | --- | --- | --- |
| Culture No. \_\_\_\_\_\_\_ Pathogen No. \_\_\_\_\_\_\_ | Culture No. \_\_\_\_\_\_\_ Pathogen No. \_\_\_\_\_\_\_ | Culture No. \_\_\_\_\_\_\_ Pathogen No. \_\_\_\_\_\_\_ | Culture No. \_\_\_\_\_\_\_ Pathogen No. \_\_\_\_\_\_\_ |
| Amoxicillin-clavulanic acid | S I R N  | Amoxicillin-clavulanic acid | S I R N  | Amoxicillin-clavulanic acid | S I R N  | Amoxicillin-clavulanic acid | S I R N  |
| Ampicillin | S I R N  | Ampicillin | S I R N  | Ampicillin | S I R N  | Ampicillin | S I R N  |
| Azithromycin | S I R N  | Azithromycin | S I R N  | Azithromycin | S I R N  | Azithromycin | S I R N  |
| Cefoxitin | S I R N  | Cefoxitin | S I R N  | Cefoxitin | S I R N  | Cefoxitin | S I R N  |
| Ceftiofur | S I R N  | Ceftiofur | S I R N  | Ceftiofur | S I R N  | Ceftiofur | S I R N  |
| Ceftriaxone | S I R N  | Ceftriaxone | S I R N  | Ceftriaxone | S I R N  | Ceftriaxone | S I R N  |
| Chloramphenicol | S I R N  | Chloramphenicol | S I R N  | Chloramphenicol | S I R N  | Chloramphenicol | S I R N  |
| Ciprofloxacin | S I R N  | Ciprofloxacin | S I R N  | Ciprofloxacin | S I R N  | Ciprofloxacin | S I R N  |
| Gentamicin | S I R N  | Gentamicin | S I R N  | Gentamicin | S I R N  | Gentamicin | S I R N  |
| Kanamycin | S I R N  | Kanamycin | S I R N  | Kanamycin | S I R N  | Kanamycin | S I R N  |
| Streptomycin | S I R N  | Streptomycin | S I R N  | Streptomycin | S I R N  | Streptomycin | S I R N  |
| Sulfamethoxazole | S I R N  | Sulfamethoxazole | S I R N  | Sulfamethoxazole | S I R N  | Sulfamethoxazole | S I R N  |
| Tetracycline | S I R N  | Tetracycline | S I R N  | Tetracycline | S I R N  | Tetracycline | S I R N  |
|  | S I R N  |  | S I R N  |  | S I R N  |  | S I R N  |
|  | S I R N  |  | S I R N  |  | S I R N  |  | S I R N  |
|  | S I R N  |  | S I R N  |  | S I R N  |  | S I R N  |

 |

1. **Culture-Independent Diagnostic Tests:**

|  |  |
| --- | --- |
| **Test** | **Results & Notes** |
|  |  |
|  |  |
|  |  |
|  |  |

**END OF ABSTRACTION**