CDC Resident ID: ___-___-_____

Nursing Home Prevalence Survey: Resident Antimicrobial Use Form

Survey Date: ☐☐/☐☐/☐☐☐☐ Date Form Completed: ☐☐/☐☐/☐☐☐☐ Data Collected by: _____ (initials)

Complete the Antimicrobial Drug Table below for all antimicrobial drugs given on the survey date or the calendar day prior to the survey date.

One record should be entered for each drug/route combination (e.g., separate entries for vancomycin IV and vancomycin PO)

Resident name:_____ Medical Record Number: _____ **FOR LOCAL USE ONLY, WILL NOT BE TRANSMITTED TO CDC**

	Drug name	Route	Rationale	Treatment site	First date (mm/dd/yyyy)	End date (mm/dd/yyyy), or # days	Total dose
1		☐ IV ☐ IM ☐ PO/ENT ☐ INH	☐ Tx. active infection ☐ Medical prophylaxis ☐ Surgical prophylaxis ☐ Non-infectious ☐ Not documented	☐ Bloodstream ☐ Bone/joint ☐ Ear, nose, mouth ☐ Eye ☐ Gastrointestinal ☐ Genital tract ☐ Respiratory tract ☐ Sepsis ☐ Skin or wound ☐ Urinary tract ☐ Other …… ☐ Not documented	____/____/_____	____/____/_____ _____ days	_____ ☐ g ☐ mg ☐ other….....
2		☐ IV ☐ IM ☐ PO/ENT ☐ INH	☐ Tx. active infection ☐ Medical prophylaxis ☐ Surgical prophylaxis ☐ Non-infectious ☐ Not documented	☐ Bloodstream ☐ Bone/joint ☐ Ear, nose, mouth ☐ Eye ☐ Gastrointestinal ☐ Genital tract ☐ Respiratory tract ☐ Sepsis ☐ Skin or wound ☐ Urinary tract ☐ Other …… ☐ Not documented	____/____/_____	____/____/_____ _____ days	_____ ☐ g ☐ mg ☐ other….....
3		☐ IV ☐ IM ☐ PO/ENT ☐ INH	☐ Tx. active infection ☐ Medical prophylaxis ☐ Surgical prophylaxis ☐ Non-infectious ☐ Not documented	☐ Bloodstream ☐ Bone/joint ☐ Ear, nose, mouth ☐ Eye ☐ Gastrointestinal ☐ Genital tract ☐ Respiratory tract ☐ Sepsis ☐ Skin or wound ☐ Urinary tract ☐ Other …… ☐ Not documented	____/____/_____	____/____/_____ _____ days	_____ ☐ g ☐ mg ☐ other….....
4		☐ IV ☐ IM ☐ PO/ENT ☐ INH	☐ Tx. active infection ☐ Medical prophylaxis ☐ Surgical prophylaxis ☐ Non-infectious ☐ Not documented	☐ Bloodstream ☐ Bone/joint ☐ Ear, nose, mouth ☐ Eye ☐ Gastrointestinal ☐ Genital tract ☐ Respiratory tract ☐ Sepsis ☐ Skin or wound ☐ Urinary tract ☐ Other …… ☐ Not documented	____/____/_____	____/____/_____ _____ days	_____ ☐ g ☐ mg ☐ other….....

****FORM IS COMPLETE****

CDC Resident ID: ___-___-_____

5		☐ IV ☐ IM ☐ PO/ENT ☐ INH	☐ Tx. active infection ☐ Medical prophylaxis ☐ Surgical prophylaxis ☐ Non-infectious ☐ Not documented	☐ Bloodstream ☐ Bone/joint ☐ Ear, nose, mouth ☐ Eye ☐ Gastrointestinal ☐ Genital tract	☐ Respiratory tract ☐ Sepsis ☐ Skin or wound ☐ Urinary tract ☐ Other …… ☐ Not documented	____/____/_____	____/____/_____ _____ days	_____ ☐ g ☐ mg ☐ other…..…

Using information from the table check all scenarios below that apply to this resident and follow the form completion instructions:

☐ Any drug with the treatment site = "Urinary Tract" → Complete Resident Infection Form sections A and B

☐ Metronidazole, Fidaxomixin, or oral (PO) Vancomycin with treatment site = Gastrointestinal → Complete Resident Infection Form sections A and E

******FORM IS COMPLETE******