

**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
<b>Grafts</b>					
<b>Staples/sutures</b>					
<b>Drains</b>					

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

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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,
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	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