

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY**

Form Approved  
OMB No. 0920-0852  
Exp. Date 12/31/2016

**PATIENT INFORMATION FORM**

CDC ID: - Survey date: // Data collector initials: \_\_\_\_\_

If data collected on survey date, enter data collection time: : am pm

OR  Data collection done retrospectively

I. Identifiers <i>(for Primary Team and EIP Team use only; identifiers are not transmitted to CDC)</i>	
Patient name: _____ <small>(Last, First, MI)</small>	Date of birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Hospital name: _____	Hospital unit name: _____
Room number: _____	Medical record no.: _____

II. Demographic information			
Age: _____ <input type="checkbox"/> yrs <input type="checkbox"/> mos <input type="checkbox"/> dys <input type="checkbox"/> Unknown	Admission date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown	CDC location code: _____		
<b>Race <i>(check all that apply)</i>:</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> Asian	<input type="checkbox"/> White <input type="checkbox"/> Other race <input type="checkbox"/> Unknown	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	<b>Primary Payer:</b> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> No charge <input type="checkbox"/> Other <input type="checkbox"/> Unknown

III. Weight and height
<b>For infants in neonatal locations (e.g., CC-NURS, CCS-NURS, S-NURS, W-NURS, W-LDRP):</b> Birthweight: _____ pounds _____ ounces OR _____ grams OR <input type="checkbox"/> Birthweight unknown
<b>For other patients:</b> BMI: _____ OR <input type="checkbox"/> Unknown <i>(if BMI unknown, enter Height and Weight below)</i> Height: _____ feet _____ inches OR _____ cm OR <input type="checkbox"/> Height unknown Weight: _____ pounds _____ ounces OR _____ kilograms OR <input type="checkbox"/> Weight unknown

IV. Devices	
Urinary catheter: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Ventilator: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Central line: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <i>If "Yes," indicate how many lines: <input type="checkbox"/>1 line <input type="checkbox"/> &gt;1 line <input type="checkbox"/> Unknown</i>	

V. Antimicrobials	
Antimicrobials administered <u>or</u> scheduled to be administered:	
On the survey date:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
On the day before the survey date:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

Public reporting burden of this collection of information is estimated to average 17 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0852).

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**VI. Follow-up information**

Enter date of follow-up data collection: //

Hospital discharge date: // OR check one: Unknown Still in hospital

Patient outcome at time of hospital discharge: Survived Died Unknown Still in hospital

**FORM IS COMPLETE**