

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY
ANTIMICROBIAL QUALITY ASSESSMENT (AQUA) FORM 1: CASE ELIGIBILITY**

CDCID: -

Date: //

Data collector initials: _____

Instructions: Refer to question 5 on the Antimicrobial Use Form (AUF); complete each section below, or check "Not applicable based on AUF" if the patient is not eligible based on question 5 of the AUF.

A. Patient age eligibility

1. Was the patient ≥ 1 year old on the survey date or day prior?

- No \rightarrow NOT eligible for ANY AQUA Form. Go to HAI Form.
 Yes \rightarrow MAY be eligible for one or more AQUA Forms.

B. VANCOMYCIN eligibility

Not applicable based on AUF

2. Patient ≥ 1 year old and received vancomycin IV for infection treatment on the survey date or day prior?

- No \rightarrow NOT eligible for AQUA Vancomycin Form.
 Yes \rightarrow Eligible for AQUA Vancomycin Form.

C. FLUOROQUINOLONE eligibility

Not applicable based on AUF

3. Patient ≥ 18 years old and received a fluoroquinolone for infection treatment on the survey date or day prior?

- No \rightarrow NOT eligible for AQUA Fluoroquinolone Form.
 Yes \rightarrow Eligible for AQUA Fluoroquinolone Form.

D. COMMUNITY-ACQUIRED PNEUMONIA (CAP) eligibility

Not applicable based on AUF

4. In patients ≥ 1 year old given an antimicrobial drug(s) for site code "PNE" with onset "C" on the survey date or day prior, is there documentation in the medical record of any of the following conditions?

- Nursing home or long term care facility or long term acute care hospital residence prior to survey hospital admission
 Hospitalized ≥ 2 days in the 90 days prior to admission
 Received IV antimicrobials in the 30 days prior to admission
 Received cancer chemotherapy in the 30 days prior to admission
 Received wound care in the 30 days prior to admission
 Chronic hemodialysis
 Home mechanical ventilation
 AIDS
 Solid organ, bone marrow, or stem cell transplant
 Long-term (>30 days) high-dose corticosteroid or other immunosuppressive treatment
 Other congenital or acquired immunodeficiency
 Cystic fibrosis
 None

5. Based on question 4, confirm patient eligibility for the AQUA CAP Form:

- ≥ 1 condition checked in question 4 \rightarrow NOT eligible for AQUA CAP Form.
 "None" checked in question 4 \rightarrow Eligible for AQUA CAP Form.

E. URINARY TRACT INFECTION (UTI) eligibility

Not applicable based on AUF

6. Patient ≥ 1 year old and site code "UTI" with onset "C," "L" or "O" for any antimicrobial drug on the survey date or day prior?

- No \rightarrow NOT eligible for AQUA UTI Form.
 Yes \rightarrow Eligible for AQUA UTI Form.

F. AQUA eligibility summary

7. Check all AQUA Forms that need to be completed for this patient:

- AQUA Vancomycin AQUA Fluoroquinolone AQUA CAP AQUA UTI None

8. Confirm next steps in data collection:

- If "None" is checked in question 7 \rightarrow Antimicrobial use data collection is complete. Go to HAI Form.
 If any of the AQUA Form boxes are checked in question 7 \rightarrow Complete AQUA Form 2: General Patient Assessment, then complete the appropriate AQUA Forms 3a-3d. HAI Form also required.

FORM IS COMPLETE

HAI & ANTIMICROBIAL USE PREVALENCE SURVEY

ANTIMICROBIAL QUALITY ASSESSMENT (AQUA) FORM 2: GENERAL PATIENT ASSESSMENT

CDC ID: -

Date: //

Data collector initials: _____

Healthcare exposures

1. Indicate the location from which the patient was admitted to the survey hospital (check one):

- Private residence Long term care/SNF LTACH Another acute care hospital Homeless Incarcerated
 Other _____ Unknown

2. In the 30 days prior to admission to the survey hospital, did the patient receive (check all that apply):

- IV antimicrobials Cancer chemotherapy Wound care Chronic hemodialysis Surgery
 None Unknown

3. Was the patient hospitalized in an acute care hospital for ≥2 days in the 90 days prior to this admission?

- Yes No Unknown

Antimicrobial allergies

4. Is an antimicrobial drug allergy recorded in the medical record? Yes No Unknown

4a. If yes, specify drug class or classes to which patient is allergic, and reaction(s):

Drug class	Nausea, vomiting and/or diarrhea	Hives or urticaria	Other skin rash	Wheezing, throat tightness, trouble breathing	Angio-edema or face swelling	Anaphylaxis	Not specified	Other (specify)
<input type="checkbox"/> Penicillins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Macrolides	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Fluoroquinolones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Vancomycin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes _____

Underlying conditions

5. Check all that apply: None: Unknown:

- | | |
|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Kidney stones/nephrolithiasis |
| <input type="checkbox"/> Alcoholism in past year | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asplenia | <input type="checkbox"/> Lymphoma or multiple myeloma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> MRSA colonization or infection history |
| <input type="checkbox"/> Cerebrovascular disease/stroke (except hemiplegia) | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Chronic cognitive deficit | <input type="checkbox"/> Neutropenia (absolute neutrophil count <500 cells / μL) |
| <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)/emphysema | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Chronic lung disease (other than COPD/emphysema, asthma) | <input type="checkbox"/> Recurrent cystitis or urinary tract infection |
| <input type="checkbox"/> Chronic steroid or other immunosuppressive therapy | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Congenital urinary tract abnormality (not VUR) | <input type="checkbox"/> Smoking in home or living environment (other than patient) |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Smoking in past year (patient) |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Solid tumor malignancy, metastatic (not urologic/renal) |
| <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Solid tumor malignancy, not metastatic (not urologic/renal) |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Spinal cord injury or paraplegia or quadriplegia |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Transplant, hematopoietic stem cell or bone marrow |
| <input type="checkbox"/> Diabetes mellitus with complications | <input type="checkbox"/> Transplant, solid organ |
| <input type="checkbox"/> Diabetes mellitus without complications | <input type="checkbox"/> Ureteral stent |
| <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Urinary tract abnormality, not otherwise specified |
| <input type="checkbox"/> HIV without AIDS | <input type="checkbox"/> Urostomy or nephrostomy |
| <input type="checkbox"/> IVDU in past year | <input type="checkbox"/> Urologic or renal malignancy |
| | <input type="checkbox"/> Vesicoureteral reflux (VUR) |

CDCID: -

Infections present during the hospitalization

6. Complete table: No infections:

No.	Infection (code)	Onset date	Signs and symptoms documented in medical record (check all that apply)			Was infection treated with antimicrobials?
1	_____ SSI? <input type="checkbox"/> Y	<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hosp day 3 <input type="checkbox"/> In hospital, day unk <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Unknown	<input type="checkbox"/> Mental status change <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging <input type="checkbox"/> None	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2	_____ SSI? <input type="checkbox"/> Y	<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hosp day 3 <input type="checkbox"/> In hospital, day unk <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Unknown	<input type="checkbox"/> Mental status change <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging <input type="checkbox"/> None	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3	_____ SSI? <input type="checkbox"/> Y	<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hosp day 3 <input type="checkbox"/> In hospital, day unk <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Unknown	<input type="checkbox"/> Mental status change <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging <input type="checkbox"/> None	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4	_____ SSI? <input type="checkbox"/> Y	<input type="checkbox"/> Before hospitalization <input type="checkbox"/> Hospital days 1-2 <input type="checkbox"/> On/after hosp day 3 <input type="checkbox"/> In hospital, day unk <input type="checkbox"/> Unknown	<input type="checkbox"/> Cough or dyspnea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Unknown	<input type="checkbox"/> Mental status change <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Positive imaging <input type="checkbox"/> None	<input type="checkbox"/> Pus, drainage, abscess <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

More infections than fit in the table:

Infection codes: BJI, BSI, CDI, CNS, CVI, DIS, ENT, GTI, HEB, IAB, LRI, PNE, REP, SST, UND, UNK, UTI

Severity of illness

7. Was the patient in an ICU at any time during the hospitalization? Yes No Unknown

7a. If yes, enter the dates of the first ICU admission during the hospitalization:

ICU admission date: ___ / ___ / ___ or Unknown ICU discharge date: ___ / ___ / ___ or Unknown

8. Complete the table using data from the first 24-hour period of treatment during the hospitalization:

Parameter	First day, CAP treatment:	First day, IV vancomycin:	First day, fluoroquinolone:	First day, UTI treatment
	___ / ___ / ___ or <input type="checkbox"/> NA	___ / ___ / ___ or <input type="checkbox"/> NA	___ / ___ / ___ or <input type="checkbox"/> NA	___ / ___ / ___ or <input type="checkbox"/> NA
Temperature:				
Highest:	___ °C <input type="checkbox"/> °F or <input type="checkbox"/> Unk	___ °C <input type="checkbox"/> °F or <input type="checkbox"/> Unk	___ °C <input type="checkbox"/> °F or <input type="checkbox"/> Unk	___ °C <input type="checkbox"/> °F or <input type="checkbox"/> Unk
Lowest:	___ °C <input type="checkbox"/> °F or <input type="checkbox"/> Unk	___ °C <input type="checkbox"/> °F or <input type="checkbox"/> Unk	___ °C <input type="checkbox"/> °F or <input type="checkbox"/> Unk	___ °C <input type="checkbox"/> °F or <input type="checkbox"/> Unk
Heart rate:				
Highest:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Lowest:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Respiratory:				
Highest resp rate:	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk	___ bpm or <input type="checkbox"/> Unk
Lowest PaCO ₂ :	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
Mechanical vent:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
WBC count:				
Highest:	___ cells/mm ³ or <input type="checkbox"/> Unk	___ cells/mm ³ or <input type="checkbox"/> Unk	___ cells/mm ³ or <input type="checkbox"/> Unk	___ cells/mm ³ or <input type="checkbox"/> Unk
Lowest:	___ cells/mm ³ or <input type="checkbox"/> Unk	___ cells/mm ³ or <input type="checkbox"/> Unk	___ cells/mm ³ or <input type="checkbox"/> Unk	___ cells/mm ³ or <input type="checkbox"/> Unk
Highest %bands:	___ % or <input type="checkbox"/> Unk	___ % or <input type="checkbox"/> Unk	___ % or <input type="checkbox"/> Unk	___ % or <input type="checkbox"/> Unk
Blood pressure:				
Lowest systolic BP:	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
Lowest mean arterial pressure:	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk	___ mmHg or <input type="checkbox"/> Unk
On vasopressors:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Lactate	___ <input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L or Unk <input type="checkbox"/>	___ <input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L or Unk <input type="checkbox"/>	___ <input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L or Unk <input type="checkbox"/>	___ <input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L or Unk <input type="checkbox"/>

FORM IS COMPLETE → Go to AQUA Forms 3a-3d

HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA) FORM 3a: VANCOMYCIN

CDC ID: -

Date: //

Data collector initials: _____

Laboratory testing

1. Complete the table for POSITIVE cultures collected from the date 5 days before vancomycin IV first date (5 days before: ___/___/___) through the vancomycin IV last date (___/___/___): No positive cultures: Culture data unknown:

No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Pathogens identified (insert code)	Pathogen susceptible to oxacillin, methicillin or ceftioxin?	Pathogen susceptible to penicillin or ampicillin?	Pathogen susceptible to vancomycin?	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
7	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
8	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
9	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
10	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

CDC ID: -

2. Complete the table for NEGATIVE cultures collected from 5 days before vancomycin IV first date (5 days before: ___/___/___) through the vancomycin IV last date (___/___/___):

No negative cultures: Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

No.	Collect date (mm/dd/yy)	Specimen
6	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
7	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
8	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
9	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
10	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

More negative cultures than fit in the table:

3. Was an MRSA surveillance culture(s) done during this admission? Yes No Unknown

3a. If yes to question 3, were any MRSA surveillance cultures positive for MRSA during this admission?

Yes No Unknown

4. Complete the table for non-culture microbiology tests (positive and negative) collected from 5 days before vancomycin IV first date through the vancomycin IV last date:

No non-culture tests done: Non-culture test data unknown:

No.	Collect date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____

More tests than fit in the table:

Post-discharge antimicrobial treatment

5. Was vancomycin IV prescribed at discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge)? Yes No Unknown

5a. If yes to question 5, what is the total duration of the post-discharge vancomycin IV prescription?

_____ days, OR the prescription end date is ___/___/_____, OR Duration is unknown

FORM IS COMPLETE

HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA) FORM 3b: FLUOROQUINOLONE

CDC ID: - Date: // Data collector initials: _____ Drugs given: Ciprofloxacin Levofloxacin Moxifloxacin

Laboratory testing									
1. Complete the table for POSITIVE cultures collected from the date 5 days before fluoroquinolone first date (5 days before: ___/___/___) through the fluoroquinolone last date (___/___/___): No positive cultures: <input type="checkbox"/> Culture data unknown: <input type="checkbox"/>									
No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Pathogens identified (insert code)	Pathogen susceptible to ciprofloxacin?	Pathogen susceptible to levofloxacin?	Pathogen susceptible to moxifloxacin?	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
7	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
8	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
9	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
10	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

CDCID: -

2. Complete the table for NEGATIVE cultures collected from 5 days before fluoroquinolone first date (5 days before: ___/___/___) through the fluoroquinolone last date (___/___/___):

No negative cultures: Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

No.	Collect date (mm/dd/yy)	Specimen
6	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
7	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
8	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
9	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
10	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

More negative cultures than fit in the table:

3. Complete the table for non-culture microbiology tests (positive and negative) collected from 5 days before fluoroquinolone first date through the fluoroquinolone last date:

No non-culture tests done: Non-culture test data unknown:

No.	Collect date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____

More tests than fit in the table:

IV to PO conversion

4. Between the fluoroquinolone first date and the fluoroquinolone last date, was there a conversion from IV to PO fluoroquinolone administration? Check one:

Yes → Date of conversion from IV to PO administration: ___/___/___ or Date unknown

No → For example, patient received only IV fluoroquinolones, or was switched from PO to IV fluoroquinolones, or was switched from IV to PO to IV.

Not applicable → Patient received only PO fluoroquinolones.

Unknown

CDCID: -

Post-discharge antimicrobial treatment

5. Was a fluoroquinolone prescribed at discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge)?

Yes No Unknown

5a. If yes to question 5, what drug(s) were prescribed? Check all that apply:

Drug	IV route	PO route	Unknown route
<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Moxifloxacin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

5b. If yes to question 5, what is the total duration of the post-discharge fluoroquinolone prescription?

_____ days, OR the prescription end date is ____ / ____ / _____, OR Duration is unknown

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

HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA)

FORM 3c: CAP

CDC ID: -

Date: / /

Data collector initials: _____

Clinical information

1. Check any of the following ICD-9 codes that were present on admission for this patient: None
 480.0 480.1 480.2 480.3 480.8 480.9 481 482.0 482.1 482.2
 482.30 482.31 482.32 482.39 482.40 482.41 482.42 482.49 482.81 482.82
 482.83 482.84 482.89 482.9 483.0 483.1 483.8 485 486 487.0
 487.1 487.8

2. CAP onset date (mm/dd/yy): ___ / ___ / ___ or
 Prior to survey hospitalization but specific date unknown Unable to determine

3. CAP signs and symptoms in first 2 hospital days; check all that apply: None
 Fever Increased secretions/sputum production Grunting
 Chills or rigors Hemoptysis Nasal flaring
 Cough Chest pain Head bobbing
 Dyspnea Mental status changes or functional decline Chest wall retractions
 O₂ saturation < 90% Apnea Wheezing
 Sore throat Rhinorrhea Muscle aches

4. Did the patient require mechanical ventilation during the hospitalization?

Yes
 No
 Unknown

4a. If yes, was the patient removed from mechanical ventilation before hospital discharge?

Yes, clinical status improved
 Yes, removed from mechanical ventilation for end-of-life care (or for reasons other than improvement)
 No
 Unknown

5. Complete the chest imaging table, recording studies done in the first 5 hospital days (___ / ___ / ___ through ___ / ___ / ___):

No imaging studies done: Unknown whether imaging studies were done:

	Date (mm/dd/yy)	Findings on chest imaging studies			
1	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
2	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
3	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
4	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
5	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these

Go to page 2

CDC ID: -

CAP treatment

6. Was the patient receiving antimicrobial treatment for this episode of CAP before the survey hospitalization?

Yes No Unknown

7. CAP treatment start date during the survey hospitalization (mm/dd/yy): ___/___/___ or Unknown

8. Complete the table for all antimicrobial drugs given to treat CAP during the survey hospitalization:

No.	Drug name	First date (mm/dd/yy)	First route	Last date (mm/dd/yy)	Last route
1		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
2		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
3		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
4		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
5		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH

More than 5 antimicrobial drugs were given to treat CAP:

9. Were antimicrobial drugs prescribed at hospital discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge) to treat CAP?

Yes
 No
 Unknown

9a. If yes to question 9, what was the total duration of the post-discharge CAP treatment?

___ days, OR the prescription end date is ___/___/___, OR Duration is unknown

9b. If yes to question 9, what antimicrobial drugs were prescribed?

One antimicrobial drug was prescribed (enter name: _____)
 Two or more antimicrobial drugs were prescribed
(enter up to 3 names: _____, _____, _____)
 Unknown

Go to page 3

Laboratory testing

10. Complete table below for POSITIVE cultures collected in the first 5 hospital days (___/___/___ through ___/___/___):

No positive cultures: Culture data unknown:

No.	Specimen	Collect date (mm/dd/yy)	Culture result final date (mm/dd/yy)	Pathogens identified (insert codes)	Culture growth quantity* for lower respiratory cultures only	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
7	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
8	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

ETA=endotracheal aspirate (or tracheal aspirate). BAL=bronchoalveolar lavage (includes bronchial lavage, mini-BAL).

*Check "≥10⁴ CFU/ml or similar" if quantity of growth in the culture is reported to be as follows: moderate, many, heavy, abundant, etc. Check "<10⁴ or similar" if quantity of growth in the culture is reported to be <10⁴ CFU/ml or as follows: few, scarce, scant, rare, etc. Check "unknown" if no organism quantity is noted in the culture report.

CDC ID: -

11. During the first 5 hospital days did the patient have a Gram stain of lower respiratory secretions (sputum, BAL, ETA, etc.)? Yes No Unknown

11a. If yes, did the Gram stain report indicate the following:

- Heavy, 4+, or ≥25 neutrophils (or white blood cells) per low power field [x100]
 Rare, occasional, few, 1+ or 2+, or ≤10 squamous epithelial cells per low power field [x100]
 Neither of the above
 Unknown

12. Complete the table for NEGATIVE cultures collected during the first 5 hospital days (___/___/___ through ___/___/___):

No negative cultures: Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen	No.	Collect date (mm/dd/yy)	Specimen
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	6	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	7	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	8	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	9	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	10	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

More negative cultures than fit in the table:

13. Complete the table for non-culture microbiology tests (positive and negative) collected during the first 5 hospital days:

No non-culture tests done: Non-culture test data unknown:

No.	Collect Date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____ Path3_____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____ Path3_____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____ Path3_____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____ Path3_____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____ Path3_____

More tests than fit in the table:

14. Did the patient have any of the following blood test results during the first 2 hospital days?

Check all that apply, or None.

- Arterial pH < 7.35 BUN > 30 mg/dL (11 mmol/L) Glucose > 250 mg/dL
 PaO₂ < 60 mmHg Sodium < 130 mmol/L Hematocrit < 30%

FORM IS COMPLETE

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA)
FORM 3d: UTI**

CDC ID: -

Date: //

Data collector initials: _____

Clinical information

1. Check any of the following ICD-9 codes that were present on admission for this patient: None

590.10 590.11 590.2 590.3 590.80 590.81
590.9 595.0 597.0 597.80 599.0

2. UTI onset date (mm/dd/yy): ___ / ___ / ___ or
 Prior to survey hospitalization but specific date unknown Unable to determine

3. UTI signs and symptoms in first 2 hospital days; check all that apply: None

<input type="checkbox"/> Fever	<input type="checkbox"/> Frequency	<input type="checkbox"/> Costovertebral angle (CVA) pain or tenderness
<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Visible blood in urine	<input type="checkbox"/> Suprapubic pain, swelling or tenderness
<input type="checkbox"/> Urgency	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Mental status changes or functional decline
<input type="checkbox"/> Rigors	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Pain or burning with urination

4. Did the patient have an indwelling urinary catheter in place for ≥2 days on the day of UTI onset or on the day prior to UTI onset (or if onset date unknown, on the day of survey hospital admission)?
 Yes No Unknown

4a. If yes, were any of the following done within 5 days after UTI onset date (or if onset date unknown, within 5 days after survey hospital admission)?
 Catheter changed Catheter removed Catheter neither changed nor removed Unknown

UTI treatment

5. Was the patient receiving antimicrobial treatment for this UTI before the survey hospitalization?
 Yes No Unknown

6. UTI treatment start date during the survey hospitalization (mm/dd/yy): ___ / ___ / ___ or Unknown

7. Complete the table for all antimicrobial drugs given to treat UTI during the survey hospitalization:

No.	Drug name	First date (mm/dd/yy)	First route	Last date (mm/dd/yy)	Last route
1		___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
2		___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
3		___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
4		___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
5		___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH

More than 5 antimicrobial drugs were given to treat UTI:

8. Were antimicrobial drugs prescribed at hospital discharge to treat this UTI (i.e., prescribed to be administered to the patient for additional days after hospital discharge)?
 Yes No Unknown

8a. If yes to question 8, what is the total duration of the post-discharge UTI treatment?
 ___ days, OR the prescription end date is ___ / ___ / ___, OR Duration is unknown

8b. If yes to question 8, what antimicrobial drugs were prescribed?
 One antimicrobial drug was prescribed (enter name: _____)
 Two or more antimicrobial drugs were prescribed
 (enter up to 3 names: _____, _____, _____)
 Unknown

CDC ID: -

Laboratory testing

9. Complete table below for POSITIVE cultures collected in the first 5 hospital days (___/___/___ through ___/___/___):

No positive cultures: Culture data unknown:

No.	Specimen	Collect date (mm/dd/yy)	Culture result final date (mm/dd/yy)	Pathogens identified (insert codes)	Culture growth quantity* for urine cultures only	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
7	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
8	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁵ CFU/ml or similar <input type="checkbox"/> <10 ⁵ or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

Urine CC=urine clean catch. Urine cath=urine collected from an indwelling urinary catheter. Urine other=urine collected via other or unspecified means.

*Check "≥10⁵ CFU/ml or similar" if quantity of growth in the culture is reported to be as follows: moderate, many, heavy, abundant, etc.; Check "<10⁵ or similar" if quantity of growth in the culture is reported to be <10⁵ CFU/ml or as follows: few, scarce, scant, rare, etc. Check "unknown" if no organism quantity is noted in the culture report.

CDCID: -

10. Complete the table for NEGATIVE cultures collected in the first 5 hospital days (___ / ___ / ___ through ___ / ___ / ___):

No negative cultures: Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen
1	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
2	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
3	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
4	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
5	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

No.	Collect date (mm/dd/yy)	Specimen
6	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
7	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
8	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
9	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
10	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

More negative cultures than fit in the table:

11. Complete the table for urinalyses collected in the first 5 hospital days:

No urinalyses done: Unknown whether urinalyses were done:

No.	Urinalysis date (mm/dd/yy)	Pyuria (>5 WBCs / hpf)	Nitrites	Leukocyte esterase	Bacteria	Yeast
1	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
2	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
3	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
4	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
5	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

12. Complete the table for non-culture tests (positive and negative) collected in the first 5 hospital days:

No non-culture tests done: Non-culture test data unknown:

No.	Collect Date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
2	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
3	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
4	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
5	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____

More tests than fit in the table:

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