

# Urinary Tract infection (UTI)

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\*required for saving \*\*required for completion

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| Facility ID:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Event #:                         |                                                                 |                                                                                                                                                  |
| *Patient ID:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Social Security #:               |                                                                 |                                                                                                                                                  |
| Secondary ID:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Medicare #:                      |                                                                 |                                                                                                                                                  |
| Patient Name, Last:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | First:                           | Middle:                                                         |                                                                                                                                                  |
| *Gender: F M Other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | *Date of Birth:                  |                                                                 |                                                                                                                                                  |
| Ethnicity (Specify):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Race (Specify):                  |                                                                 |                                                                                                                                                  |
| *Event Type: UTI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | *Date of Event:                  |                                                                 |                                                                                                                                                  |
| Post-procedure UTI: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Date of Procedure:               |                                                                 |                                                                                                                                                  |
| NHSN Procedure Code:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ICD-9-CM Procedure Code:         |                                                                 |                                                                                                                                                  |
| *MDRO Infection Surveillance:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                 |                                                                                                                                                  |
| <input type="checkbox"/> Yes, this infection's pathogen & location are in-plan for Infection Surveillance in the MDRO/CDI Module<br><input type="checkbox"/> No, this infection's pathogen & location are <b>not</b> in-plan for Infection Surveillance in the MDRO/CDI Module                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                 |                                                                                                                                                  |
| *Date Admitted to Facility:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  | *Location:                                                      |                                                                                                                                                  |
| <b>Risk Factors</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                 |                                                                                                                                                  |
| *Urinary Catheter status:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  |                                                                 |                                                                                                                                                  |
| <input type="checkbox"/> In place – Urinary catheter in place > 2 days on the date of event <input type="checkbox"/> Removed – Urinary catheter in place > 2 days but removed the day before the date of event <input type="checkbox"/> Neither – Not catheter associated – Neither in place nor removed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |                                                                 |                                                                                                                                                  |
| Location of Device Insertion: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  | Date of Device Insertion: ____ / ____ / ____                    |                                                                                                                                                  |
| If NICU, birth weight (gms): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                  |                                                                 |                                                                                                                                                  |
| <b>Event Details</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  |                                                                 |                                                                                                                                                  |
| *Specific Event: <input type="checkbox"/> Symptomatic UTI (SUTI) <input type="checkbox"/> Asymptomatic Bacteremic UTI (ABUTI) <input type="checkbox"/> Urinary System Infection (USI)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                 |                                                                                                                                                  |
| *Specify Criteria Used: (check all that apply)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                 |                                                                                                                                                  |
| <u>Signs &amp; Symptoms</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                 |                                                                                                                                                  |
| <u>Any Patient</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                  | <u>≤ 1 year old</u>                                             |                                                                                                                                                  |
| <input type="checkbox"/> Fever                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Urgency | <input type="checkbox"/> Fever                                  | <u>Laboratory &amp; Diagnostic Testing</u>                                                                                                       |
| <input type="checkbox"/> Frequency                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Dysuria | <input type="checkbox"/> Hypothermia                            |                                                                                                                                                  |
| <input type="checkbox"/> Pain or tenderness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Abscess | <input type="checkbox"/> Apnea                                  | <input type="checkbox"/> 1 positive culture with no more than 2 species of organisms, at least one of which is a bacterium of $\geq 10^5$ CFU/ml |
| <input type="checkbox"/> Acute pain, swelling, or tenderness of testes, epididymis, or prostate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | <input type="checkbox"/> Bradycardia                            | <input type="checkbox"/> Positive culture                                                                                                        |
| <input type="checkbox"/> Suprapubic tenderness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | <input type="checkbox"/> Lethargy                               | <input type="checkbox"/> Positive blood culture                                                                                                  |
| <input type="checkbox"/> Costovertebral angle pain or tenderness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  | <input type="checkbox"/> Vomiting                               | <input type="checkbox"/> Imaging test evidence of infection                                                                                      |
| <input type="checkbox"/> Purulent drainage from affected site                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                 |                                                                                                                                                  |
| <input type="checkbox"/> Other evidence of infection found on invasive procedure, gross anatomic exam, or histopathologic exam <sup>‡</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                 |                                                                                                                                                  |
| * per specific site criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                 |                                                                                                                                                  |
| *Secondary Bloodstream Infection: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |                                                                 |                                                                                                                                                  |
| **Died: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | UTI Contributed to Death: Yes No                                |                                                                                                                                                  |
| Discharge Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | *Pathogens Identified: Yes No    *If Yes, specify on pages 2-4. |                                                                                                                                                  |
| Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)). Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666). CDC 57.114 (Front) Rev 9, v8.3.1 |                                  |                                                                 |                                                                                                                                                  |

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| Pathogen # | Gram-positive Organisms                                                            |                         |                |                            |                         |                            |                         |                      |
|------------|------------------------------------------------------------------------------------|-------------------------|----------------|----------------------------|-------------------------|----------------------------|-------------------------|----------------------|
| _____      | <i>Staphylococcus</i> coagulase-negative<br>(specify species if available):        |                         | VANC<br>SIRN   |                            |                         |                            |                         |                      |
| _____      | _____ <i>Enterococcus faecium</i>                                                  |                         | DAPTO<br>SNSN  | GENTHL <sup>§</sup><br>SRN | LNZ<br>SIRN             | VANC<br>SIRN               |                         |                      |
| _____      | _____ <i>Enterococcus faecalis</i>                                                 |                         |                |                            |                         |                            |                         |                      |
| _____      | _____ <i>Enterococcus</i> spp.<br>(Only those not identified to the species level) |                         |                |                            |                         |                            |                         |                      |
| _____      | <i>Staphylococcus aureus</i>                                                       | CIPRO/LEVO/MOXI<br>SIRN | CLIND<br>SIRN  | DAPTO<br>SNSN              | DOXY/MINO<br>SIRN       | ERYTH<br>SIRN              | GENT<br>SIRN            | LNZ<br>SRN           |
|            |                                                                                    | OX/CEFOX/METH<br>SIRN   | RIF<br>SIRN    | TETRA<br>SIRN              | TIG<br>SNSN             | TMZ<br>SIRN                | VANC<br>SIRN            |                      |
| Pathogen # | Gram-negative Organisms                                                            |                         |                |                            |                         |                            |                         |                      |
| _____      | <i>Acinetobacter</i><br>(specify species)                                          | AMK<br>SIRN             | AMPSUL<br>SIRN | AZT<br>SIRN                | CEFEP<br>SIRN           | CEFTAZ<br>SIRN             | CIPRO/LEVO<br>SIRN      | COL/PB<br>SIRN       |
|            | _____                                                                              | GENT<br>SIRN            | IMI<br>SIRN    | MERO/DORI<br>SIRN          | PIP/PIPTAZ<br>SIRN      | TETRA/DOXY/MINO<br>SIRN    |                         |                      |
|            |                                                                                    | TMZ<br>SIRN             | TOBRA<br>SIRN  |                            |                         |                            |                         |                      |
| _____      | <i>Escherichia coli</i>                                                            | AMK<br>SIRN             | AMP<br>SIRN    | AMPSUL/AMXCLV<br>SIRN      | AZT<br>SIRN             | CEFAZ<br>SIRN              | CEFEP<br>SIRN           | CEFOT/CEFTRX<br>SIRN |
|            |                                                                                    | CEFTAZ<br>SIRN          | CEFUR<br>SIRN  | CEFOX/CTET<br>SIRN         | CIPRO/LEVO/MOXI<br>SIRN | COL/PB <sup>†</sup><br>SRN |                         |                      |
|            |                                                                                    | ERTA<br>SIRN            | GENT<br>SIRN   | IMI<br>SIRN                | MERO/DORI<br>SIRN       | PIPTAZ<br>SIRN             | TETRA/DOXY/MINO<br>SIRN |                      |
|            |                                                                                    | TIG<br>SIRN             | TMZ<br>SIRN    | TOBRA<br>SIRN              |                         |                            |                         |                      |
| _____      | <i>Enterobacter</i><br>(specify species)                                           | AMK<br>SIRN             | AMP<br>SIRN    | AMPSUL/AMXCLV<br>SIRN      | AZT<br>SIRN             | CEFAZ<br>SIRN              | CEFEP<br>SIRN           | CEFOT/CEFTRX<br>SIRN |
|            | _____                                                                              | CEFTAZ<br>SIRN          | CEFUR<br>SIRN  | CEFOX/CTET<br>SIRN         | CIPRO/LEVO/MOXI<br>SIRN | COL/PB <sup>†</sup><br>SRN |                         |                      |
|            |                                                                                    | ERTA<br>SIRN            | GENT<br>SIRN   | IMI<br>SIRN                | MERO/DORI<br>SIRN       | PIPTAZ<br>SIRN             | TETRA/DOXY/MINO<br>SIRN |                      |
|            |                                                                                    | TIG<br>SIRN             | TMZ<br>SIRN    | TOBRA<br>SIRN              |                         |                            |                         |                      |
| _____      | _____ <i>Klebsiella pneumoniae</i>                                                 | AMK<br>SIRN             | AMP<br>SIRN    | AMPSUL/AMXCLV<br>SIRN      | AZT<br>SIRN             | CEFAZ<br>SIRN              | CEFEP<br>SIRN           | CEFOT/CEFTRX<br>SIRN |
|            | _____ <i>Klebsiella oxytoca</i>                                                    | CEFTAZ<br>SIRN          | CEFUR<br>SIRN  | CEFOX/CTET<br>SIRN         | CIPRO/LEVO/MOXI<br>SIRN | COL/PB <sup>†</sup><br>SRN |                         |                      |
|            |                                                                                    | ERTA<br>SIRN            | GENT<br>SIRN   | IMI<br>SIRN                | MERO/DORI<br>SIRN       | PIPTAZ<br>SIRN             | TETRA/DOXY/MINO<br>SIRN |                      |
|            |                                                                                    | TIG<br>SIRN             | TMZ<br>SIRN    | TOBRA<br>SIRN              |                         |                            |                         |                      |

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| Pathogen # | Gram-negative Organisms ( <i>continued</i> )              |                 |                    |                     |                 |                     |                 |                    |                 |                 |
|------------|-----------------------------------------------------------|-----------------|--------------------|---------------------|-----------------|---------------------|-----------------|--------------------|-----------------|-----------------|
| _____      | <i>Pseudomonas aeruginosa</i>                             | AMK<br>SIR N    | AZT<br>SIR N       | CEFEP<br>SIR N      | CEFTAZ<br>SIR N | CIPRO/LEVO<br>SIR N | COL/PB<br>SIR N | GENT<br>SIR N      |                 |                 |
| _____      |                                                           | IMI<br>SIR N    | MERO/DORI<br>SIR N | PIP/PIPTAZ<br>SIR N | TOBRA<br>SIR N  |                     |                 |                    |                 |                 |
| Pathogen # | Fungal Organisms                                          |                 |                    |                     |                 |                     |                 |                    |                 |                 |
| _____      | <i>Candida</i><br>(specify species if available)<br>_____ | ANID<br>SIR N   | CASPO<br>S NS N    | FLUCO<br>S S-DD R N | FLUCY<br>SIR N  | ITRA<br>S S-DD R N  | MICA<br>S NS N  | VORI<br>S S-DD R N |                 |                 |
| Pathogen # | Other Organisms                                           |                 |                    |                     |                 |                     |                 |                    |                 |                 |
| _____      | Organism 1<br>(specify)<br>_____                          | Drug 1<br>SIR N | Drug 2<br>SIR N    | Drug 3<br>SIR N     | Drug 4<br>SIR N | Drug 5<br>SIR N     | Drug 6<br>SIR N | Drug 7<br>SIR N    | Drug 8<br>SIR N | Drug 9<br>SIR N |
| _____      | Organism 1<br>(specify)<br>_____                          | Drug 1<br>SIR N | Drug 2<br>SIR N    | Drug 3<br>SIR N     | Drug 4<br>SIR N | Drug 5<br>SIR N     | Drug 6<br>SIR N | Drug 7<br>SIR N    | Drug 8<br>SIR N | Drug 9<br>SIR N |
| _____      | Organism 1<br>(specify)<br>_____                          | Drug 1<br>SIR N | Drug 2<br>SIR N    | Drug 3<br>SIR N     | Drug 4<br>SIR N | Drug 5<br>SIR N     | Drug 6<br>SIR N | Drug 7<br>SIR N    | Drug 8<br>SIR N | Drug 9<br>SIR N |

### Result Codes

**S = Susceptible**   **I = Intermediate**   **R = Resistant**   **NS = Non-susceptible**   **S-DD = Susceptible-dose dependent**  
**N = Not tested**

<sup>s</sup> **GENTHL results: S = Susceptible/Synergistic and R = Resistant/Not Synergistic**

<sup>†</sup> **Clinical breakpoints have not been set by FDA or CLSI, Sensitive and Resistant designations should be based upon epidemiological cutoffs of Sensitive MIC ≤ 2 and Resistant MIC ≥ 4**

### Drug Codes:

|                                      |                       |                                      |                                     |
|--------------------------------------|-----------------------|--------------------------------------|-------------------------------------|
| AMK = amikacin                       | CEFTRX = ceftriaxone  | FLUCY = flucytosine                  | OX = oxacillin                      |
| AMP = ampicillin                     | CEFUR= cefuroxime     | GENT = gentamicin                    | PB = polymyxin B                    |
| AMPSUL = ampicillin/sulbactam        | CTET= cefotetan       | GENTHL = gentamicin –high level test | PIP = piperacillin                  |
| AMXCLV = amoxicillin/clavulanic acid | CIPRO = ciprofloxacin | IMI = imipenem                       | PIPTAZ = piperacillin/tazobactam    |
| ANID = anidulafungin                 | CLIND = clindamycin   | ITRA = itraconazole                  | RIF = rifampin                      |
| AZT = aztreonam                      | COL = colistin        | LEVO = levofloxacin                  | TETRA = tetracycline                |
| CASPO = caspofungin                  | DAPTO = daptomycin    | LNZ = linezolid                      | TIG = tigecycline                   |
| CEFAZ= ceftazidime                   | DORI = doripenem      | MERO = meropenem                     | TMZ = trimethoprim/sulfamethoxazole |
| CEFEP = cefepime                     | DOXY = doxycycline    | METH = methicillin                   | TOBRA = tobramycin                  |
| CEFOT = cefotaxime                   | ERTA = ertapenem      | MICA = micafungin                    | VANC = vancomycin                   |
| CEFOX= cefoxitin                     | ERYTH = erythromycin  | MINO = minocycline                   | VORI = voriconazole                 |
| CEFTAZ = ceftazidime                 | FLUCO = fluconazole   | MOXI = moxifloxacin                  |                                     |



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### Custom Fields

Label

|       |                |
|-------|----------------|
| _____ | ____/____/____ |
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Label

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### Comments