Patient ID: _____ _____ _____ _____ _____ _____ _____ _____

–Healthcare-Associated Infections Community Interface (HAIC) Case Report–

Patient's Name: _____ (Last, First, M.I.) Phone No.: ( ) _____

Address: _____ (Number, Street, Apt. No.) Patient Chart No.: _____

_____ (City, State) _____ (Zip Code) Hospital: _____

– Patient identifier information is NOT transmitted to CDC –

Invasive Methicillin-Resistant Staphylococcus aureus Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2016

Form Approved
OMB No. 0920-0978
Expires xx/xx/xxxx

– SHADED AREAS BELOW INDICATE CORE VARIABLES –

1. STATE: (Residence of patient) ☐☐

2. COUNTY: (Residence of Patient) _____

3. STATE I.D.: ☐☐☐☐☐☐☐

4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: ☐☐☐☐☐

4b. HOSPITAL I.D. WHERE PATIENT TREATED: ☐☐☐☐☐

5. SEX:
1 ☐ Male
2 ☐ Female

6. DATE OF BIRTH: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

7a. AGE: ☐☐☐

7b. Is age in day/mo/yr?
1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

8. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED: (Check all that apply)
1 ☐ Blood
1 ☐ CSF
1 ☐ Pleural fluid
1 ☐ Peritoneal fluid
1 ☐ Pericardial fluid
1 ☐ Joint/Synovial fluid
1 ☐ Bone
1 ☐ Muscle
1 ☐ Internal body site (specify) _____
1 ☐ Other sterile site (specify) _____

9. DATE OF INITIAL CULTURE: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

10a. WAS THE PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If YES: Date of admission Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

11. WAS CULTURE COLLECTED >3 CALENDAR DAYS AFTER HOSPITAL ADMISSION?
1 ☐ Yes (HO-MRSA case) 2 ☐ No (Complete CRF, CA-MRSA or HACO-MRSA case)
If yes, was the case selected for full CRF based on sampling frame 1:10?
1 ☐ Yes (Complete CRF) 2 ☐ No (STOP data abstraction)

12a. ETHNIC ORIGIN:
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

12b. RACE: (Check all that apply)
1 ☐ White
1 ☐ Black or African American
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Native Hawaiian or Other Pacific Islander

10b. IF PATIENT WAS HOSPITALIZED, WAS THIS PATIENT ADMITTED TO THE ICU DURING HOSPITALIZATION?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

12c. WEIGHT: 1 ☐ Unknown
_____ lbs _____ oz OR _____ kg

12d. HEIGHT: 1 ☐ Unknown
_____ ft _____ in OR _____ cm

12e. BMI: 1 ☐ Unknown
_____ (do not calculate, only if available in the MR)

13. At time of first positive culture, patient was:
1 ☐ Pregnant
2 ☐ Post-partum
3 ☐ Neither
9 ☐ Unknown

14. If case is ≤12 months of age, type of birth hospitalization:
1 ☐ NICU/SCN
2 ☐ Well Baby Nursery
9 ☐ Unknown

15. Where was the patient located on the 4th calendar day prior to the date of initial culture?
1 ☐ Private Residence
1 ☐ Long Term Care Facility Facility ID _____
1 ☐ Long Term Acute Care Hospital Facility ID _____
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Hospital Inpatient Facility ID _____
1 ☐ Other _____
1 ☐ Unknown

16. LOCATION OF CULTURE COLLECTION: (Check one)

Hospital Inpatient
1 ☐ ICU
6 ☐ Surgery/OR
7 ☐ Radiology
2 ☐ Other Unit
3 ☐ Emergency Room
16 ☐ Observational Unit/Clinical Decision Unit

Outpatient
8 ☐ Clinic/ Doctors Office
11 ☐ Surgery
15 ☐ Dialysis/Renal Clinic
4 ☐ Other Outpatient

5 ☐ LTCF Facility ID _____
13 ☐ LTACH Facility ID _____
14 ☐ Autopsy
9 ☐ Unknown
10 ☐ Other

17. Were cultures of the SAME or OTHER sterile site(s) positive within 30 days after initial culture date?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If yes, indicate site and date of last positive culture:
1 ☐ Blood, Date:_____
1 ☐ CSF, Date:_____
1 ☐ Pleural fluid, Date:_____
1 ☐ Peritoneal fluid, Date:_____
1 ☐ Pericardial fluid, Date:_____
1 ☐ Joint/Synovial fluid, Date:_____
1 ☐ Bone, Date:_____
1 ☐ Muscle, Date:_____
1 ☐ Internal body site Date:_____
1 ☐ Other sterile site (specify)_____ Date:_____

18. PATIENT OUTCOME: 9 ☐ Unknown

1 ☐ Survived
Date of discharge Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

— If survived, was the patient transferred to a LTCF? 1 ☐ Yes 2 ☐ No If Yes, Facility ID _____

— If survived, was the patient transferred to a LTACH? 1 ☐ Yes 2 ☐ No If Yes, Facility ID _____

2 ☐ Died
Date of death Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

— Was MRSA cultured from a normally sterile site < calendar day 7 before death?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

19. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply) 1 ☐ None 1 ☐ Unknown

1 ☐ Abscess (not skin)
1 ☐ AV Fistula/Graft Infection
1 ☐ Bacteremia
1 ☐ Bursitis
1 ☐ Catheter Site Infection
1 ☐ Cellulitis
1 ☐ Chronic Ulcer/Wound (non-decubitus)
1 ☐ Decubitus/Pressure Ulcer
1 ☐ Empyema
1 ☐ Endocarditis
1 ☐ Meningitis
1 ☐ Peritonitis
1 ☐ Pneumonia
1 ☐ Osteomyelitis
1 ☐ Septic Arthritis
1 ☐ Septic Emboli
1 ☐ Septic Shock
1 ☐ Skin Abscess
1 ☐ Surgical Incision
1 ☐ Surgical Site (Internal)
1 ☐ Traumatic Wound
1 ☐ Urinary Tract
1 ☐ Other: (specify) _____

20. UNDERLYING CONDITIONS: (Check all that apply) (if none or no chart available, check appropriate box) 1 ☐ None 1 ☐ Unknown

1 ☐ Abscess/Boil (Recurrent)
1 ☐ AIDS
1 ☐ Chronic Cognitive Deficit
1 ☐ Chronic Liver Disease
1 ☐ Chronic Pulmonary Disease
1 ☐ Chronic Kidney Disease
1 ☐ Chronic Skin Breakdown
1 ☐ Congestive Heart Failure
1 ☐ Connective Tissue Disease
1 ☐ Current Smoker
1 ☐ CVA/Stroke
1 ☐ Cystic Fibrosis
1 ☐ Decubitus/Pressure Ulcer
1 ☐ Dementia
1 ☐ Diabetes
1 ☐ Hematologic Malignancy
1 ☐ Hemiplegia/Paraplegia
1 ☐ HIV
1 ☐ Influenza (within 10 days of initial culture)
1 ☐ IVDU
1 ☐ Metastatic Solid Tumor
1 ☐ Myocardial Infarct
1 ☐ Obesity
1 ☐ Other Drug Use
1 ☐ Peptic Ulcer Disease
1 ☐ Peripheral Vascular Disease (PVD)
1 ☐ Premature Birth
1 ☐ Solid Tumor (non metastatic)
1 ☐ Other: (specify only for cases ≤ 12 months of age) _____

21. PRIOR HEALTHCARE EXPOSURE – Healthcare-associated and Community-associated: (Check all that apply) 1 ☐ None 1 ☐ Unknown

1 ☐ Previous documented MRSA infection or colonization
If YES: Month ☐☐ Year ☐☐☐☐ OR previous STATE I.D.: ☐☐☐☐☐☐☐

1 ☐ Hospitalized within year before initial culture date.
If YES: Date of discharge Mo. ☐☐ Day ☐☐ Year ☐☐☐☐ 1 ☐ Unknown

If known, Facility ID _____

1 ☐ Surgery within year before initial culture date.
If yes, list the surgeries and dates of surgery that occurred within 90 days prior to the initial culture:

Surgery	Date
1. _____	____/____/____
2. _____	____/____/____
3. _____	____/____/____
4. _____	____/____/____

1 ☐ Dialysis within year before initial culture date. (*Hemodialysis or Peritoneal dialysis*)
1 ☐ Current chronic dialysis
Type ☐ Peritoneal ☐ Unknown
☐ Hemodialysis
Type of vascular access
☐ AV fistula / graft
☐ Hemodialysis CVC
☐ Unknown

1 ☐ Residence in a long-term care facility within year before initial culture date.
If known, Facility ID _____
1 ☐ Admitted to a LTACH within year before initial culture date.
If known, Facility ID _____
1 ☐ Central vascular catheter in place at any time in the 2 calendar days prior to initial culture.

– THIS SHADED AREA FOR OFFICE USE ONLY –

22. Was case first identified through audit?	23. CRF status:	24. Does this case have recurrent MRSA disease?	If YES, previous (1st) STATE I.D.:	25. Date reported to EIP site:	26. Initials of S.O:
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Complete 2 ☐ Incomplete 3 ☐ Edited & Correct 4 ☐ Chart unavailable after 3 requests	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	☐☐☐☐☐☐☐	Mo. ☐☐ Day ☐☐ Year ☐☐☐☐	_____

27 COMMENTS: _____