Patient ID: ____________________

Form Approved OMB No. 0920-0978

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

2018 Multi-site Gram-Negative Surveillance Initiative (MuGSI) Healthcare Associated Infection Community Interface (HAIC) Case Report

Patient's Name ____________________ **Phone no.** (______)____________
(Last, First, MI)

Address ____________________ **MRN** ____________

City ____________ **State** ______ **Zip** ________ **Hospital** ____________

— Patient identifier information is NOT transmitted to CDC —

1. STATE: ☐☐

2. COUNTY: ____________

3. STATE ID: ____________

4a. LABORATORY ID WHERE CULTURE IDENTIFIED: ____________

4b. FACILITY ID WHERE PATIENT TREATED: ____________

5. Where was the patient located on the 4th calendar day prior to the date of initial culture?
- ☐ Private residence
- ☐ LTCF Facility ID: ____________
- ☐ LTACH Facility ID: ____________
- ☐ Homeless
- ☐ Incarcerated
- ☐ Hospital Inpatient
  - **Was the patient transferred from this hospital?** ☐ Yes ☐ No ☐ Unknown
  - Facility ID: ____________
- ☐ Other (specify): ____________
- ☐ Unknown

6. DATE OF BIRTH: ☐☐/☐☐/☐☐☐☐

7a. AGE: ☐☐☐

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

8a. SEX:
- ☐ Male
- ☐ Female

8b. ETHNIC ORIGIN:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

8c. RACE (Check all that apply):
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown

8d. WEIGHT:
______lbs ______oz OR ______kg ☐ Unknown

8e. HEIGHT:
______ft ______in OR ______cm ☐ Unknown

8f. BMI (Record only if ht and/or wt is not available):
____________ ☐ Unknown

9. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?
☐ Yes ☐ No ☐ Unknown

If yes: Date of admission ☐☐/☐☐/☐☐☐☐ **Date of discharge** ☐☐/☐☐/☐☐☐☐

10a. DATE OF INITIAL CULTURE
☐☐/☐☐/☐☐☐☐

11a. Was the patient in the ICU in the 7 days *prior* to their initial culture?
☐ Yes ☐ No ☐ Unknown

10b. LOCATION OF CULTURE COLLECTION:

Hospital Inpatient
- ☐ ICU
- ☐ Surgery/OR
- ☐ Radiology
- ☐ Other Unit
- ☐ Emergency Room

Outpatient
- ☐ Clinic/Doctors Office
- ☐ Surgery
- ☐ Other Outpatient
- ☐ Dialysis Center
- ☐ Observational Unit/Clinical Decision Unit

- ☐ LTCF Facility ID: ____________
- ☐ LTACH Facility ID: ____________
- ☐ Autopsy
- ☐ Unknown

11b. Was the patient in the ICU on the date of or in the 7 days *after* the initial culture?
☐ Yes ☐ No ☐ Unknown

12. PATIENT OUTCOME: ☐ Survived ☐ Died ☐ Unknown

If survived, transferred to:
- ☐ Private residence
- ☐ LTCF Facility ID: ____________
- ☐ LTACH Facility ID: ____________
- ☐ Unknown
- ☐ Other (specify): ____________

If died, date of death:
☐☐/☐☐/☐☐☐☐

Was the organism cultured from a normally sterile site or urine, ≤ calendar day 7 before death?
☐ Yes ☐ No ☐ Unknown

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

IMPORTANT— PLEASE COMPLETE THE BACK OF THIS FORM

13a. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE:

Carbapenem-resistant:

☐ *Enterobacteriaceae (CRE):*
- ☐ *Escherichia coli*
- ☐ *Enterobacter cloacae*
- ☐ *Enterobacter aerogenes*
- ☐ *Klebsiella pneumoniae*
- ☐ *Klebsiella oxytoca*

☐ *A. baumannii (CRAB)*

13b. Was the initial culture polymicrobial?

☐ Yes ☐ No ☐ Unknown

13c. Was the initial isolate tested for carbapenemase?

☐ Yes
☐ No
☐ Laboratory Not Testing
☐ Unknown

If yes, what testing method was used (check all that apply):

☐ Automated Molecular Assay (specify): ________________
☐ CarbaNP ☐ E Test
☐ PCR ☐ Modified Hodge Test (MHT)
☐ Other (specify): ___________
☐ Unknown

If tested, what was the testing result?

☐ Positive
☐ Negative
☐ Indeterminate
☐ Unknown

14. INITIAL CULTURE SITE:

☐ Blood ☐ Joint/synovial fluid
☐ CSF ☐ Bone
☐ Pleural fluid ☐ Urine
☐ Peritoneal fluid ☐ Other normally sterile site
☐ Pericardial fluid ____________________________

URINE Cultures ONLY:
14a. Was the urine collected through an indwelling urethral catheter?

☐ Yes
☐ No
☐ Unknown

URINE Cultures ONLY:
14b. Record the colony count

____

URINE Cultures ONLY:
14c. Signs and Symptoms associated with urine culture.
Please indicate if any of the following symptoms where reported during the 5 day time period including the 2 calendar days before through the 2 calendar days after the date of initial culture.
Then go to question 14d.

☐ **None**
☐ Costovertebral angle pain or tenderness
☐ Dysuria
☐ Fever [temperature ≥ 100.4 °F (38 °C)]

☐ **Unknown**
☐ Frequency
☐ Suprapubic tenderness
☐ Urgency

Symptoms for patients ≤ 1 year of age only:

☐ Apnea
☐ Bradycardia
☐ Lethargy
☐ Vomiting

URINE Cultures ONLY:
14d. Was a blood culture positive in the 3 calendar days before through the 3 calendar days after the initial urine culture for the same MuGSI organism?

☐ Yes
☐ No
☐ Unknown

15. Was the same organism (Q13a) cultured from a different sterile site or urine in the 30 days after the date of initial culture (of this current episode)?

☐ Yes ☐ No ☐ Unknown

If yes, source (check all that apply):

☐ Blood ☐ Joint/synovial fluid
☐ CSF ☐ Bone
☐ Pleural fluid ☐ Urine
☐ Peritoneal fluid ☐ Other normally sterile site ____________________________
☐ Pericardial fluid

16. *Enterobacteriaceae* ONLY:
Were cultures of sterile site(s) or urine positive in the 30 days *prior* to the date of initial culture, for a DIFFERENT organism (Q13a)?

☐ Yes ☐ No ☐ Unknown ☐ NA

If yes, source (check all that apply):

☐ Blood ☐ Joint/synovial fluid
☐ CSF ☐ Bone
☐ Pleural fluid ☐ Urine
☐ Peritoneal fluid ☐ Other normally sterile site ________________________
☐ Pericardial fluid

If yes, indicate organism type and associated State ID for the incident closest to the date of initial culture:

Organism	State ID
Escherichia coli	
Enterobacter cloacae	
Enterobacter aerogenes	
Klebsiella pneumoniae	
Klebsiella oxytoca	

16a. *A. baumannii* Cultures ONLY:
Were cultures of OTHER sterile site(s) or urine positive in the 30 days *prior* to the date of initial culture, for another *A. baumannii?*

☐ Yes ☐ No ☐ Unknown ☐ NA

If yes, source (check all that apply):

☐ Blood ☐ Joint/synovial fluid
☐ CSF ☐ Bone
☐ Pleural fluid ☐ Urine
☐ Peritoneal fluid ☐ Other normally sterile site
☐ Pericardial fluid ______________________

If yes, State ID for the organism closest to the date of initial culture:

____

16b. *A. baumannii* Cultures ONLY:
Did the patient have a sputum culture positive for CRAB in the 30 days *prior* to the date of culture (Day 1)?

☐ Yes ☐ No ☐ Unknown ☐ NA

17a. Was this patient positive for the SAME organism in the *year prior* to the date of the initial culture (Q10a):

☐ Yes ☐ No (GO TO Q17c) ☐ Unknown (GO TO Q17c)

17b. If yes, specify date of culture and State ID for the first positive culture in the *year prior*:

☐☐/☐☐/☐☐☐☐

State ID: ____

17c. *Enterobacteriaceae* ONLY:
Was this patient positive for a MuGSI *Enterobacteriaceae* in the *year prior* to the date of initial culture (Q10a)?

☐ Yes ☐ No (GO TO Q18) ☐ Unknown (GO TO Q18) ☐ NA (GO TO Q18)

17d. If yes, specify organism, date of culture and State ID for the first positive *Enterobacteriaceae* culture in the *year prior* to the date of initial culture (Q10a):

Carbapenem-resistant *Enterobacteriaceae* (CRE):

- ☐ *Escherichia coli*
- ☐ *Enterobacter cloacae*
- ☐ *Enterobacter aerogenes*
- ☐ *Klebsiella pneumoniae*
- ☐ *Klebsiella oxytoca*

Date of Culture: ☐☐/☐☐/☐☐☐☐

State ID: ___________________________________

18. Susceptibility Results: (please complete the table below based on the information found in the indicated data source). Shaded antibiotics are required to have the MIC entered into the MuGSI-CM system, if available.

Data Source	Medical Record		Microscan		Vitek		Phoenix		Kirby-Bauer		E-test	
Antibiotic	**MIC**	**Interp**	**MIC**	**Interp**	**MIC**	**Interp**	**MIC**	**Interp**	**Zone Diam**	**Interp**	**MIC**	**Interp**
Amikacin												
Amoxicillin/Clavulanate												
Ampicillin												
Ampicillin/Sulbactam												
Aztreonam												
Cefazolin												
CEFEPIME												
CEFOTAXIME												
CEFTAZIDIME												
CEFTRIAXONE												
Cephalothin												
Ciprofloxacin												
COLISTIN												
DORIPENEM												
ERTAPENEM												
Gentamicin												
IMIPENEM												
Levofloxacin												
MEROPENEM												
Moxifloxacin												
Nitrofurantoin												
Piperacillin/Tazobactam												
POLYMYXIN B												
TIGECYCLINE												
Tobramycin												
Trimethoprim-sulfamethoxazole												

19. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S) *(check all that apply)*: ☐ **None** ☐ **Unknown**

- ☐ Abscess, not skin
- ☐ AV fistula/graft infection
- ☐ Bacteremia
- ☐ Bursitis
- ☐ Catheter site infection (CVC)
- ☐ Cellulitis
- ☐ Chronic ulcer/wound (not decubitus)
- ☐ Decubitus/pressure ulcer
- ☐ Empyema
- ☐ Endocarditis
- ☐ Epidural Abscess
- ☐ Meningitis
- ☐ Osteomyelitis
- ☐ Peritonitis
- ☐ Pneumonia
- ☐ Pyelonephritis
- ☐ Septic arthritis
- ☐ Septic emboli
- ☐ Septic shock
- ☐ Skin abscess
- ☐ Surgical incision infection
- ☐ Surgical site infection (internal)
- ☐ Traumatic wound
- ☐ Urinary tract infection
- ☐ Other ______________________

20. UNDERLYING CONDITIONS *(check all that apply)*: ☐ **None** ☐ **Unknown**

- ☐ AIDS/CD4 count < 200
- ☐ Alcohol abuse
- ☐ Chronic Liver Disease
- ☐ Chronic Pulmonary Disease
- ☐ Chronic Renal Insufficiency
- ☐ Chronic Skin Breakdown
- ☐ Congestive Heart Failure
- ☐ Connective Tissue Disease
- ☐ Current Smoker
- ☐ CVA/Stroke
- ☐ Cystic Fibrosis
- ☐ Decubitus/Pressure Ulcer
- ☐ Dementia/Chronic Cognitive Deficit
- ☐ Diabetes
- ☐ Hemiplegia/Paraplegia
- ☐ HIV
- ☐ Hematologic Malignancy
- ☐ IVDU
- ☐ Liver failure
- ☐ Metastatic Solid Tumor
- ☐ Myocardial Infarct
- ☐ Neurological Problems
- ☐ Obesity or Morbid Obesity
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Premature Birth
- ☐ Solid Tumor (non metastatic)
- ☐ Spina bifida
- ☐ Transplant Recipient
- ☐ Urinary Tract Problems/Abnormalities

IMPORTANT— PLEASE COMPLETE THE NEXT PAGE OF THIS FORM

21. RISK FACTORS OF INTEREST *(check all that apply)*: ☐ **None** ☐ **Unknown**

☐ Culture collected ≥ calendar day 3 after hospital admission

☐ Hospitalized within year before date of initial culture:

If yes, enter mo/yr ☐☐ / ☐☐☐☐ OR ☐ Unknown

If known, prior hospital ID:____________________

☐ Surgery within year before date of initial culture

☐ Current chronic dialysis: ☐ Peritoneal ☐ Hemodialysis ☐ Unknown

Hemodialysis Access: ☐ AV fistula/graft ☐ CVC ☐ Unknown

☐ Residence in LTCF within year before date of initial culture

If known, facility ID: ______________________

☐ Admitted to a LTACH within year before initial culture date

If known, facility ID: ______________________

☐ Central venous catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture

☐ Urinary catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture

If checked, indicate all that apply:

☐ Indwelling Urethral Catheter ☐ Suprapubic Catheter

☐ Condom Catheter ☐ Other: _____________

☐ Any OTHER indwelling device in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture

If checked, indicate all that apply:

☐ ET/NT Tube ☐ Gastrostomy Tube ☐ NG Tube

☐ Tracheostomy ☐ Nephrostomy Tube ☐ Other: _____________

☐ Patient traveled internationally in the two months prior to the date of initial culture.

Country:__________________, __________________, __________________

☐ Patient was hospitalized while visiting country (ies) listed above

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22. Was case first identified through audit?	**23. CRF status:**	**24. Date reported to EIP site:**	**25. SO initials:**
☐ Yes ☐ No ☐ Unknown	☐ Complete ☐ Pending ☐ Chart unavailable	☐☐ / ☐☐ / ☐☐☐☐	__________________

26. Comments:

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