

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: _____



**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) <input type="text"/>	2. COUNTY: (Residence of Patient) <input type="text"/>	3. STATE I.D.: <input type="text"/>	4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED: <input type="text"/>	4b. HOSPITAL I.D. WHERE PATIENT TREATED: <input type="text"/>
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5. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	6. DATE OF BIRTH: Mo. Day Year <input type="text"/>	7a. AGE: <input type="text"/> 7b. Is age in day/mo/yr? 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.	8. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED: (Check all that apply) 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Internal body site (specify) _____ 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Joint/Synovial fluid _____ 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Bone _____ 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Muscle _____
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9. DATE OF INITIAL CULTURE: Mo. Day Year <input type="text"/>	10a. WAS THE PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES: Date of admission Mo. Day Year <input type="text"/>	11. WAS CULTURE COLLECTED >3 CALENDAR DAYS AFTER HOSPITAL ADMISSION? 1 <input type="checkbox"/> Yes (HO-MRSA case) 2 <input type="checkbox"/> 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 <input type="checkbox"/> Yes (Complete CRF) 2 <input type="checkbox"/> No (STOP data abstraction)
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12a. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown 12b. RACE: (Check all that apply) 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	10b. IF PATIENT WAS HOSPITALIZED, WAS THIS PATIENT ADMITTED TO THE ICU DURING HOSPITALIZATION? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 12c. WEIGHT: 1 <input type="checkbox"/> Unknown _____ lbs _____ oz OR _____ kg 12d. HEIGHT: 1 <input type="checkbox"/> Unknown _____ ft _____ in OR _____ cm 12e. BMI: 1 <input type="checkbox"/> Unknown _____ (do not calculate, only if available in the MR)	13. At time of first positive culture, patient was: 1 <input type="checkbox"/> Pregnant 2 <input type="checkbox"/> Post-partum 3 <input type="checkbox"/> Neither 9 <input type="checkbox"/> Unknown 14. If case is ≤12 months of age, type of birth hospitalization: 1 <input type="checkbox"/> NICU/SCN 2 <input type="checkbox"/> Well Baby Nursery 9 <input type="checkbox"/> Unknown	15. Where was the patient located on the 4th calendar day prior to the date of initial culture? 1 <input type="checkbox"/> Private Residence 1 <input type="checkbox"/> Long Term Care Facility Facility ID _____ 1 <input type="checkbox"/> Long Term Acute Care Hospital Facility ID _____ 1 <input type="checkbox"/> Homeless 1 <input type="checkbox"/> Incarcerated 1 <input type="checkbox"/> Hospital Inpatient Facility ID _____ 1 <input type="checkbox"/> Other _____ 1 <input type="checkbox"/> Unknown
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16. LOCATION OF CULTURE COLLECTION: (Check one) Hospital Inpatient 5 <input type="checkbox"/> LTCF Facility ID _____ 1 <input type="checkbox"/> ICU 8 <input type="checkbox"/> Clinic/Doctors Office _____ 6 <input type="checkbox"/> Surgery/OR 11 <input type="checkbox"/> Surgery 13 <input type="checkbox"/> LTACH Facility ID _____ 7 <input type="checkbox"/> Radiology 15 <input type="checkbox"/> Dialysis/Renal Clinic 2 <input type="checkbox"/> Other Unit 4 <input type="checkbox"/> Other Outpatient 3 <input type="checkbox"/> Emergency Room 14 <input type="checkbox"/> Autopsy 16 <input type="checkbox"/> Observational Unit/Clinical Decision Unit 9 <input type="checkbox"/> Unknown 10 <input type="checkbox"/> Other	17. Were cultures of the SAME or OTHER sterile site(s) positive within 30 days after initial culture date? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If yes, indicate site and date of last positive culture: 1 <input type="checkbox"/> Blood, Date: _____ 1 <input type="checkbox"/> Pericardial fluid, Date: _____ 1 <input type="checkbox"/> Internal body site Date: _____ 1 <input type="checkbox"/> CSF, Date: _____ 1 <input type="checkbox"/> Joint/Synovial fluid, Date: _____ 1 <input type="checkbox"/> Other sterile site (specify) _____ Date: _____ 1 <input type="checkbox"/> Pleural fluid, Date: _____ 1 <input type="checkbox"/> Bone, Date: _____ 1 <input type="checkbox"/> Peritoneal fluid, Date: _____ 1 <input type="checkbox"/> Muscle, Date: _____
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18. PATIENT OUTCOME: 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Survived Date of discharge Mo. Day Year <input type="text"/> — If survived, was the patient transferred to a LTCF? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Facility ID _____ — If survived, was the patient transferred to a LTACH? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Facility ID _____	2 <input type="checkbox"/> Died Date of death Mo. Day Year <input type="text"/> — Was MRSA cultured from a normally sterile site < calendar day 7 before death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
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Public reporting burden of this collection of information is estimated to average 10 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978)

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

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

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

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

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

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

1 Hospitalized within year before initial culture date.
 Date of discharge
 If YES: 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 Residence in a long-term care facility within year before initial culture date.
 If known, Facility ID _____

1 Current chronic dialysis
 Type Peritoneal Unknown
 Hemodialysis
 Type of vascular access
 AV fistula / graft
 Hemodialysis CVC
 Unknown

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? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23. CRF status: 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Incomplete 3 <input type="checkbox"/> Edited & Correct 4 <input type="checkbox"/> Chart unavailable after 3 requests	24. Does this case have recurrent MRSA disease? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	If YES, previous (1st) STATE I.D.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	25. Date reported to EIP site: Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	26. Initials of S.O: _____
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27 COMMENTS:

