

Patient ID: _____

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

2015 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: <input type="checkbox"/> <input type="checkbox"/> | 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? <input type="checkbox"/> Private residence <input type="checkbox"/> LTCF <input type="checkbox"/> LTACH <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated <input type="checkbox"/> Hospital Inpatient (If transferred, hospital ID _____) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown | 6. DATE OF BIRTH: ____ / ____ / ____ ____ | 7a. AGE: ____ | 7b. Is age in day/mo/yr? <input type="checkbox"/> Days <input type="checkbox"/> Mos <input type="checkbox"/> Yrs |
|---|--|-------------------------|--|

| | | |
|---|--|--|
| 8a. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female | 8c. RACE (Check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown | 8d. WEIGHT: ____ lbs ____ oz OR ____ kg <input type="checkbox"/> Unknown |
| 8b. ETHNIC ORIGIN: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown | 8e. HEIGHT: ____ ft ____ in OR ____ cm <input type="checkbox"/> Unknown | 8f. BMI (Record only if ht and/or wt is not available): _____ <input type="checkbox"/> 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 <i>prior</i> to their initial culture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|--|

| | | | | | | | | | | | | | | | | | | | |
|---|--|----------------------------------|--|------------------------------|--|-------------------------------|-------------------------------------|----------------------------------|--------------------------------|------------------------------------|---|----------------------------------|-------------------------------------|--|----------------------------------|---|--|--|---|
| 10b. LOCATION OF CULTURE COLLECTION: <table style="width: 100%;"> <tr> <td style="width: 33%;">Hospital Inpatient</td> <td style="width: 33%;">Outpatient</td> <td style="width: 33%;"></td> </tr> <tr> <td><input type="checkbox"/> ICU</td> <td><input type="checkbox"/> Clinic/Doctors Office</td> <td><input type="checkbox"/> LTCF</td> </tr> <tr> <td><input type="checkbox"/> Surgery/OR</td> <td><input type="checkbox"/> Surgery</td> <td><input type="checkbox"/> LTACH</td> </tr> <tr> <td><input type="checkbox"/> Radiology</td> <td><input type="checkbox"/> Other Outpatient</td> <td><input type="checkbox"/> Autopsy</td> </tr> <tr> <td><input type="checkbox"/> Other Unit</td> <td><input type="checkbox"/> Dialysis Center</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Emergency Room</td> <td><input type="checkbox"/> Observational Unit/Clinical Decision Unit</td> <td></td> </tr> </table> | Hospital Inpatient | Outpatient | | <input type="checkbox"/> ICU | <input type="checkbox"/> Clinic/Doctors Office | <input type="checkbox"/> LTCF | <input type="checkbox"/> Surgery/OR | <input type="checkbox"/> Surgery | <input type="checkbox"/> LTACH | <input type="checkbox"/> Radiology | <input type="checkbox"/> Other Outpatient | <input type="checkbox"/> Autopsy | <input type="checkbox"/> Other Unit | <input type="checkbox"/> Dialysis Center | <input type="checkbox"/> Unknown | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Observational Unit/Clinical Decision Unit | | 11b. Was the patient in the ICU on the date of or in the 7 days <i>after</i> the initial culture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Hospital Inpatient | Outpatient | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> ICU | <input type="checkbox"/> Clinic/Doctors Office | <input type="checkbox"/> LTCF | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Surgery/OR | <input type="checkbox"/> Surgery | <input type="checkbox"/> LTACH | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Other Outpatient | <input type="checkbox"/> Autopsy | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other Unit | <input type="checkbox"/> Dialysis Center | <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Observational Unit/Clinical Decision Unit | | | | | | | | | | | | | | | | | | |

12. PATIENT OUTCOME: Survived Died Unknown

If survived, transferred to:
 Private residence
 LTCF
 LTACH
 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 Reports Clearance Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0978)

13a. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE:
 Carbapenem-resistant:
 Enterobacteriaceae (CRE):
 E. 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 Unknown

If yes, what testing method was used (check all that apply):
 Modified Hodge Test (MHT)
 E Test
 PCR
 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. How was the urine collected?
 Clean Catch
 In and Out Catheter
 Indwelling Catheter
 Condom Catheter
 Other: _____
 Unknown

URINE Cultures ONLY:
14b. Record the colony count for the organism indicated in Q13a:
 ≤100,000
 >100,000
 Unknown

URINE Cultures ONLY:
14c. Signs and Symptoms associated with urine culture. Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before and the 2 calendar days after the day of initial culture:

| | | | |
|---|---|--|-------------------------------|
| <input type="checkbox"/> Altered mental status | <input type="checkbox"/> Fever | <input type="checkbox"/> Pyuria | <input type="checkbox"/> None |
| <input type="checkbox"/> Acute pain, swelling or tenderness of the testes, epididymis or prostate | <input type="checkbox"/> Frequency | <input type="checkbox"/> Retention | |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Hematuria | <input type="checkbox"/> Suprapubic tenderness | |
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Unspecified abdominal pain/tenderness | |
| <input type="checkbox"/> Costovertebral angle pain or tenderness | <input type="checkbox"/> Leukocytosis | <input type="checkbox"/> Urgency | |
| <input type="checkbox"/> Dysuria | <input type="checkbox"/> Malodorous | <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Purulent discharge | <input type="checkbox"/> Other (specify): _____ | |

15. Were cultures of OTHER sterile site(s) or urine positive in the 30 days after the date of initial culture, for the SAME organism (Q13a)?
 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 |
|-------------------------------|----------|
| <i>E. coli</i> | |
| <i>Enterobacter cloacae</i> | |
| <i>Enterobacter aerogenes</i> | |
| <i>Klebsiella pneumoniae</i> | |
| <i>Klebsiella oxytoca</i> | |

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:

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:

Carbapenem-resistant Enterobacteriaceae (CRE):

- E. 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 | |
|-------------------------------|----------------|--------|-----------|--------|-------|--------|---------|--------|-------------|--------|--------|--------|
| | 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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Abscess, not skin | <input type="checkbox"/> Chronic ulcer/wound (not decubitus) | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Skin abscess |
| <input type="checkbox"/> AV fistula/graft infection | <input type="checkbox"/> Decubitus/pressure ulcer | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Surgical incision infection |
| <input type="checkbox"/> Bacteremia | <input type="checkbox"/> Empyema | <input type="checkbox"/> Pyelonephritis | <input type="checkbox"/> Surgical site infection (internal) |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Septic arthritis | <input type="checkbox"/> Traumatic wound |
| <input type="checkbox"/> Catheter site infection (CVC) | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Septic emboli | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Septic shock | <input type="checkbox"/> Other _____ |

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

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

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
- Admitted to a LTACH within year before initial culture date
- 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

SURVEILLANCE OFFICE USE ONLY

| | | | |
|--|---|--|----------------------------------|
| 22. Was case first identified through audit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | 23. CRF status: <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Chart unavailable | 24. Date reported to EIP site: <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. SO initials: _____ |
| 26. Comments: _____ _____ _____ _____ _____ | | | |