Patient ID: ____

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

Surveillance for Extended-Spectrum Beta- Lactamase-Producing Enterobacteriaceae
Multi-Site Gram-Negative Bacilli Surveillance (MuGSI)
Healthcare Associated Infection Community Interface (HAIC) Case Report

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

Patient's name: ______________________________ **Phone no.** (______)____________________

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
- ☐Unknown

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

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 the initial culture date?

☐Yes ☐No ☐Unknown

10b. LOCATION OF CULTURE COLLECTION:

- ☐ Hospital Inpatient
- ☐ Emergency Room
- ☐ LTCF Facility ID: ____________
- ☐ LTACH Facility ID: ____________
- ☐ Observational Unit/Clinical Decision Unit
- ☐ Unknown

Outpatient:
- ☐ Clinic/Doctors Office
- ☐ Surgery
- ☐ Other Outpatient
- ☐ Dialysis Center

11b. Was the patient in the ICU on the date of or in the 7 days *after* the initial culture date?

☐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:
___ ___ - ___ ___ - ___ ___ ___ ___

13. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE:
Extended-Spectrum Cephalosporin-resistant:
- ☐ *Escherichia coli*
- ☐ *Klebsiella pneumoniae*
- ☐ *Klebsiella oxytoca*

14a. INITIAL CULTURE SITE:

- ☐ Blood
- ☐ Bone
- ☐ Brain
- ☐ CSF
- ☐ Heart
- ☐ Joint/synovial fluid
- ☐ Kidney
- ☐ Liver
- ☐ Lymph node
- ☐ Ovary
- ☐ Pancreas
- ☐ Pericardial fluid
- ☐ Peritoneal fluid
- ☐ Pleural fluid
- ☐ Spleen
- ☐ Urine
- ☐ Vascular tissue
- ☐ Vitreous
- ☐ Other fluid (sterile)
- ☐ Deep tissue
- ☐ Other normally sterile site
  ____

URINE Cultures ONLY:
14b. 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 date of initial culture.

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

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 D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978)

15a. Susceptibility Results: Please complete the table below based on the primary antibiotic testing report. Shaded antibiotics are required to have the MIC entered into the ESBL Case Management system, if available.

Data Source	Microscan		Vitek		Phoenix		Kirby-Bauer		E-test	
Antibiotic	MIC	Interp	MIC	Interp	MIC	Interp	Zone Diam	Interp	MIC	Interp
Amikacin										
Amoxicillin/Clavulanate										
Ampicillin										
Ampicillin/Sulbactam										
Aztreonam										
Cefazolin										
Cefepime										
CEFOTAXIME										
CEFTAZIDIME										
CEFTRIAXONE										
Ceftazidime/Avibactam										
Ceftolozane/Tazobactam										
Cephalothin										
Ciprofloxacin										
Colistin										
DORIPENEM										
ERTAPENEM										
Fosfomycin										
Gentamicin										
IMIPENEM										
Levofloxacin										
MEROPENEM										
Moxifloxacin										
Nitrofurantoin										
Piperacillin-Tazobactam										
Polymyxin B										
Tigecycline										
Tobramycin										
Trimethoprim-sulfamethoxazole										
Other (Specify) _______________										

15b. Did clinical laboratory identify isolate as ESBL producer?
☐Yes ☐No ☐Unknown

15c. What confirmatory testing method was used? (check all that apply):
☐ Broth microdilution (ATI)
☐ Disk diffusion
☐ Other (specify): ______________________________________
☐ None
☐ Unknown

15d. If TESTED, what was the test result?
☐Positive ☐Negative
☐Indeterminate ☐Unknown

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

☐Abscess, not skin
☐Appendicitis
☐AV fistula/graft infection
☐Bacteremia
☐Catheter site infection (CVC)
☐Cholangitis
☐Chronic ulcer/wound (not decubitus)
☐Decubitus/pressure ulcer
☐Diverticulitis
☐Empyema
☐Endocarditis
☐Epididymitis
☐Epidural abscess
☐Meningitis
☐Osteomyelitis
☐Peritonitis
☐Pneumonia
☐Prostatitis
☐Pyelonephritis
☐Septic arthritis
☐Surgical incision infection
☐Surgical site infection (internal)
☐Traumatic wound
☐Urinary tract infection
☐Other ______________________

17. 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
☐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
☐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

18. RISK FACTORS OF INTEREST (Check all that apply): ☐None ☐Unknown

☐Hospitalized within year before date of initial culture:
☐Yes ☐No ☐Unknown
If yes, enter mo/yr ___ ___ - ___ ___ ___ ___ OR ☐Unknown
If known, prior hospital ID: ___________________________

☐Surgery within year before date of initial culture

☐Current chronic dialysis

☐Residence in LTCF within year before date of initial culture
If known, facility ID: _________________________

☐Admitted to a LTACH within year before date of initial culture
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 initial 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 initial 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

19a. Is antimicrobial use (IV or oral) in the *30 days* before the date of initial culture collection documented in the H&P or medical administration record?
☐**Yes *(complete 19b)*** ☐**No** ☐**Unknown**

19b. If yes, indicate all antibiotics given in the 30 days before the date of initial culture collection:

☐ Amikacin	☐ Ceftazidime	☐ Doxycycline	☐ Piperacillin-Tazobactam
☐ Amoxicillin	☐ Ceftazidime/Avibactam	☐ Ertapenem	☐ Polymyxin B
☐ Amoxicillin/Clavulanic Acid	☐ Ceftizoxime	☐ Fosfomycin	☐ Rifampin
☐ Ampicillin/Sulbactam	☐ Ceftolozane/Tazobactam	☐ Gentamicin	☐ Tetracycline
☐ Azithromycin	☐ Ceftriaxone	☐ Imipenem	☐ Ticarcillin/Clavulanic Acid
☐ Aztreonam	☐ Cefuroxime	☐ Levofloxacin	☐ Tigecycline
☐ Cefaclor	☐ Cephalexin	☐ Linezolid	☐ Tobramycin
☐ Cefazolin	☐ Ciprofloxacin	☐ Meropenem	☐ Trimethoprim-Sulfamethoxazole
☐ Cefdinir	☐ Clarithromycin	☐ Metronidazole	☐ Vancomycin, IV
☐ Cefepime	☐ Clindamycin	☐ Moxifloxacin	☐ Vancomycin, oral
☐ Cefotaxime	☐ Colistin	☐ Nitrofurantoin	☐ Unknown
☐ Cefpodoxime	☐ Daptomycin	☐ Ofloxacin	☐ Other (specify):________________
☐ Cefprozil	☐ Doripenem	☐ Penicillin	☐ Other (specify):________________

20. CRF status:
☐Complete
☐Pending
☐Chart unavailable

21. Date reported to EIP site:
____ ____ - ____ ____ - ____ ____ ____ ____

22. SO initials:
____

23. Comments:

____

____

____