

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 – 2018

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

— SHADED AREAS BELOW INDICATE CORE VARIABLES —

<b>1. STATE:</b> (Residence of patient)	<b>2. COUNTY:</b> (Residence of Patient)	<b>3. STATE I.D.:</b>	<b>4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED:</b>	<b>4b. HOSPITAL I.D. WHERE PATIENT TREATED:</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>5. SEX:</b> 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	<b>6. DATE OF BIRTH:</b> Mo. Day Year <input type="text"/>	<b>7a. AGE:</b> <input type="text"/> <b>7b. Is age in day/mo/yr?</b> 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.	<b>8. STERILE SITE(S) FROM WHICH MRSA WAS INITIALLY ISOLATED:</b> (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"/> Other sterile site (specify) _____ 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Muscle
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<b>9. DATE OF INITIAL CULTURE:</b> Mo. Day Year <input type="text"/>	<b>10a. WAS THE PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>If YES: Date of admission</b> Mo. Day Year <input type="text"/>	<b>11. WAS CULTURE COLLECTED &gt;3 CALENDAR DAYS AFTER HOSPITAL ADMISSION?</b> 1 <input type="checkbox"/> Yes (HO-MRSA case) 2 <input type="checkbox"/> No (Complete CRF, CA-MRSA or HACO-MRSA case) <b>If yes, was the case selected for full CRF based on sampling frame 1:10?</b> 1 <input type="checkbox"/> Yes (Complete CRF) 2 <input type="checkbox"/> No (STOP data abstraction)
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<b>12a. ETHNIC ORIGIN:</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown <b>12b. RACE:</b> (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 1 <input type="checkbox"/> Unknown	<b>10b. IF PATIENT WAS HOSPITALIZED, WAS THIS PATIENT ADMITTED TO THE ICU DURING HOSPITALIZATION?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>12c. WEIGHT:</b> 1 <input type="checkbox"/> Unknown _____ lbs _____ oz OR _____ kg <b>12d. HEIGHT:</b> 1 <input type="checkbox"/> Unknown _____ ft _____ in OR _____ cm <b>12e. BMI:</b> 1 <input type="checkbox"/> Unknown _____ (do not calculate, only if available in the MR)	<b>13. At time of first positive culture, patient was:</b> 1 <input type="checkbox"/> Pregnant 2 <input type="checkbox"/> Post-partum 3 <input type="checkbox"/> Neither 9 <input type="checkbox"/> Unknown <b>14. If case is ≤12 months of age, type of birth hospitalization:</b> 1 <input type="checkbox"/> NICU/SCN 2 <input type="checkbox"/> Well Baby Nursery 9 <input type="checkbox"/> Unknown	<b>15. Where was the patient located on the 4th calendar day prior to the date of initial culture?</b> 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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<b>16. LOCATION OF CULTURE COLLECTION:</b> (Check one) <b>Hospital Inpatient</b> 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 14 <input type="checkbox"/> Autopsy 2 <input type="checkbox"/> Other Unit 4 <input type="checkbox"/> Other Outpatient 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Emergency Room 10 <input type="checkbox"/> Other 16 <input type="checkbox"/> Observational Unit/Clinical Decision Unit	<b>17. Were cultures of the SAME or OTHER sterile site(s) positive within 30 days after initial culture date?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>If yes, indicate site and date of last positive culture:</b> 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: _____ <b>17b. Date of first SA blood culture after which SA not isolated for 14 days:</b> _____
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<b>18. PATIENT OUTCOME:</b> 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Survived <b>Date of discharge</b> 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 9 <input type="checkbox"/> Unknown If Yes, Facility ID _____ — If survived, was the patient transferred to a LTACH? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If Yes, Facility ID _____	2 <input type="checkbox"/> Died <b>Date of death</b> 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"/> Epidural Abscess	1 <input type="checkbox"/> Septic Arthritis	1 <input type="checkbox"/> Surgical Site (Internal)
1 <input type="checkbox"/> AV Fistula/Graft Infection	1 <input type="checkbox"/> Chronic Ulcer/Wound (non-decubitus)	1 <input type="checkbox"/> Meningitis	1 <input type="checkbox"/> Septic Emboli	1 <input type="checkbox"/> Traumatic Wound
1 <input type="checkbox"/> Bacteremia	1 <input type="checkbox"/> Decubitus/Pressure Ulcer	1 <input type="checkbox"/> Peritonitis	1 <input type="checkbox"/> Septic Shock	1 <input type="checkbox"/> Urinary Tract
1 <input type="checkbox"/> Bursitis	1 <input type="checkbox"/> Empyema	1 <input type="checkbox"/> Pneumonia	1 <input type="checkbox"/> Skin Abscess	1 <input type="checkbox"/> Other: (specify) _____
1 <input type="checkbox"/> Catheter Site Infection	1 <input type="checkbox"/> Endocarditis	1 <input type="checkbox"/> Osteomyelitis	1 <input type="checkbox"/> Surgical Incision	

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

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

1 <input type="checkbox"/> Previous documented MRSA infection or colonization	1 <input type="checkbox"/> Surgery within year before initial culture date.										
If YES: Month Year OR previous STATE I.D.: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, list the surgeries and dates of surgery that occurred within <u>90 days</u> prior to the initial culture: <table border="0"> <tr> <th>Surgery</th> <th>Date</th> </tr> <tr> <td>1. _____</td> <td>____/____/____</td> </tr> <tr> <td>2. _____</td> <td>____/____/____</td> </tr> <tr> <td>3. _____</td> <td>____/____/____</td> </tr> <tr> <td>4. _____</td> <td>____/____/____</td> </tr> </table>	Surgery	Date	1. _____	____/____/____	2. _____	____/____/____	3. _____	____/____/____	4. _____	____/____/____
Surgery	Date										
1. _____	____/____/____										
2. _____	____/____/____										
3. _____	____/____/____										
4. _____	____/____/____										
1 <input type="checkbox"/> Hospitalized within year before initial culture date.											
Date of discharge If YES: Mo. Day Year 1 <input type="checkbox"/> Unknown <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
If known, Facility ID _____											
1 <input type="checkbox"/> Dialysis within year before initial culture date. (Hemodialysis or Peritoneal dialysis)	1 <input type="checkbox"/> Residence in a long-term care facility within year before initial culture date. If known, Facility ID _____										
1 <input type="checkbox"/> Current chronic dialysis Type <input type="checkbox"/> Peritoneal <input type="checkbox"/> Unknown <input type="checkbox"/> Hemodialysis Type of vascular access <input type="checkbox"/> AV fistula / graft <input type="checkbox"/> Hemodialysis CVC <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Admitted to a LTACH within year before initial culture date. If known, Facility ID _____  1 <input type="checkbox"/> Central vascular catheter in place at any time in the 2 calendar days prior to initial culture.										

**22. SUSCEPTIBILITY RESULTS [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)]**

Cefoxitin <input type="checkbox"/> S <input type="checkbox"/> R <input type="checkbox"/> U	Oxacillin <input type="checkbox"/> S <input type="checkbox"/> R <input type="checkbox"/> U	Vancomycin <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U
Clindamycin <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U	Trimethoprim-Sulfamethoxazole <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U	

- THIS SHADED AREA FOR OFFICE USE ONLY -

<b>23. Was case first identified through audit?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>24. CRF status:</b> 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	<b>25. Does this case have recurrent MRSA disease?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If YES, previous (1 <sup>st</sup> ) STATE I.D.: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>26. Date reported to EIP site:</b> Mo. Day Year <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>27. Initials of S.O:</b> _____
<b>28 COMMENTS:</b> _____ _____ _____				