

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: _____
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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 Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated <input type="checkbox"/> Hospital Inpatient Was the patient transferred from this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Facility 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
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8a. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	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	9. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of admission: ____ - ____ - ____ Date of discharge: ____ - ____ - ____
8b. ETHNIC ORIGIN: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		

10a. DATE OF INITIAL CULTURE ____ - ____ - ____	11a. Was the patient in the ICU in the 7 days <u>prior</u> to the initial culture date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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10b. LOCATION OF CULTURE COLLECTION: <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Observational Unit/Clinical Decision Unit <input type="checkbox"/> Unknown Outpatient: <input type="checkbox"/> Clinic/Doctors Office <input type="checkbox"/> Surgery <input type="checkbox"/> Other Outpatient <input type="checkbox"/> Dialysis Center	11b. Was the patient in the ICU on the date of or in the 7 days <u>after</u> the initial culture date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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12. PATIENT OUTCOME: <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown If survived, transferred to: <input type="checkbox"/> Private residence <input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____ If died, date of death: ____ - ____ - ____	13. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE: Extended-Spectrum Cephalosporin-resistant: <input type="checkbox"/> <i>Escherichia coli</i> <input type="checkbox"/> <i>Klebsiella pneumoniae</i> <input type="checkbox"/> <i>Klebsiella oxytoca</i>
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14a. INITIAL CULTURE SITE: <input type="checkbox"/> Blood <input type="checkbox"/> Bone <input type="checkbox"/> Brain <input type="checkbox"/> CSF <input type="checkbox"/> Heart <input type="checkbox"/> Joint/synovial fluid <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Lymph node <input type="checkbox"/> Ovary <input type="checkbox"/> Pancreas <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Spleen <input type="checkbox"/> Urine <input type="checkbox"/> Vascular tissue <input type="checkbox"/> Vitreous <input type="checkbox"/> Other fluid (sterile) <input type="checkbox"/> Deep tissue <input type="checkbox"/> 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. <input type="checkbox"/> None <input type="checkbox"/> Costovertebral angle pain or tenderness <input type="checkbox"/> Dysuria <input type="checkbox"/> Fever [temperature ≥ 100.4°F (38°C)] <input type="checkbox"/> Unknown <input type="checkbox"/> Frequency <input type="checkbox"/> Suprapubic tenderness <input type="checkbox"/> Urgency
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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	
	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 (ATL) None
 Disk diffusion Unknown
 Other (specify): _____

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

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

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

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

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:

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

20. CRF status:

Complete
 Pending
 Chart unavailable

21. Date reported to EIP site:

_____ - _____ - _____

22. SO initials:

23. Comments:

