

Patient ID: _____

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

2018 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 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: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	7a. AGE: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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 <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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: Hospital Inpatient <input type="checkbox"/> ICU <input type="checkbox"/> Surgery/OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other Unit <input type="checkbox"/> Emergency Room Outpatient <input type="checkbox"/> Clinic/Doctors Office <input type="checkbox"/> Surgery <input type="checkbox"/> Other Outpatient <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Observational Unit/Clinical Decision Unit <input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Unknown	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
--	---

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:
 / /

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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

13a. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE:
 Carbapenem-resistant:
 Enterobacteriaceae (CRE):
 Escherichia 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
 Laboratory Not Testing
 Unknown

If yes, what testing method was used (check all that apply):
 Automated Molecular Assay (specify): _____
 CarbaNP E Test
 PCR Modified Hodge Test (MHT)
 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. Was the urine collected through an indwelling urethral catheter?
 Yes
 No
 Unknown

URINE Cultures ONLY:
14b. Record the colony count

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 through the 2 calendar days after the date of initial culture.
 Then go to question 14d.

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

Symptoms for patients ≤ 1 year of age only:
 Apnea
 Bradycardia
 Lethargy
 Vomiting

URINE Cultures ONLY:
14d. Was a blood culture positive in the 3 calendar days before through the 3 calendar days after the initial urine culture for the same MuGSI organism?
 Yes
 No
 Unknown

15. Was the same organism (Q13a) cultured from a different sterile site or urine in the 30 days after the date of initial culture (of this current episode)?
 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>Escherichia 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: _____

16b. A. baumannii Cultures ONLY:
Did the patient have a sputum culture positive for CRAB in the 30 days prior to the date of culture (Day 1)?
 Yes No Unknown NA

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 to the date of initial culture (Q10a):

Carbapenem-resistant *Enterobacteriaceae* (CRE):

- Escherichia 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.

Antibiotic	Data Source		Medical Record		Microscan		Vitek		Phoenix		Kirby-Bauer		E-test	
	MIC	Interp	MIC	Interp	MIC	Interp	MIC	Interp	MIC	Interp	Zone Diam	Interp	MIC	Interp
Amikacin														
Amoxicillin/Clavulanate														
Ampicillin														
Ampicillin/Sulbactam														
Aztreonam														
Cefazolin														
CEFEPIME														
CEFOTAXIME														
CEFTAZIDIME														
CEFTRIAZONE														
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"/> Decubitus/pressure ulcer | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Surgical site infection (internal) |
| <input type="checkbox"/> AV fistula/graft infection | <input type="checkbox"/> Empyema | <input type="checkbox"/> Pyelonephritis | <input type="checkbox"/> Traumatic wound |
| <input type="checkbox"/> Bacteremia | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Septic arthritis | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Epidural Abscess | <input type="checkbox"/> Septic emboli | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Catheter site infection (CVC) | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Septic shock | |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Skin abscess | |
| <input type="checkbox"/> Chronic ulcer/wound (not decubitus) | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Surgical incision infection | |

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 \geq 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
 If known, facility ID: _____
- Admitted to a LTACH within year before initial culture date
 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 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

<p>22. Was case first identified through audit?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<p>23. CRF status:</p> <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Chart unavailable	<p>24. Date reported to EIP site:</p> <p><input type="checkbox"/><input type="checkbox"/> / <input type="checkbox"/><input type="checkbox"/> / <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></p>	<p>25. SO initials:</p> <p>_____</p>
<p>26. Comments:</p> <hr/> <hr/> <hr/> <hr/> <hr/>			