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

Invasive Methicillin-Resistant Staphylococcus aureus Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2019

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: ______
4. PATIENT ID: ______
5. LABORATORY ID WHERE INCIDENT SPECIMEN INDENTIFIED: ______
6. FACILITY ID WHERE PATIENT TREATED: ______

7. SEX AT BIRTH: 1 ☐ Male 2 ☐ Female 9 ☐ Unknown 1 ☐ Check if transgendered

8. DATE OF BIRTH: __ __ - __ __ - __ __ __ __

9. AGE __ __ __ 1 ☐ Male 2 ☐ Mos. 3 ☐ Years

10. RACE: (Check all that apply)
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ White
1 ☐ Unknown

13. ETHNIC ORIGIN: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

12. WEIGHT: ______ lbs. ______ oz. OR ______ kg. 1 ☐ Unknown

13. HEIGHT: ______ ft. ______ in. OR ______ cm. 1 ☐ Unknown

14. BMI (record only if ht. and/or wt. is not available) ______ 1 ☐ Unknown

15. DATE OF INCIDENT SPECIMEN COLLECTION (DISC): __ __ - __ __ - __ __ __ __

16. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER, THE DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown **IF YES, date of admission:** __ __ - __ __ - __ __ __ __

17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?
1 ☐ Yes (HO-MRSA case) 2 ☐ No (CA-MRSA or HACO-MRSA case)

18. INCIDENT SPECIMEN COLLECTION SITE: (Check all that apply)
1 ☐ Blood 1 ☐ Bone 1 ☐ CSF 1 ☐ Internal body site (specify): ______ 1 ☐ Joint/Synovial fluid 1 ☐ Muscle 1 ☐ Pericardial fluid 1 ☐ Peritoneal fluid
1 ☐ Pleural fluid 1 ☐ Other normally sterile site (specify): ______

19. LOCATION OF SPECIMEN COLLECTION:

1 ☐ **Outpatient** Facility ID: ______
- 3 ☐ Emergency room
- 8 ☐ Clinic/doctor's office
- 15 ☐ Dialysis center
- 11 ☐ Surgery
- 16 ☐ Observation/Clinical decision unit
- 4 ☐ Other outpatient

1 ☐ **Inpatient** Facility ID: ______
- 1 ☐ ICU
- 6 ☐ OR
- 7 ☐ Radiology
- 2 ☐ Other Inpatient

5 ☐ **LTCF** Facility ID: ______
13 ☐ **LTACH** Facility ID: ______
14 ☐ **Autopsy**
10 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
9 ☐ **Unknown**

20. WERE CULTURES OF THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:
1 ☐ Blood Date: ______ 1 ☐ Bone Date: ______ 1 ☐ CSF Date: ______
1 ☐ Internal body site Date: ______ 1 ☐ Joint/Synovial fluid Date: ______ 1 ☐ Muscle Date: ______
1 ☐ Peritoneal fluid Date: ______ 1 ☐ Pericardial fluid Date: ______ 1 ☐ Pleural fluid Date: ______
1 ☐ Other normally sterile site (specify): ______ Date: ______

21. DATE OF FIRST SA BLOOD CULTURE AFTER WHICH SA NOT ISOLATED FOR 14 DAYS:
__ __ - __ __ - __ __ __ __

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

Antibiotic					Antibiotic					Antibiotic				
Cefazolin	☐ S	☐ I	☐ R	☐ U	Cefoxitin	☐ S	☐ I	☐ R	☐ U	Clindamycin	☐ S	☐ I	☐ R	☐ U
Nafcillin	☐ S	☐ I	☐ R	☐ U	Oxacillin	☐ S	☐ I	☐ R	☐ U	Trimethoprim-Sulfamethozazole	☐ S	☐ I	☐ R	☐ U
Vancomycin	☐ S	☐ I	☐ R	☐ U										

23. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC?
1 ☐ Private residence
1 ☐ LTCF Facility ID: ______
1 ☐ Hospital Inpatient Facility ID: ______
Was patient transferred from this hosptial? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
1 ☐ LTACH Facility ID: ______
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Other (specify): ______
1 ☐ Unknown

24. IF CASE IS ≤12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION:
1 ☐ NICU/SCN 2 ☐ Well Baby Nusery 9 ☐ Unknown

25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, birth weight: ______ **lbs.** ______ **oz. OR** ______ **g.** OR 1 ☐ Unknown birth weight
IF YES, estimated gestational age: ______ weeks OR 1 ☐ Unknown gestational age

26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, date of ICU admission: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, date of ICU admission: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

Public reporting burden of this collection of information is estimated to average 25 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).

— IMPORTANT — PLEASE COMPLETE THE BACK OF THIS FORM —

28. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply) 1 ☐ None 1 ☐ Unknown

1 ☐ Abscess (not skin)	1 ☐ Cellulitis	1 ☐ Epidural Abscess	1 ☐ Septic Arthritis	1 ☐ Surgical Site (Internal)
1 ☐ AV Fistula/Graft Infection	1 ☐ Chronic Ulcer/Wound (non-decubitus)	1 ☐ Meningitis	1 ☐ Septic Emboli	1 ☐ Traumatic Wound
1 ☐ Bacteremia	1 ☐ Decubitus/Pressure Ulcer	1 ☐ Peritonitis	1 ☐ Septic Shock	1 ☐ Urinary Tract
1 ☐ Bursitis	1 ☐ Empyema	1 ☐ Pneumonia	1 ☐ Skin Abscess	1 ☐ Other: (specify)
1 ☐ Catheter Site Infection	1 ☐ Endocarditis	1 ☐ Osteomyelitis	1 ☐ Surgical Incision	______________

29. UNDERLYING CONDITIONS: (Check all that apply) 1 ☐ None 1 ☐ Unknown

CHRONIC LUNG DISEASE
Cystic fibrosis
Chronic pulmonary disease

CHRONIC METABOLIC DISEASE
1 ☐ Diabetes mellitus
  1 ☐ With chronic complications

CARDIOVASCULAR DISEASE
1 ☐ CVA/Stroke/TIA
1 ☐ Congenital heart disease
1 ☐ Congestive heart failure
1 ☐ Myocardial infarction
1 ☐ Peripheral vascular disease (PVD)

GASTROINTESTINAL DISEASE
1 ☐ Diverticular disease
1 ☐ Inflammatory bowel disease
1 ☐ Peptic ulcer disease
1 ☐ Short gut syndrome

IMMUNOCOMPROMISED CONDITION
1 ☐ HIV infection
  1 ☐ AIDS/CD4 count <200
1 ☐ Primary immunodeficiency
1 ☐ Transplant, hematopoetic stem cell
1 ☐ Transplant, solid organ

LIVER DISEASE
1 ☐ Chronic liver disease
  1 ☐ Ascites
  1 ☐ Cirrhosis
  1 ☐ Hepatic encephalopathy
  1 ☐ Variceal bleeding
1 ☐ Hepatitis C
  1 ☐ Treated, in SVR
  1 ☐ Current, chronic

MALIGNANCY
1 ☐ Malignancy, hematologic
1 ☐ Malignancy, solid organ (non-metastatic)
1 ☐ Malignancy, solid organ (metastatic)

NEUROLOGIC CONDITION
1 ☐ Cerebral palsy
1 ☐ Chronic cognitive deficit
1 ☐ Dementia
1 ☐ Epilepsy/seizure/seizure disorder
1 ☐ Multiple sclerosis
1 ☐ Neuropathy
1 ☐ Parkinson's Disease
1 ☐ Other (specify): ______________

PLEGIAS/PARALYSIS
1 ☐ Hemiplegia
1 ☐ Paraplegia
1 ☐ Quadriplegia

RENAL DISEASE
1 ☐ Chronic kidney disease
  Lowest serum creatinine: ________mg/DL

SKIN CONDITION
1 ☐ Burn
1 ☐ Decubitus/pressure ulcer
1 ☐ Surgical wound
1 ☐ Other chronic ulcer or chronic wound
1 ☐ Other skin condition (specify): ______________

OTHER
1 ☐ Connective tissue disease
1 ☐ Obesity or morbid obesity
1 ☐ Pregnant
1 ☐ Other (specify only for cases ≤12 months of age): ______________

30. SUBSTANCE USE, CURRENT

SMOKING: (Check all that apply)
1 ☐ None 1 ☐ Unknown 1 ☐ Tobacco 1 ☐ E-nicotine delivery system 1 ☐ Marijuana

ALCOHOL ABUSE:
1 ☐ Yes 1 ☐ No 1 ☐ Unknown

OTHER SUBSTANCES: (CHECK ALL THAT APPLY) 1 ☐ None 1 ☐ Unknown

	DOCUMENTED USE DISORDER (DUD)/ABUSE:	MODE OF DELIVERY (Check all that apply):			
1 ☐ Marijuana/cannabinoid (other than smoking)	1 ☐ DUD or abuse	☐ IDU	☐ Skin popping	☐ Non-IDU	☐ Unknown
1 ☐ Opioid, DEA schedule I (e.g., heroin)	1 ☐ DUD or abuse	☐ IDU	☐ Skin popping	☐ Non-IDU	☐ Unknown
1 ☐ Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	1 ☐ DUD or abuse	☐ IDU	☐ Skin popping	☐ Non-IDU	☐ Unknown
1 ☐ Cocaine or methamphetamine	1 ☐ DUD or abuse	☐ IDU	☐ Skin popping	☐ Non-IDU	☐ Unknown
1 ☐ Other (specify):______________	1 ☐ DUD or abuse	☐ IDU	☐ Skin popping	☐ Non-IDU	☐ Unknown
1 ☐ Unknown substance	1 ☐ DUD or abuse	☐ IDU	☐ Skin popping	☐ Non-IDU	☐ Unknown

31. PRIOR HEALTHCARE EXPOSURE(S):

PREVIOUS DOCUMENTED MRSA INFECTION OR COLONIZATION
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If YES: ______ (Month) ______ (Year) OR previous STATE I.D.: ______________

PREVIOUS HOSPITALIZATION IN THE YEAR BEFORE DISC
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If YES, DATE OF DISCHARGE CLOSEST TO DISC: __ __ - __ __ - __ __ __ __
OR, 1 ☐ Date unknown
Facility ID: ______________

OVERNIGHT STAY IN LTACH IN THE YEAR BEFORE DISC
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
Facility ID ______________

OVERNIGHT STAY IN LTCF IN THE YEAR BEFORE DISC
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
Facility ID ______________

SURGERY IN THE YEAR BEFORE DISC 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, Unknown list the surgeries and dates of surgery that occurred within 90 days prior to the DISC:

	Surgery	Date
1.	______________	__ __ - __ __ - __ __ __ __
2.	______________	__ __ - __ __ - __ __ __ __
3.	______________	__ __ - __ __ - __ __ __ __
4.	______________	__ __ - __ __ - __ __ __ __

CENTRAL LINE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC
1 ☐ Yes 2 ☐ No 9 ☐ Unknown **CHECK HERE** if central line in place for >2 calendar days 1 ☐

DIALYSIS IN THE YEAR BEFORE DISC (Hemodialysis or Peritoneal dialysis)
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

CURRENT CHRONIC DIALYSIS 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
TYPE: ☐ Hemodialysis ☐ Peritoneal ☐ Unknown
IF HEMODIALYSIS, type of vascular access: 1 ☐ AV fistual/graft 2 ☐ Hemodialysis central line 9 ☐ Unknown

32. PATIENT OUTCOME 1 ☐ Survived

DATE OF DISCHARGE: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

1 ☐ Left against medical advice (AMA)

IF SURVIVED, DISCHARGED TO:

1 ☐ Private Residence
2 ☐ LTCF Facility ID: ____________
3 ☐ LTACH Facility ID: ____________
4 ☐ Other (specify): ____________
9 ☐ Unknown

2 ☐ Died

DATE OF DEATH: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

ON THE DAY OF OR IN THE 6 CALENDAR DAYS BEFORE DEATH, WAS THE PATHOGEN OF INTEREST ISOLATED FROM A SITE THAT MEETS THE CASE DEFINITION?

1 ☐ Yes ☐ No ☐ Unknown

2 ☐ Unknown

– THIS SHADED AREA FOR OFFICE USE ONLY –

33. WAS CASE FIRSTIDENTIFIED THROUGH AUDIT?	**34. CRF STATUS:**	**35. DOES THIS CASE HAVE RECURRENT MRSA DISEASE ?**	**IF YES, PREVIOUS (1ST) STATE I.D.**	**36. DATE REPORTED TO EIP SITE:**	**37. S.O. INITIALS:**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Complete 2 ☐ Incomplete 3 ☐ Edited & Correct 4 ☐ Chart unavailable after 3 requests	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	____________	__ __ - __ __ - __ __ __ __	____________

38 COMMENTS: