



**2019 Carbapenem Resistant Enterobacteriaceae (CRE)/ Carbapenem Resistant *A. baumannii* (CRAB)  
Multi-site Gram-Negative Surveillance Initiative (MuGSI)  
Healthcare-Associated Infections Community Interface (HAIC) Case Report**

Form Approved  
OMB No. 0920-0978  
Exp. Date: XX-XX-XXXX

Patient's Name: _____		Phone no. (    ) _____	
Address: _____		MRN: _____	
City: _____	State _____	ZIP: _____	Hospital: _____
----Patient Identifier information is not transmitted to CDC----			
<b>DEMOGRAPHICS</b>			
<b>1. STATE:</b> _____	<b>2. COUNTY:</b> _____	<b>3. STATE ID:</b> _____	<b>4a. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED:</b> _____
<b>5. DATE OF BIRTH:</b> ____ - ____ - ____		<b>7. SEX AT BIRTH:</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> Unknown <input type="checkbox"/> Check if transgender	<b>8a. ETHNIC ORIGIN:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
<b>6. AGE:</b> _____ <input type="checkbox"/> Days <input type="checkbox"/> Mos. <input type="checkbox"/> Yrs.		<b>8b. RACE: (Check all that apply)</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	
<b>9. DATE OF INCIDENT SPECIMEN COLLECTION (DISC):</b> ____ - ____ - ____		<b>10. ORGANISM:</b> Carbapenem-resistant: <input type="checkbox"/> Enterobacteriaceae (CRE): <input type="checkbox"/> <i>Escherichia coli</i> <input type="checkbox"/> <i>Klebsiella pneumoniae</i> <input type="checkbox"/> <i>Enterobacter cloacae</i> <input type="checkbox"/> <i>Klebsiella oxytoca</i> <input type="checkbox"/> <i>Klebsiella aerogenes</i> <input type="checkbox"/> <i>A. baumannii</i> (CRAB)	
<b>11. INCIDENT SPECIMEN COLLECTION SITE:</b> <input type="checkbox"/> Blood <input type="checkbox"/> Bone <input type="checkbox"/> CSF <input type="checkbox"/> Internal body site (specify): _____ <input type="checkbox"/> Joint/synovial fluid <input type="checkbox"/> Muscle <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Urine <input type="checkbox"/> Other normally sterile site (specify): _____			
<b>12. LOCATION OF SPECIMEN COLLECTION:</b> <input type="checkbox"/> <b>OUTPATIENT:</b> Facility ID: _____ <input type="checkbox"/> Emergency room <input type="checkbox"/> Clinic/Doctor's office <input type="checkbox"/> Dialysis center <input type="checkbox"/> Surgery <input type="checkbox"/> Observational/Clinical decision unit <input type="checkbox"/> Other outpatient <input type="checkbox"/> <b>INPATIENT:</b> Facility ID: _____ <input type="checkbox"/> ICU <input type="checkbox"/> OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other inpatient <input type="checkbox"/> <b>LTCF:</b> Facility ID: _____ <input type="checkbox"/> <b>LTACH:</b> Facility ID: _____ <input type="checkbox"/> <b>Autopsy</b> <input type="checkbox"/> <b>Other (specify):</b> _____ <input type="checkbox"/> <b>Unknown</b>			<b>13. WHERE WAS THE PATIENT LOCATED ON THE 3<sup>RD</sup> CALENDAR DAY BEFORE THE DISC?</b> <input type="checkbox"/> Private residence <input type="checkbox"/> LTACH <input type="checkbox"/> LTCF   Facility ID: _____ <input type="checkbox"/> Hospital inpatient   Facility ID: _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown Was the patient transferred from this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>14. WAS THE PATIENT HOSPITALIZED ON THE DAY OF OR IN THE 29 CALENDAR DAYS AFTER THE DISC?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown IF YES, DATE OF ADMISSION: ____ - ____ - ____		<b>15a. WAS THE PATIENT IN AN ICU IN THE 7 DAYS BEFORE THE DISC?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown IF YES, DATE OF ICU ADMISSION: ____ - ____ - ____ OR <input type="checkbox"/> Date unknown <b>15b. WAS THE PATIENT IN AN ICU ON THE DAY OF INCIDENT SPECIMEN COLLECTION OR IN THE 6 DAYS AFTER THE DISC?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown IF YES, DATE OF ICU ADMISSION: ____ - ____ - ____ OR <input type="checkbox"/> Date unknown	
<b>16. PATIENT OUTCOME:</b> <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown DATE OF DISCHARGE: ____ - ____ - ____ OR <input type="checkbox"/> Date unknown <input type="checkbox"/> Left against medical advice (AMA) DATE OF DEATH: ____ - ____ - ____ OR <input type="checkbox"/> Date unknown IF SURVIVED, DISCHARGED TO: <input type="checkbox"/> Private residence <input type="checkbox"/> LTCF   Facility ID: _____ <input type="checkbox"/> LTACH   Facility ID: _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).



**17. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply)**  None  Unknown

<input type="checkbox"/> Abscess, not skin	<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Epidural Abscess	<input type="checkbox"/> Pyelonephritis	<input type="checkbox"/> Surgical incision infection
<input type="checkbox"/> AV fistula/graft infection	<input type="checkbox"/> Chronic ulcer/wound (not decubitus)	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Septic arthritis	<input type="checkbox"/> Surgical site infection (internal)
<input type="checkbox"/> Bacteremia	<input type="checkbox"/> Decubitus/pressure ulcer	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Septic emboli	<input type="checkbox"/> Traumatic wound
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Empyema	<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Septic shock	<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Catheter site infection (CVC)	<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Skin abscess	<input type="checkbox"/> Other (specify): _____

**18. UNDERLYING CONDITIONS: (Check all that apply)**  None  Unknown

<b>CHRONIC LUNG DISEASE</b>	<b>IMMUNOCOMPROMISED CONDITION</b>	<b>NEUROLOGIC CONDITION</b>	<b>SKIN CONDITION</b>
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> HIV infection	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Burn
<input type="checkbox"/> Chronic pulmonary disease	<input type="checkbox"/> AIDS/CD4 count < 200	<input type="checkbox"/> Chronic cognitive deficit	<input type="checkbox"/> Decubitus/pressure ulcer
<b>CHRONIC METABOLIC DISEASE</b>	<input type="checkbox"/> Primary immunodeficiency	<input type="checkbox"/> Dementia	<input type="checkbox"/> Surgical wound
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Transplant, hematopoietic stem cell	<input type="checkbox"/> Epilepsy/seizure/seizure disorder	<input type="checkbox"/> Other chronic ulcer or chronic wound
<input type="checkbox"/> With chronic complications	<input type="checkbox"/> Transplant, solid organ	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Other (specify): _____
<b>CARDIOVASCULAR DISEASE</b>	<b>LIVER DISEASE</b>	<input type="checkbox"/> Neuropathy	<b>OTHER</b>
<input type="checkbox"/> CVA/Stroke/TIA	<input type="checkbox"/> Chronic liver disease	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Connective tissue disease
<input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> Ascites	<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Obesity or morbid obesity
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Cirrhosis	<b>PLEGIAS/PARALYSIS</b>	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Myocardial infarction	<input type="checkbox"/> Hepatic encephalopathy	<input type="checkbox"/> Hemiplegia	<b>MUGSI CONDITIONS</b>
<input type="checkbox"/> Peripheral vascular disease (PVD)	<input type="checkbox"/> Variceal bleeding	<input type="checkbox"/> Paraplegia	<input type="checkbox"/> Urinary tract problems/abnormalities
<b>GASTROINTESTINAL DISEASE</b>	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Quadriplegia	<input type="checkbox"/> Premature birth
<input type="checkbox"/> Diverticular disease	<input type="checkbox"/> Treated, in SVR	<b>RENAL DISEASE</b>	<input type="checkbox"/> Spina bifida
<input type="checkbox"/> Inflammatory bowel disease	<input type="checkbox"/> Current, chronic	<input type="checkbox"/> Chronic kidney disease	
<input type="checkbox"/> Peptic ulcer disease	<b>MALIGNANCY</b>	Lowest serum creatinine: _____ mg/DL	
<input type="checkbox"/> Short gut syndrome	<input type="checkbox"/> Malignancy, hematologic		
	<input type="checkbox"/> Malignancy, solid organ (non-metastatic)		
	<input type="checkbox"/> Malignancy, solid organ (metastatic)		

**19. SUBSTANCE USE, CURRENT**  None  Unknown

<b>SMOKING:</b> (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Unknown	<b>ALCOHOL ABUSE:</b>	<b>OTHER SUBSTANCES: (Check all that apply)</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown	<b>DOCUMENTED USE DISORDER (DUD)/ABUSE:</b>	<b>MODE OF DELIVERY:</b> (Check all that apply)
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Yes	<input type="checkbox"/> Marijuana/cannabinoid (other than smoking)	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> E-nicotine delivery system	<input type="checkbox"/> No	<input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin)	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Unknown	<input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
		<input type="checkbox"/> Cocaine or methamphetamine	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
		<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
		<input type="checkbox"/> Unknown substance	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown

**20. RISK FACTORS: (Check all that apply)**  None  Unknown

**WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?**  Yes  No

**PREVIOUS HOSPITALIZATION IN THE YEAR BEFORE DISC:**  Yes  No  Unknown

If YES, DATE OF DISCHARGE CLOSEST TO DISC: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

OR, DATE UNKNOWN

Facility ID: \_\_\_\_\_

**OVERNIGHT STAY IN LTCF IN THE YEAR BEFORE DISC:**  Yes  No  Unknown

Facility ID: \_\_\_\_\_

**OVERNIGHT STAY IN LTACH IN THE YEAR BEFORE DISC:**  Yes  No  Unknown

Facility ID: \_\_\_\_\_

**SURGERY IN THE YEAR BEFORE DISC:**  Yes  No  Unknown

**CURRENT CHRONIC DIALYSIS:**  Yes  No  Unknown

If YES, TYPE:  Hemodialysis  Peritoneal  Unknown

If HEMODIALYSIS, TYPE OF VASCULAR ACCESS:

AV fistula/graft  Hemodialysis central line  Unknown

**CENTRAL LINE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:**  Yes  No  Unknown

Check here if central line in place for > 2 calendar days:

**URINARY CATHETER IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:**  Yes  No  Unknown

If YES, CHECK ALL THAT APPLY:

Indwelling Urethral Catheter  Suprapubic Catheter

Condom Catheter  Other (specify): \_\_\_\_\_

**ANY OTHER INDWELLING DEVICE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:**  Yes  No  Unknown

If YES, CHECK ALL THAT APPLY:

ET/NT Tube  Gastrostomy Tube  NG Tube

Tracheostomy  Nephrostomy Tube  Other (specify): \_\_\_\_\_

**PATIENT TRAVELED INTERNATIONALLY IN THE YEAR BEFORE DISC:**  Yes  No  Unknown

COUNTRY: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

<b>21a. WEIGHT:</b> _____ lbs. _____ oz. OR _____ kg <input type="checkbox"/> Unknown	<b>21b. HEIGHT:</b> _____ ft. _____ in. OR _____ cm <input type="checkbox"/> Unknown	<b>21c. BMI:</b> _____ <input type="checkbox"/> Unknown
---	--	---

**PATIENT HOSPITALIZED WHILE VISITING COUNTRY(IES) ABOVE:**  Yes  No  Unknown



<p><b>URINE CULTURES ONLY:</b> 22a. WAS THE URINE COLLECTED THROUGH AN INDWELLING URETHRAL CATHETER?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p><b>URINE CULTURES ONLY:</b> 22c. SIGNS AND SYMPTOMS ASSOCIATED WITH URINE CULTURE</p> <p>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 DISC.</p> <p><input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Costovertebral angle pain or tenderness <input type="checkbox"/> Frequency</p> <p><input type="checkbox"/> Dysuria <input type="checkbox"/> Suprapubic tenderness</p> <p><input type="checkbox"/> Fever [temperature <math>\geq</math> 100.4 °F (38 °C)] <input type="checkbox"/> Urgency</p>	<p><b>URINE CULTURES ONLY:</b> 22d. WAS A BLOOD CULTURE POSITIVE IN THE 3 CALENDAR DAYS BEFORE THROUGH THE 3 CALENDAR DAYS AFTER THE DISC FOR THE SAME MuGSI ORGANISM?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>												
<p><b>URINE CULTURES ONLY:</b> 22b. RECORD THE COLONY COUNT: _____</p>	<p><b>Symptoms for patients <math>\leq</math> 1 year of age only:</b></p> <p><input type="checkbox"/> Apnea</p> <p><input type="checkbox"/> Bradycardia</p> <p><input type="checkbox"/> Lethargy</p> <p><input type="checkbox"/> Vomiting</p>													
<p><b>23. WAS THE INCIDENT SPECIMEN POLYMICROBIAL?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p><b>24a. WAS THE INCIDENT SPECIMEN TESTED FOR CARBAPENEMASE?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Laboratory not testing <input type="checkbox"/> Unknown</p>	<p><b>24b. IF YES, WHAT TESTING METHOD WAS USED? (Check all that apply):</b></p> <p><b>Non-Molecular Tests</b></p> <p><input type="checkbox"/> CarbaNP</p> <p><input type="checkbox"/> Carbapenemase Inactivation Method (CIM)</p> <p><input type="checkbox"/> Disk Diffusion/ROSCO Disk</p> <p><input type="checkbox"/> E-test</p> <p><input type="checkbox"/> Modified Carbapenemase Inactivation Method (mCIM)</p> <p><input type="checkbox"/> Modified Hodge Test (MHT)</p> <p><input type="checkbox"/> RAPIDEC</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> Unknown</p>	<p><b>24c. IF TESTED, WHAT WAS THE TESTING RESULT?</b></p> <p><b>Non-Molecular Test Results:</b></p> <p><input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Negative <input type="checkbox"/> Unknown</p> <p><b>Molecular Test Results:</b></p> <p><input type="checkbox"/> NDM <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Ind <input type="checkbox"/> Unk</p> <p><input type="checkbox"/> KPC <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Ind <input type="checkbox"/> Unk</p> <p><input type="checkbox"/> OXA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Ind <input type="checkbox"/> Unk</p> <p><input type="checkbox"/> OXA-48 <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Ind <input type="checkbox"/> Unk</p> <p><input type="checkbox"/> VIM <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Ind <input type="checkbox"/> Unk</p> <p><input type="checkbox"/> IMP <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Ind <input type="checkbox"/> Unk</p>											
<p><b>25. WAS THE SAME ORGANISM (Q10) CULTURED FROM A DIFFERENT STERILE SITE OR URINE IN THE 30 DAYS AFTER THE DISC?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>IF YES, SOURCE: (check all that apply)</b></p> <p><input type="checkbox"/> Blood <input type="checkbox"/> Muscle</p> <p><input type="checkbox"/> Bone <input type="checkbox"/> Peritoneal fluid</p> <p><input type="checkbox"/> CSF <input type="checkbox"/> Pericardial fluid</p> <p><input type="checkbox"/> Internal body site (specify): _____</p> <p><input type="checkbox"/> Urine</p> <p><input type="checkbox"/> Other normally sterile site (specify): _____</p> <p><input type="checkbox"/> Joint/synovial fluid</p>	<p><b>26. ENTEROBACTERIACEAE ONLY: WERE CULTURES OF STERILE SITE(S) OR URINE POSITIVE IN THE 30 DAYS BEFORE THE DISC, FOR A DIFFERENT ORGANISM (Q10)?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A</p> <p><b>IF YES, SOURCE: (check all that apply)</b></p> <p><input type="checkbox"/> Blood <input type="checkbox"/> Muscle</p> <p><input type="checkbox"/> Bone <input type="checkbox"/> Peritoneal fluid</p> <p><input type="checkbox"/> CSF <input type="checkbox"/> Pericardial fluid</p> <p><input type="checkbox"/> Internal body site (specify): _____</p> <p><input type="checkbox"/> Urine</p> <p><input type="checkbox"/> Other normally sterile site (specify): _____</p> <p><input type="checkbox"/> Joint/synovial fluid</p>	<p><b>IF YES, INDICATE ORGANISM TYPE AND ASSOCIATED STATE ID FOR THE INCIDENT CLOSEST TO THE DISC:</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;">Organism</th> <th style="width:30%;">State ID</th> </tr> </thead> <tbody> <tr> <td><i>Escherichia coli</i></td> <td></td> </tr> <tr> <td><i>Enterobacter cloacae</i></td> <td></td> </tr> <tr> <td><i>Klebsiella aerogenes</i></td> <td></td> </tr> <tr> <td><i>Klebsiella pneumoniae</i></td> <td></td> </tr> <tr> <td><i>Klebsiella oxytoca</i></td> <td></td> </tr> </tbody> </table>	Organism	State ID	<i>Escherichia coli</i>		<i>Enterobacter cloacae</i>		<i>Klebsiella aerogenes</i>		<i>Klebsiella pneumoniae</i>		<i>Klebsiella oxytoca</i>	
Organism	State ID													
<i>Escherichia coli</i>														
<i>Enterobacter cloacae</i>														
<i>Klebsiella aerogenes</i>														
<i>Klebsiella pneumoniae</i>														
<i>Klebsiella oxytoca</i>														
<p><b>27a. A. BAUMANNII CULTURES ONLY:</b> WERE CULTURES OF OTHER STERILE SITE(S) OR URINE POSITIVE IN THE 30 DAYS BEFORE THE DISC, FOR ANOTHER A. BAUMANNII?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A</p> <p><b>IF YES, SOURCE: (check all that apply)</b></p> <p><input type="checkbox"/> Blood <input type="checkbox"/> Muscle</p> <p><input type="checkbox"/> Bone <input type="checkbox"/> Peritoneal fluid</p> <p><input type="checkbox"/> CSF <input type="checkbox"/> Pericardial fluid</p> <p><input type="checkbox"/> Internal body site (specify): _____</p> <p><input type="checkbox"/> Urine</p> <p><input type="checkbox"/> Other normally sterile site (specify): _____</p>	<p><b>27b. A. BAUMANNII CULTURES ONLY:</b> DID THE PATIENT HAVE A SPUTUM CULTURE POSITIVE FOR CRAB IN THE 30 DAYS BEFORE THE DISC?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A</p>	<p><b>27c. A. BAUMANNII CULTURES ONLY:</b> <b>RISK FACTORS IN THE 7 DAYS BEFORE THE DISC:</b></p> <p><input type="checkbox"/> Non-invasive positive pressure ventilation (CPAP or BiPAP) at any time in the 7 calendar days before the DISC</p> <p><input type="checkbox"/> Nebulizer treatment at any time in the 7 calendar days before the DISC</p> <p><input type="checkbox"/> Mechanical ventilation at any time in the 7 calendar days before the DISC</p>												
<p><b>28a. WAS THE PATIENT POSITIVE FOR THE SAME ORGANISM IN THE YEAR BEFORE THE DISC?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p><b>28b. IF YES, SPECIFY DATE OF CULTURE AND STATE ID FOR THE FIRST POSITIVE CULTURE IN THE YEAR BEFORE:</b></p> <p><b>DATE OF CULTURE:</b> _____ - _____ - _____</p> <p><b>STATE ID:</b> _____</p>													
<p><b>29a. ENTEROBACTERIACEAE ONLY:</b> WAS THE PATIENT POSITIVE FOR A MuGSI ENTEROBACTERIACEAE IN THE YEAR BEFORE THE DISC?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A</p>	<p><b>29b. IF YES, SPECIFY ORGANISM, DATE OF CULTURE, AND STATE ID FOR THE FIRST POSITIVE ENTEROBACTERIACEAE CULTURE IN THE YEAR BEFORE THE DISC:</b></p> <p>Carbapenem-resistant Enterobacteriaceae (CRE):</p> <p><input type="checkbox"/> <i>Escherichia coli</i></p> <p><input type="checkbox"/> <i>Enterobacter cloacae</i></p> <p><input type="checkbox"/> <i>Klebsiella aerogenes</i></p> <p><input type="checkbox"/> <i>Klebsiella pneumoniae</i></p> <p><input type="checkbox"/> <i>Klebsiella oxytoca</i></p> <p><b>DATE OF CULTURE:</b> _____ - _____ - _____</p> <p><b>STATE ID:</b> _____</p>													



**30. 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.

Data Source	Medical Record		Microscan		Vitek		Phoenix		Kirby-Bauer		E-test	
	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												
Meropenem-vaborbactam												
Minocycline												
Doxycycline												
Plazomicin												
Tetracycline												
Rifampin												
Ceftazidime/Avibactam												
Ceftolozane/Tazobactam												
Fosfomycin												
Imipenem-relebactam												

**31a. WAS CASE FIRST IDENTIFIED THROUGH AUDIT?**

- Yes
- No

**31b. CRF STATUS:**

- Complete
- Pending
- Chart unavailable after 3 requests

**31c. SO INITIALS:**

\_\_\_\_\_

**31d. COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_