



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

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:	4. PATIENT ID:	5. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED:	6. FACILITY ID WHERE PATIENT TREATED:			
7. SEX AT BIRTH: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Check if transgendered	8. DATE OF BIRTH: ____-____-____ 9. AGE ____ 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Years	10. RACE: (Check all that apply) 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> Unknown			13. ETHNIC ORIGIN: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
12. WEIGHT: ____ lbs. ____ oz. OR ____ kg. 1 <input type="checkbox"/> Unknown		13. HEIGHT: ____ ft. ____ in. OR ____ cm. 1 <input type="checkbox"/> Unknown	14. BMI (record only if ht. and/or wt. is not available) ____ 1 <input type="checkbox"/> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of admission: ____-____-____			17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION? 1 <input type="checkbox"/> Yes (HO-MRSA case) 2 <input type="checkbox"/> No (CA-MRSA or HACO-MRSA case)					
18. INCIDENT SPECIMEN COLLECTION SITE: (Check all that apply) 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> CSF 1 <input type="checkbox"/> Internal body site (specify): _____ 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> Muscle 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Other normally sterile site (specify): _____								
19. LOCATION OF SPECIMEN COLLECTION: 1 <input type="checkbox"/> Outpatient Facility ID: _____ 3 <input type="checkbox"/> Emergency room 8 <input type="checkbox"/> Clinic/doctor's office 15 <input type="checkbox"/> Dialysis center 11 <input type="checkbox"/> Surgery 16 <input type="checkbox"/> Observation/Clinical decision unit 4 <input type="checkbox"/> Other outpatient			1 <input type="checkbox"/> Inpatient Facility ID: _____ 5 <input type="checkbox"/> LTCF Facility ID: _____ 13 <input type="checkbox"/> LTACH Facility ID: _____ 14 <input type="checkbox"/> Autopsy 10 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 9 <input type="checkbox"/> Unknown			20. WERE CULTURES OF THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE: 1 <input type="checkbox"/> Blood Date: _____ 1 <input type="checkbox"/> Bone Date: _____ 1 <input type="checkbox"/> CSF Date: _____ 1 <input type="checkbox"/> Internal body site Date: _____ 1 <input type="checkbox"/> Joint/Synovial fluid Date: _____ 1 <input type="checkbox"/> Muscle Date: _____ 1 <input type="checkbox"/> Peritoneal fluid Date: _____ 1 <input type="checkbox"/> Pericardial fluid Date: _____ 1 <input type="checkbox"/> Pleural fluid Date: _____ 1 <input type="checkbox"/> Other normally sterile site (specify): _____ Date: _____		
21. DATE OF FIRST SA BLOOD CULTURE AFTER WHICH SA NOT ISOLATED FOR 14 DAYS: ____-____-____								
22. SUSCEPTIBILITY RESULTS [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)] Cefazolin <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U Cefoxitin <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 Nafcillin <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U Oxacillin <input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> U Trimethoprim-Sulfamethozazole <input type="checkbox"/> S <input type="checkbox"/> I <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								
23. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC? 1 <input type="checkbox"/> Private residence 1 <input type="checkbox"/> LTACH Facility ID: _____ 1 <input type="checkbox"/> LTCF Facility ID: _____ 1 <input type="checkbox"/> Homeless 1 <input type="checkbox"/> Hospital Inpatient Facility ID: _____ 1 <input type="checkbox"/> Incarcerated Was patient transferred from this hospital? 1 <input type="checkbox"/> Other (specify): _____ 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Unknown			24. IF CASE IS ≤12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION: 1 <input type="checkbox"/> NICU/SCN 2 <input type="checkbox"/> Well Baby Nursery 9 <input type="checkbox"/> Unknown			25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, birth weight: ____ lbs. ____ oz. OR ____ g. OR 1 <input type="checkbox"/> Unknown birth weight IF YES, estimated gestational age: ____ weeks OR 1 <input type="checkbox"/> Unknown gestational age		
26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of ICU admission: ____-____-____ OR 1 <input type="checkbox"/> Date Unknown			27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of ICU admission: ____-____-____ OR 1 <input type="checkbox"/> 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).

28. 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 | |

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

CHRONIC LUNG DISEASE

- 1 Cystic fibrosis
1 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, hematopoietic 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 <input type="checkbox"/> Marijuana/cannabinoid (other than smoking) | 1 <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU | <input type="checkbox"/> Skin popping | <input type="checkbox"/> Non-IDU | <input type="checkbox"/> Unknown |
| 1 <input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin) | 1 <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU | <input type="checkbox"/> Skin popping | <input type="checkbox"/> Non-IDU | <input type="checkbox"/> Unknown |
| 1 <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone) | 1 <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU | <input type="checkbox"/> Skin popping | <input type="checkbox"/> Non-IDU | <input type="checkbox"/> Unknown |
| 1 <input type="checkbox"/> Cocaine or methamphetamine | 1 <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU | <input type="checkbox"/> Skin popping | <input type="checkbox"/> Non-IDU | <input type="checkbox"/> Unknown |
| 1 <input type="checkbox"/> Other (specify): _____ | 1 <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU | <input type="checkbox"/> Skin popping | <input type="checkbox"/> Non-IDU | <input type="checkbox"/> Unknown |
| 1 <input type="checkbox"/> Unknown substance | 1 <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU | <input type="checkbox"/> Skin popping | <input type="checkbox"/> Non-IDU | <input type="checkbox"/> Unknown |

31. PRIOR HEALTHCARE EXPOSURE(S):

PREVIOUS DOCUMENTED MRSA INFECTION OR COLONIZATION

- 1 Yes 2 No 9 Unknown

If YES: _____ OR previous STATE I.D.: _____
Month Year

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 fistula/graft 2 Hemodialysis central line
9 Unknown

32. PATIENT OUTCOME 1 Survived

2 Died

2 Unknown

DATE OF DISCHARGE: ____ - ____ - ____ OR 1 Date Unknown

DATE OF DEATH: ____ - ____ - ____ OR 1 Date Unknown

1 Left against medical advice (AMA)

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?

IF SURVIVED, DISCHARGED TO:

1 Private Residence

4 Other (specify): _____

2 LTCF Facility ID: _____

1 Yes No Unknown

3 LTACH Facility ID: _____

9 Unknown

- THIS SHADED AREA FOR OFFICE USE ONLY -

33. WAS CASE FIRST IDENTIFIED THROUGH AUDIT?

1 Yes 2 No

9 Unknown

34. CRF STATUS:

1 Complete

2 Incomplete

3 Edited & Correct

4 Chart unavailable after 3 requests

35. DOES THIS CASE HAVE RECURRENT MRSA DISEASE ?

1 Yes 2 No

9 Unknown

IF YES, PREVIOUS (1ST) STATE I.D.

36. DATE REPORTED TO EIP SITE:

____ - ____ - ____

37. S.O. INITIALS:

38 COMMENTS: