

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA) FORM 3a: VANCOMYCIN**

CDC ID: -

Date: //

Data collector initials: \_\_\_\_\_

**Laboratory testing**

1. Complete the table for POSITIVE cultures collected from the date 5 days before vancomycin IV first date (5 days before: \_\_\_/\_\_\_/\_\_\_) through the vancomycin IV last date (\_\_\_/\_\_\_/\_\_\_): No positive cultures:  Culture data unknown:

No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Pathogens identified (insert code)	Pathogen susceptible to oxacillin, methicillin or ceftioxin?	Pathogen susceptible to penicillin or ampicillin?	Pathogen susceptible to vancomycin?	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
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5	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
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8	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
9	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
10	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

CDC ID: -

**2. Complete the table for NEGATIVE cultures collected from 5 days before vancomycin IV first date (5 days before: \_\_\_/\_\_\_/\_\_\_) through the vancomycin IV last date (\_\_\_/\_\_\_/\_\_\_):**

No negative cultures:  Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

No.	Collect date (mm/dd/yy)	Specimen
6	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
7	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
8	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
9	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
10	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

More negative cultures than fit in the table:

**3. Was an MRSA surveillance culture(s) done during this admission?** Yes No Unknown

**3a. If yes to question 3, were any MRSA surveillance cultures positive for MRSA during this admission?**

Yes No Unknown

**4. Complete the table for non-culture microbiology tests (positive and negative) collected from 5 days before vancomycin IV first date through the vancomycin IV last date:**

No non-culture tests done:  Non-culture test data unknown:

No.	Collect date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____

More tests than fit in the table:

**Post-discharge antimicrobial treatment**

**5. Was vancomycin IV prescribed at discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge)?** Yes No Unknown

**5a. If yes to question 5, what is the total duration of the post-discharge vancomycin IV prescription?**

\_\_\_\_\_ days, OR the prescription end date is \_\_\_/\_\_\_/\_\_\_, OR Duration is unknown

\*\*\*FORM IS COMPLETE\*\*\*

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA) FORM 3b: FLUOROQUINOLONE**

CDC ID: - Date: // Data collector initials: \_\_\_\_\_ Drugs given: Ciprofloxacin Levofloxacin Moxifloxacin

<b>Laboratory testing</b>									
1. Complete the table for POSITIVE cultures collected from the date 5 days before fluoroquinolone first date (5 days before: ___/___/___) through the fluoroquinolone last date (___/___/___): No positive cultures: <input type="checkbox"/> Culture data unknown: <input type="checkbox"/>									
No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Pathogens identified (insert code)	Pathogen susceptible to ciprofloxacin?	Pathogen susceptible to levofloxacin?	Pathogen susceptible to moxifloxacin?	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
7	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
8	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
9	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
10	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

CDCID:   -

**2. Complete the table for NEGATIVE cultures collected from 5 days before fluoroquinolone first date (5 days before: \_\_\_/\_\_\_/\_\_\_) through the fluoroquinolone last date (\_\_\_/\_\_\_/\_\_\_):**

No negative cultures:  Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

No.	Collect date (mm/dd/yy)	Specimen
6	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
7	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
8	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
9	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
10	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

More negative cultures than fit in the table:

**3. Complete the table for non-culture microbiology tests (positive and negative) collected from 5 days before fluoroquinolone first date through the fluoroquinolone last date:**

No non-culture tests done:  Non-culture test data unknown:

No.	Collect date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____Path3_____

More tests than fit in the table:

**IV to PO conversion**

**4. Between the fluoroquinolone first date and the fluoroquinolone last date, was there a conversion from IV to PO fluoroquinolone administration? Check one:**

Yes → Date of conversion from IV to PO administration: \_\_\_/\_\_\_/\_\_\_ or  Date unknown

No → For example, patient received only IV fluoroquinolones, or was switched from PO to IV fluoroquinolones, or was switched from IV to PO to IV.

Not applicable → Patient received only PO fluoroquinolones.

Unknown

CDCID: -

**Post-discharge antimicrobial treatment**

**5. Was a fluoroquinolone prescribed at discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge)?**

Yes No Unknown

**5a. If yes to question 5, what drug(s) were prescribed? Check all that apply:**

Drug	IV route	PO route	Unknown route
<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Moxifloxacin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

**5b. If yes to question 5, what is the total duration of the post-discharge fluoroquinolone prescription?**

\_\_\_\_\_ days, OR the prescription end date is \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_, OR Duration is unknown

**\*\*\*FORM IS COMPLETE\*\*\***

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA)**

**FORM 3c: CAP**

CDC ID:   -

Date:   /   /

Data collector initials: \_\_\_\_\_

**Clinical information**

**1. Check any of the following ICD-9 codes that were present on admission for this patient:**  None  
 480.0  480.1  480.2  480.3  480.8  480.9  481  482.0  482.1  482.2  
 482.30  482.31  482.32  482.39  482.40  482.41  482.42  482.49  482.81  482.82  
 482.83  482.84  482.89  482.9  483.0  483.1  483.8  485  486  487.0  
 487.1  487.8

**2. CAP onset date (mm/dd/yy):** \_\_\_ / \_\_\_ / \_\_\_ or  
 Prior to survey hospitalization but specific date unknown  Unable to determine

**3. CAP signs and symptoms in first 2 hospital days; check all that apply:**  None  
 Fever  Increased secretions/sputum production  Grunting  
 Chills or rigors  Hemoptysis  Nasal flaring  
 Cough  Chest pain  Head bobbing  
 Dyspnea  Mental status changes or functional decline  Chest wall retractions  
 O<sub>2</sub> saturation < 90%  Apnea  Wheezing  
 Sore throat  Rhinorrhea  Muscle aches

**4. Did the patient require mechanical ventilation during the hospitalization?**  
 Yes  
 No  
 Unknown

**4a. If yes, was the patient removed from mechanical ventilation before hospital discharge?**  
 Yes, clinical status improved  
 Yes, removed from mechanical ventilation for end-of-life care (or for reasons other than improvement)  
 No  
 Unknown

**5. Complete the chest imaging table, recording studies done in the first 5 hospital days ( \_\_\_ / \_\_\_ / \_\_\_ through \_\_\_ / \_\_\_ / \_\_\_ ):  
 No imaging studies done:  Unknown whether imaging studies were done:**

	Date (mm/dd/yy)	Findings on chest imaging studies			
1	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
2	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
3	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
4	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
5	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these

Go to page 2

CDC ID: -

**CAP treatment**

**6. Was the patient receiving antimicrobial treatment for this episode of CAP before the survey hospitalization?**

Yes  No  Unknown

**7. CAP treatment start date during the survey hospitalization (mm/dd/yy):** \_\_\_/\_\_\_/\_\_\_ or  Unknown

**8. Complete the table for all antimicrobial drugs given to treat CAP during the survey hospitalization:**

No.	Drug name	First date (mm/dd/yy)	First route	Last date (mm/dd/yy)	Last route
1		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
2		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
3		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
4		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
5		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH

More than 5 antimicrobial drugs were given to treat CAP:

**9. Were antimicrobial drugs prescribed at hospital discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge) to treat CAP?**

Yes  
 No  
 Unknown

**9a. If yes to question 9, what was the total duration of the post-discharge CAP treatment?**

\_\_\_ days, OR the prescription end date is \_\_\_/\_\_\_/\_\_\_, OR  Duration is unknown

**9b. If yes to question 9, what antimicrobial drugs were prescribed?**

One antimicrobial drug was prescribed (enter name: \_\_\_\_\_)  
 Two or more antimicrobial drugs were prescribed  
(enter up to 3 names: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_)  
 Unknown

Go to page 3

**Laboratory testing**

**10. Complete table below for POSITIVE cultures collected in the first 5 hospital days ( \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_):**

No positive cultures:  Culture data unknown:

No.	Specimen	Collect date (mm/dd/yy)	Culture result final date (mm/dd/yy)	Pathogens identified (insert codes)	Culture growth quantity* for lower respiratory cultures only	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
7	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
8	<input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>4</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>4</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

ETA=endotracheal aspirate (or tracheal aspirate). BAL=bronchoalveolar lavage (includes bronchial lavage, mini-BAL).

\*Check "≥10<sup>4</sup> CFU/ml or similar" if quantity of growth in the culture is reported to be as follows: moderate, many, heavy, abundant, etc. Check "<10<sup>4</sup> or similar" if quantity of growth in the culture is reported to be <10<sup>4</sup> CFU/ml or as follows: few, scarce, scant, rare, etc. Check "unknown" if no organism quantity is noted in the culture report.



CDC ID:   -

**11. During the first 5 hospital days did the patient have a Gram stain of lower respiratory secretions (sputum, BAL, ETA, etc.)?**  Yes  No  Unknown

**11a. If yes, did the Gram stain report indicate the following:**

- Heavy, 4+, or ≥25 neutrophils (or white blood cells) per low power field [x100]  
 Rare, occasional, few, 1+ or 2+, or ≤10 squamous epithelial cells per low power field [x100]  
 Neither of the above  
 Unknown

**12. Complete the table for NEGATIVE cultures collected during the first 5 hospital days ( \_\_\_ / \_\_\_ / \_\_\_ through \_\_\_ / \_\_\_ / \_\_\_):**

No negative cultures:  Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen	No.	Collect date (mm/dd/yy)	Specimen
1	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	6	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
2	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	7	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
3	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	8	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
4	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	9	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
5	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	10	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

More negative cultures than fit in the table:

**13. Complete the table for non-culture microbiology tests (positive and negative) collected during the first 5 hospital days:**

No non-culture tests done:  Non-culture test data unknown:

No.	Collect Date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
2	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
3	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
4	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
5	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____

More tests than fit in the table:

**14. Did the patient have any of the following blood test results during the first 2 hospital days?**

Check all that apply, or  None.

- Arterial pH < 7.35       BUN > 30 mg/dL (11 mmol/L)       Glucose > 250 mg/dL  
 PaO<sub>2</sub> < 60 mmHg       Sodium < 130 mmol/L       Hematocrit < 30%

\*\*\*FORM IS COMPLETE\*\*\*

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA)  
FORM 3d: UTI**

CDC ID: -

Date: //

Data collector initials: \_\_\_\_\_

**Clinical information**

**1. Check any of the following ICD-9 codes that were present on admission for this patient:**  None

590.10 590.11 590.2 590.3 590.80 590.81  
590.9 595.0 597.0 597.80 599.0

**2. UTI onset date (mm/dd/yy):** \_\_\_/\_\_\_/\_\_\_ or  
 Prior to survey hospitalization but specific date unknown  Unable to determine

**3. UTI signs and symptoms in first 2 hospital days; check all that apply:**  None

<input type="checkbox"/> Fever	<input type="checkbox"/> Frequency	<input type="checkbox"/> Costovertebral angle (CVA) pain or tenderness
<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Visible blood in urine	<input type="checkbox"/> Suprapubic pain, swelling or tenderness
<input type="checkbox"/> Urgency	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Mental status changes or functional decline
<input type="checkbox"/> Rigors	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Pain or burning with urination

**4. Did the patient have an indwelling urinary catheter in place for ≥2 days on the day of UTI onset or on the day prior to UTI onset (or if onset date unknown, on the day of survey hospital admission)?**  
 Yes  No  Unknown

**4a. If yes, were any of the following done within 5 days after UTI onset date (or if onset date unknown, within 5 days after survey hospital admission)?**  
 Catheter changed  Catheter removed  Catheter neither changed nor removed  Unknown

**UTI treatment**

**5. Was the patient receiving antimicrobial treatment for this UTI before the survey hospitalization?**  
 Yes  No  Unknown

**6. UTI treatment start date during the survey hospitalization (mm/dd/yy):** \_\_\_/\_\_\_/\_\_\_ or  Unknown

**7. Complete the table for all antimicrobial drugs given to treat UTI during the survey hospitalization:**

No.	Drug name	First date (mm/dd/yy)	First route	Last date (mm/dd/yy)	Last route
1		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
2		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
3		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
4		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
5		___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH

More than 5 antimicrobial drugs were given to treat UTI:

**8. Were antimicrobial drugs prescribed at hospital discharge to treat this UTI (i.e., prescribed to be administered to the patient for additional days after hospital discharge)?**  
 Yes  No  Unknown

**8a. If yes to question 8, what is the total duration of the post-discharge UTI treatment?**  
 \_\_\_ days, OR the prescription end date is \_\_\_/\_\_\_/\_\_\_, OR  Duration is unknown

**8b. If yes to question 8, what antimicrobial drugs were prescribed?**  
 One antimicrobial drug was prescribed (enter name: \_\_\_\_\_)  
 Two or more antimicrobial drugs were prescribed  
 (enter up to 3 names: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_)  
 Unknown

CDC ID: -

**Laboratory testing**

**9. Complete table below for POSITIVE cultures collected in the first 5 hospital days ( \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_):**

No positive cultures:  Culture data unknown:

No.	Specimen	Collect date (mm/dd/yy)	Culture result final date (mm/dd/yy)	Pathogens identified (insert codes)	Culture growth quantity* for urine cultures only	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
7	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
8	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

Urine CC=urine clean catch. Urine cath=urine collected from an indwelling urinary catheter. Urine other=urine collected via other or unspecified means.

\*Check "≥10<sup>5</sup> CFU/ml or similar" if quantity of growth in the culture is reported to be as follows: moderate, many, heavy, abundant, etc.; Check "<10<sup>5</sup> or similar" if quantity of growth in the culture is reported to be <10<sup>5</sup> CFU/ml or as follows: few, scarce, scant, rare, etc. Check "unknown" if no organism quantity is noted in the culture report.

CDCID:   -

**10. Complete the table for NEGATIVE cultures collected in the first 5 hospital days ( \_\_\_ / \_\_\_ / \_\_\_ through \_\_\_ / \_\_\_ / \_\_\_):**

No negative cultures:  Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen
1	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
2	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
3	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
4	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
5	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

No.	Collect date (mm/dd/yy)	Specimen
6	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
7	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
8	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
9	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____
10	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____

More negative cultures than fit in the table:

**11. Complete the table for urinalyses collected in the first 5 hospital days:**

No urinalyses done:  Unknown whether urinalyses were done:

No.	Urinalysis date (mm/dd/yy)	Pyuria (>5 WBCs / hpf)	Nitrites	Leukocyte esterase	Bacteria	Yeast
1	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
2	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
3	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
4	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
5	___ / ___ / ___	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

**12. Complete the table for non-culture tests (positive and negative) collected in the first 5 hospital days:**

No non-culture tests done:  Non-culture test data unknown:

No.	Collect Date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
2	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
3	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
4	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
5	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____

More tests than fit in the table:

\*\*\*FORM IS COMPLETE\*\*\*