HAI & ANTIMICROBIAL USE PREVALENCE SURVEY
PATIENT INFORMATION FORM

Form Approved
OMB No. 0920-0852
Exp. Date xx/xx/xxxx

CDC ID: ☐☐ - ☐☐☐☐☐ **Survey date:** ☐☐ / ☐☐ / ☐☐☐☐ **Data collector initials:** ____________

If data collected on survey date, enter data collection time: ☐☐ : ☐☐ ☐ am ☐ pm **OR** ☐ Data collection done retrospectively

I. Identifiers (NOT transmitted to CDC)

Patient name: ____________ **Date of birth (mm/dd/yyyy):** ____ / ____ / ________
Hospital name: ____________ **Hospital unit name:** ____________
Room number: ____________ **Medical record no.:** ____________

II. Demographic information

Age: ________ ☐ yrs ☐ mos ☐ dys ☐ Unknown

Admission date (mm/dd/yyyy): ____ / ____ / ________

Sex at birth:
☐ Male ☐ Female ☐ Unknown

CDC location code: ____________

Race: (check all that apply)
☐ American Indian or Alaska Native
☐ Black or African American
☐ Native Hawaiian/other Pacific Islander
☐ Asian
☐ White
☐ Other race
☐ Unknown

Ethnicity:
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown

Primary Payer:
☐ Medicare
☐ Medicaid
☐ Private insurance
☐ Self-pay
☐ No charge
☐ Other
☐ Unknown

III. Weight and height

Weight: ______ lbs. ______ oz.
OR ______ kg ☐ Unknown

Height: ______ ft. ______ in.
OR ______ cm ☐ Unknown

BMI: (record only if height or weight unavailable)
________ ☐ Unknown ☐ NA

IV. Devices and pressure injuries/ulcers present on the survey date

Urinary catheter: ☐ Yes ☐ No ☐ Unknown **Ventilator:** ☐ Yes ☐ No ☐ Unknown

Central line: ☐ Yes ☐ No ☐ Unknown **If "Yes," indicate how many lines:** ☐ 1 line ☐ >1 line ☐ Unknown

Pressure injuries or ulcers : ☐ Yes ☐ No ☐ Unknown

If "Yes," were all pressure injuries or ulcers that were present on the survey date present on admission? ☐ Yes ☐ No ☐ Unknown

Indicate the highest stage of the pressure injuries or ulcers on the survey date : ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ Unstageable ☐ Unknown

V. Antimicrobials

Antimicrobials administered or scheduled to be administered:

On the survey date: ☐ Yes ☐ No ☐ Unknown
On the day before the survey date: ☐ Yes ☐ No ☐ Unknown

VI. Follow-up information

Enter date of follow-up data collection: ☐☐ / ☐☐ / ☐☐☐☐

Hospital discharge date: ☐☐ / ☐☐ / ☐☐☐☐ **OR** check one: ☐ Unknown ☐ Still in hospital

Patient outcome at time of hospital discharge: ☐ Survived ☐ Died ☐ Unknown ☐ Still in hospital

Public reporting burden of this collection of information is estimated to average 17 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0852).