Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Laboratory-identified MDRO or CDI Event

Instructions for this form are available at: http://www.cdc.gov/nhsn/forms/instr/57_128.pdf

*required for saving **conditionally required

Facility ID:	Event #:
*Patient ID:	Social Security #:
Secondary ID:	Medicare #:
Patient Name, Last: First:	Middle:
*Gender: M F	*Date of Birth:
Ethnicity (Specify):	Race (Specify):

Event Details

*Event Type: LabID	*Date Specimen Collected:

*Specific Organism Type: (Check one)

☐ MDR-*Acinetobacter* ☐ *C. difficile* ☐ CephR-*Klebsiella* ☐ CRE-*E. coli* ☐ CRE-*Enterobacter*
☐ CRE-*Klebsiella* ☐ MRSA ☐ MSSA ☐ VRE

**Was the bacterial isolate tested for carbapenemase? ☐ Yes ☐ No ☐ Unknown

If Yes, which test(s) were done? (check all that apply)

☐ Polymerase chain reaction – Klebsiella pneumoniae carbapenemase (PCR-KPC)
☐ Polymerase chain reaction – New Delhi metallo-β-lactamase (PCR-NDM)
☐ Polymerase chain reaction – Imipenemase (PCR-IMP)
☐ Polymerase chain reaction – Verona Integron-encoded metallo-β-lactamase (PCR-VIM)
☐ Polymerase chain reaction – Oxacillinase-48 like (PCR-OXA-48-like)
☐ Modified Hodge Test (MHT)
☐ Carba NP (CNP)
☐ Metallo-β-lactamase E-test (MBLe)
☐ Metallo-β-lactamase screen (MBLs)
☐ Other: (please specify): _____
☐ Unknown

**Did the isolate test positive for carbapenemase? ☐ Yes ☐ No ☐ Unknown

If Yes, please identify which carbapenemase(s) were identified (check all that apply):

☐ Klebsiella pneumoniae carbapenemase (KPC)
☐ New Delhi metallo-β-lactamase (NDM)
☐ Imipenemase (IMP)
☐ Verona Integron-encoded metallo-β-lactamase (VIM)
☐ Oxacillinase-48 like (OXA-48-like)
☐ Nonspecific carbapenemase activity (e.g., MHT or Carba NP) (NS-Carba)
☐ Nonspecific metallo-β-lactamase activity (e.g., MBL E-test or MBL screen) (NS-MBL)
☐ Other: (please specify): _____
☐ Unknown

Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Laboratory-identified MDRO or CDI Event

*required for saving **conditionally required

Event Details (continued)

*Outpatient: ☐ Yes ☐ No

*Specimen Body Site/System:	*Specimen Source:

*Date Admitted to Facility: _____	*Location:	*Date Admitted to Location: _____

**Last physical overnight location of patient immediately prior to arriving into facility (applies to specimen(s) collected in outpatient setting or <4 days after inpatient admission) (Check one):

☐ Nursing Home/Skilled Nursing Facility
☐ Personal residence/Residential care
☐ Other Inpatient Healthcare Setting (i.e., acute care hospital, IRF, LTAC, etc.)
☐ Unknown

*Has patient been discharged from <u>your</u> facility in the past 4 weeks? ☐ Yes ☐ No
If Yes, date of last discharge from your facility:_____

*Has patient been discharged from <u>another</u> facility in the past 4 weeks? ☐ Yes ☐ No ☐ Unknown
If Yes, from where (Check all that apply):

☐ Nursing Home/Skilled Nursing Facility
☐ Other Inpatient Healthcare Setting (i.e., acute care hospital, IRF, LTAC, etc.)

Custom Fields

Label	Label
_____ ____/____/____	_____ ____/____/____
_____ _____	_____ _____
_____ _____	_____ _____
_____ _____	_____ _____

Comments