Form Approved
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Invasive Methicillin-Sensitive Staphylococcus aureus Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2020

Patient's Name:			Phone No.: ( )
Address:		MRN:	
City:	State:	ZIP:	Hospital:

— PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC —

1. STATE:	2. COUNTY:	3. STATE ID:	4. PATIENT ID:	5. LABORATORY ID WHERE INCIDENT SPECIMEN INDENTIFIED:	6. FACILITY ID WHERE PATIENT TREATED:
_____ _____	_____	_____	_____	_____	_____

7. SEX AT BIRTH:
1 ☐ Male 2 ☐ Female
9 ☐ Unknown
1 ☐ Check if transgendered

8. DATE OF BIRTH:
__ __ - __ __ - __ __ __ __

9. AGE __ __ __
1 ☐ Male 2 ☐ Mos. 3 ☐ Years

10. RACE: (Check all that apply)
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ White
1 ☐ Unknown

13. ETHNIC ORIGIN:
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

12. WEIGHT:
_____ lbs. _____ oz. OR _____ kg.
1 ☐ Unknown

13. HEIGHT:
_____ ft. _____ in. OR _____ cm. 1
1 ☐ Unknown

14. BMI (record only if ht. and/or wt. is not available)
_____ 1 ☐ Unknown

15. DATE OF INCIDENT SPECIMEN COLLECTION (DISC):
__ __ - __ __ - __ __ __ __

16. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER, THE DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown **IF YES, date of admission:** __ __ - __ __ - __ __ __ __

17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?
1 ☐ Yes (HO-MRSA case) 2 ☐ No (CA-MRSA or HACO-MRSA case)

18. INCIDENT SPECIMEN COLLECTION SITE: (Check all that apply)
1 ☐ Blood 1 ☐ Bone 1 ☐ CSF 1 ☐ Internal body site (specify): _____ 1 ☐ Joint/Synovial fluid 1 ☐ Muscle
1 ☐ Pericardial fluid 1 ☐ Peritoneal fluid 1 ☐ Pleural fluid 1 ☐ Other normally sterile site (specify): _____

19. LOCATION OF SPECIMEN COLLECTION:

1 ☐ Outpatient
Facility ID: _____
3 ☐ Emergency room
8 ☐ Clinic/doctor's office
15 ☐ Dialysis center
11 ☐ Surgery
16 ☐ Observation/Clinical decision unit
4 ☐ Other outpatient

1 ☐ Inpatient
Facility ID: _____
1 ☐ ICU
6 ☐ OR
7 ☐ Radiology
2 ☐ Other Inpatient

5 ☐ LTCF
Facility ID: _____

13 ☐ LTACH
Facility ID: _____

14 ☐ Autopsy

10 ☐ Other (specify): _____

9 ☐ Unknown

20. WERE CULTURES OS THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:

1 ☐ Blood Date: _____	1 ☐ Bone Date: _____	1 ☐ CSF Date: _____
1 ☐ Internal body site Date: _____	1 ☐ Joint/Synovial fluid Date: _____	1 ☐ Muscle Date: _____
1 ☐ Peritoneal fluid Date: _____	1 ☐ Pericardial fluid Date: _____	1 ☐ Pleural fluid Date: _____

1 ☐ Other normally sterile site (specify): _____
Date: _____

21. DATE OF FIRST SA BLOOD CULTURE AFTER WHICH SA NOT ISOLATED FOR 14 DAYS: __ __ - __ __ - __ __ __ __

22. SUSCEPTIBILITY RESULTS [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)]

Cefazolin 1 ☐ S 2 ☐ I 3 ☐ R 9 ☐ U	Cefoxitin 1 ☐ S 3 ☐ R 9 ☐ U	Clindamycin 1 ☐ S 2 ☐ I 3 ☐ R 9 ☐ U
Nafcillin 1 ☐ S 2 ☐ I 3 ☐ R 9 ☐ U	Oxacillin 1 ☐ S 3 ☐ R 9 ☐ U	Trimethoprim-Sulfamethoxazole 1 ☐ S 2 ☐ I 3 ☐ R 9 ☐ U
Vancomycin 1 ☐ S 2 ☐ I 3 ☐ R 9 ☐ U		

23. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC?
1 ☐ Private residence
1 ☐ LTCF Facility ID: _____
1 ☐ Hospital Inpatient Facility ID: _____
1 ☐ LTACH Facility ID: _____
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Other (specify): _____

Was patient transferred from this hospital?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Unknown

24. IF CASE IS ≤12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION:
1 ☐ NICU/SCN 2 ☐ Well Baby Nursery 9 ☐ Unknown

25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

IF YES, birth weight: _____ **lbs.** _____ **oz. OR** _____ **g.** OR 1 ☐ Unknown birth weight

IF YES, estimated gestational age: _____ weeks OR 1 ☐ Unknown gestational age

*— **IMPORTANT** — PLEASE COMPLETE THE BACK OF THIS FORM —*

26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, date of ICU admission: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, date of ICU admission: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

28. TYPES OF MSSA INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply) 1 ☐ None 1 ☐ Unknown

1 ☐ Abscess (not skin)
1 ☐ AV Fistula/Graft Infection
1 ☐ Bacteremia
1 ☐ Bursitis
1 ☐ Catheter Site Infection
1 ☐ Cellulitis
1 ☐ Chronic Ulcer/Wound (non-decubitus)
1 ☐ Decubitus/Pressure Ulcer
1 ☐ Empyema
1 ☐ Endocarditis
1 ☐ Epidural Abscess
1 ☐ Meningitis
1 ☐ Peritonitis
1 ☐ Pneumonia
1 ☐ Osteomyelitis
1 ☐ Septic Arthritis
1 ☐ Septic Emboli
1 ☐ Septic Shock
1 ☐ Skin Abscess
1 ☐ Surgical Incision
1 ☐ Surgical Site (Internal)
1 ☐ Traumatic Wound
1 ☐ Urinary Tract
1 ☐ Other: (specify) _____

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

CHRONIC LUNG DISEASE
1 ☐ Cystic fibrosis
1 ☐ Chronic pulmonary disease

CHRONIC METABOLIC DISEASE
1 ☐ Diabetes mellitus
1 ☐ With chronic complications

CARDIOVASCULAR DISEASE
1 ☐ CVA/Stroke/TIA
1 ☐ Congenital heart disease
1 ☐ Congestive heart failure
1 ☐ Myocardial infarction
1 ☐ Peripheral vascular disease (PVD)

GASTROINTESTINAL DISEASE
1 ☐ Diverticular disease
1 ☐ Inflammatory bowel disease
1 ☐ Peptic ulcer disease
1 ☐ Short gut syndrome

IMMUNOCOMPROMISED CONDITION
1 ☐ HIV infection
1 ☐ AIDS/CD4 count <200
1 ☐ Primary immunodeficiency
1 ☐ Transplant, hematopoetic stem cell
1 ☐ Transplant, solid organ

LIVER DISEASE
1 ☐ Chronic liver disease
1 ☐ Ascites
1 ☐ Cirrhosis
1 ☐ Hepatic encephalopathy
1 ☐ Variceal bleeding
1 ☐ Hepatitis C
1 ☐ Treated, in SVR
1 ☐ Current, chronic

MALIGNANCY
1 ☐ Malignancy, hematologic
1 ☐ Malignancy, solid organ (non-metastatic)
1 ☐ Malignancy, solid organ (metastatic)

NEUROLOGIC CONDITION
1 ☐ Cerebral palsy
1 ☐ Chronic cognitive deficit
1 ☐ Dementia
1 ☐ Epilepsy/seizure/seizure disorder
1 ☐ Multiple sclerosis
1 ☐ Neuropathy
1 ☐ Parkinson's Disease
1 ☐ Other (specify): _____

PLEGIAS/PARALYSIS
1 ☐ Hemiplegia
1 ☐ Paraplegia
1 ☐ Quadriplegia

RENAL DISEASE
1 ☐ Chronic kidney disease
Lowest serum creatinine: _____mg/DL
1 ☐ Unknown or not done

SKIN CONDITION
1 ☐ Burn
1 ☐ Decubitus/pressure ulcer
1 ☐ Surgical wound
1 ☐ Other chronic ulcer or chronic wound
1 ☐ Other skin condition (specify): _____

OTHER
1 ☐ Connective tissue disease
1 ☐ Obesity or morbid obesity
1 ☐ Pregnant
1 ☐ Other (specify only for cases ≤12 months of age): _____

30. WAS THE PATIENT HOMELESS IN THE YEAR BEFORE DISC? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

31. SUBSTANCE USE:

SMOKING: 1 ☐ None 1 ☐ Unknown 1 ☐ Tobacco 1 ☐ E-nicotine delivery system 1 ☐ Marijuana

ALCOHOL ABUSE: 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

OTHER SUBSTANCES (CHECK ALL THAT APPLY): 1 ☐ None 1 ☐ Unknown

	DOCUMENTED USE DISORDER (DUD/ABUSE):	MODE OF DELIVERY (Check all that apply):
1 ☐ Marijuana, cannabinoid (other than smoking)	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Opioid, DEA schedule I (e.g., Heroin)	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Opioid, NOS	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Cocaine	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Methamphetamine	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Other (specify): _____	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Unknown substance	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown

DURING THE CURRENT HOSPITALIZATION DID THE PATIENT RECEIVE MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER? 1 ☐ Yes 2 ☐ No 9 ☐ N/A (patient not hospitalized or did not have DUD)

32. PRIOR HEALTHCARE EXPOSURE(S):

PREVIOUS DOCUMENTED MSSA INFECTION OR COLONIZATION

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

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

PREVIOUS HOSPITALIZATION IN THE YEAR BEFORE DISC

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If YES, DATE OF DISCHARGE CLOSEST TO DISC: __ __ - __ __ - __ __ __ __

OR, 1 ☐ Date unknown

Facility ID: _____

OVERNIGHT STAY IN LTACH IN THE YEAR BEFORE DISC

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Facility ID _____

OVERNIGHT STAY IN LTCF IN THE YEAR BEFORE DISC

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Facility ID _____

SURGERY IN THE YEAR BEFORE DISC 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

IF YES, list the surgeries and dates of surgery that occurred within 90 days prior to the DISC:

	Surgery	Date
1.	_____	__ __ - __ __ - __ __ __ __
2.	_____	__ __ - __ __ - __ __ __ __
3.	_____	__ __ - __ __ - __ __ __ __
4.	_____	__ __ - __ __ - __ __ __ __

CENTRAL LINE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

CHECK HERE if central line in place for >2 calendar days 1 ☐

DIALYSIS IN THE YEAR BEFORE DISC (Hemodialysis or Peritoneal dialysis)

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

CURRENT CHRONIC DIALYSIS 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

TYPE: 1 ☐ Hemodialysis 1 ☐ Peritoneal 1 ☐ Unknown

IF HEMODIALYSIS, type of vascular access:

1 ☐ AV fistual/graft 2 ☐ Hemodialysis central line 9 ☐ Unknown

33. PATIENT OUTCOME 1 ☐ Survived 2 ☐ Died 2 ☐ Unknown

DATE OF DISCHARGE: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

1 ☐ Left against medical advice (AMA)

IF SURVIVED, DISCHARGED TO:

1 ☐ Private Residence

2 ☐ LTCF Facility ID: _____

3 ☐ LTACH Facility ID: _____

4 ☐ Other (specify): _____

9 ☐ Unknown

DATE OF DEATH: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

ON THE DAY OF OR IN THE 6 CALENDAR DAYS BEFORE DEATH, WAS THE PATHOGEN OF INTEREST ISOLATED FROM A SITE THAT MEETS THE CASE DEFINITION?

34a. WAS THE PATIENT TESTED FOR SARS-CoV-2 (MOLECULAR ASSAY, SEROLOGY OR OTHER CONFIRMATORY TEST) ON OR BEFORE THE DISC?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

IF YES, DATE OF TEST:

__ __ - __ __ - __ __ __ __

OR 1 ☐ Date Unknown

IF YES, WHAT TYPE OF TEST WAS USED?

☐ Molecular assay

☐ Serology

☐ Method unknown

☐ Other (specify): _____

IF YES, TEST RESULT:

☐ Positive

☐ Negative

☐ Indeterminate

COVID-NET CASE ID

_____

NNDSS IDs (please provide at least one of the following when applicable:

Local case ID: _____ Local record ID: _____ State case identifier: _____ Legacy case identifier: _____

– THIS SHADED AREA FOR OFFICE USE ONLY –

34. WAS CASE FIRSTIDENTIFIED THROUGH AUDIT?

1 ☐ Yes 2 ☐ No

9 ☐ Unknown

35. CRF STATUS:

1 ☐ Complete

2 ☐ Incomplete

3 ☐ Edited & Correct

4 ☐ Chart unavailable after 3 requests

36. DOES THIS CASE HAVE RECURRENT MSSA DISEASE?

1 ☐ Yes 2 ☐ No

9 ☐ Unknown

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

_____

37. DATE REPORTED TO EIP SITE:

__ __ - __ __ - __ __ __ __

38. DATE ABSTRACTION:

__ __ - __ __ - __ __ __ __

39. S.O. INITIALS:

_____

40. COMMENTS: