

**Emerging Infections Programs (EIP)**  
**OMB Control Number 0920-0978**  
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**Program Contact**

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## **Circumstances of Change Request for OMB 0920-0978**

This is a nonmaterial/non-substantive change request for OMB No. 0920-0978, expiration date 02/28/2019, for the Emerging Infections Programs (EIP). All requested changes represent minor modifications to already-approved instruments including revised formatting, rewording, new answer options, and the addition/subtraction of a limited number of questions. Larger changes are being packaged together into a revision ICR that will be submitted in winter 2018/2019.

The Emerging Infections Programs (EIPs) are population-based centers of excellence established through a network of state health departments collaborating with academic institutions, local health departments, public health and clinical laboratories, infection control professionals, and healthcare providers. EIPs assist in local, state, and national efforts to prevent, control, and monitor the public health impact of infectious diseases.

Activities of the EIPs fall into the following general categories: (1) active surveillance; (2) applied public health epidemiologic and laboratory activities; (3) implementation and evaluation of pilot prevention/intervention projects; and (4) flexible response to public health emergencies. Activities of the EIPs are designed to: (1) address issues that the EIP network is particularly suited to investigate; (2) maintain sufficient flexibility for emergency response and new problems as they arise; (3) develop and evaluate public health interventions to inform public health policy and treatment guidelines; (4) incorporate training as a key function; and (5) prioritize projects that lead directly to the prevention of disease.

Activities in the EIP Network in which all applicants must participate are:

- Active Bacterial Core surveillance (ABCs): active population-based laboratory surveillance for invasive bacterial diseases.
- Foodborne Diseases Active Surveillance Network (FoodNet): active population-based laboratory surveillance to monitor the incidence of select enteric diseases.
- Influenza Hospitalization Surveillance Network (FluSurv-NET): active population-based surveillance for laboratory confirmed influenza-related hospitalizations.
- Healthcare-Associated Infections-Community Interface (HAIC) surveillance: active population-based surveillance for healthcare-associated pathogens and infections.

This non-substantive change request is for changes to the disease-specific data elements for ABCs, FluSurv-NET, and HAIC only. As a result of proposed changes, the estimated annualized burden is expected to decrease by 360 hours, from 40,347 to 39,987 and the estimated number of annual responses is shown to decrease by 8,850 from 115,600 to 106,750 responses. The data elements and justifications are described below.

The forms for which approval for changes are being sought include:

### **ABCs:**

1. 2019 ABCs Case Report Form (Att. 1)
2. 2019 ABCs *H. influenzae* Neonatal Sepsis Expanded Surveillance Form (Att. 2)
3. 2019 ABCs Neonatal Infection Expanded Tracking Form (Att. 3)
4. 2019 ABCs Non-Invasive Pneumococcal Pneumonia (SNiPP) (discontinued)

## FluSurv-NET:

5. Influenza Hospitalization Surveillance Network Case Report Form (Att. 4)

## HAIC:

6. 2019 Resistant Gram-Negative Bacilli (MuGSI) Case Report Form for Carbapenem-resistant Enterobacteriaceae and *Acinetobacter baumannii* (Att.5)
7. 2019 Multi-site Gram-Negative Surveillance Initiative (MuGSI)- Extended-Spectrum Beta-Lactamase-Producing Enterobacteriaceae (ESBL) (Att.6)
8. Multi-site Gram-Negative Surveillance Initiative (MuGSI)- Carbapenem-resistant *Pseudomonas aeruginosa* (CR-PA) (discontinued).
9. 2019 Invasive Methicillin-resistant *Staphylococcus aureus* (MRSA) Infection Case Report Form (Att. 7)
10. 2019 Invasive Methicillin-sensitive *Staphylococcus aureus* (MSSA) Infection Case Report Form (Att. 8)
11. 2019 CDI Case Report and Treatment Form (Att. 9)
12. 2019 HAIC Candidemia Case Report (Att. 10)

## Description of Changes

### ABCs:

#### **1. 2019 ABCs Case Report Form**

There is no impact on burden due to the changes on this form. Changes include:

1. Question 3 – Added collection of Patient ID, which is a person ID, to be able to link persons with multiple recurrences of invasive bacterial disease.
2. Questions T1 – T8 – Reformatting method of collection for previous Questions 3a, 3b, 3c, 3d, 12a, 12b, 13, 13b, 14, 15, and 15b to standardize the method of collection with HL7 messaging format for these question as a repeating group.
3. Question 22a, added an option for ‘Left Against Medical Advice’ (AMA) to aid in understanding impact on severity of illness.
4. Question 27, Underlying Conditions – adding checkbox for ‘HbA1C’ laboratory value and the date the value was collected. This will be collected for diabetic cases only to understand the level of management of the disease (diabetes) which can influence long-term sequelae.
5. Question 27c, Substance Use – change option ‘E-cigarette’ to ‘E-Nicotine Delivery System’
6. Question 27d, Substance Use – Added option for Marijuana/cannabinoid use (other than smoking), added checkbox for ‘Documented Use Disorder or Abuse’ for each Substance use category, added ‘Skin popping’ as option for mode of delivery for substance use. Changed ‘Illicit opioid’ to ‘Opioid, DEA schedule I (e.g. heroin)’, ‘Prescription opioid’ to ‘Opioid, DEA Schedule II – IV (e.g., methadone, oxycodone), and changed ‘Stimulant (cocaine, meth, etc.)’ to ‘Cocaine or methamphetamine’. All changes made to better capture information actually documented in the patient’s medical record and to understand the risk associated with substance use for ABCs cases.
7. Question 28c – adding ‘Medical Chart’ check box better capture the source of where vaccination history information is obtained.

## **2. 2019 ABCs *H. influenzae* Neonatal Sepsis Expanded Surveillance Form**

There is no impact on burden due to the changes on this form. Changes include:

1. Minor wording changes to instructions at the top of the form on the first page to clarify what information is being collected
2. Question 29 – added a ‘None listed’ option to better capture this information

## **3. 2019 Neonatal Infection Expanded Tracking Form**

There is no impact on burden due to the changes on this form. Changes include:

1. Question 35 will be recoded to harmonize with Question 5 on the ABCs CRF. Two wording changes:
  - a. Option 2: “Partial” changed to “Incomplete”.
  - b. Option 3 (now changing to option 4): “after 3 requests” added.

## **4. 2018 Surveillance for Non-Invasive Pneumococcal Pneumonia (SNiPP)**

This form is being removed from the package. Justification: Data collection is limited to only 9 respondents and there is no plan to increase the number of respondents in the foreseeable future. The removal of this form from the EIP ICR results in a decrease in burden of 208 hours per year.

### **FluSurv-Net:**

## **5. Influenza Hospitalization Surveillance Network Case Report Form**

On 5/22/2018, OMB approved a full revision including minor changes including test types, substance abuse, disease, treatment, and diagnosis. For this change request, proposed revisions include minor revised language and rewording to improve clarity of the data collection form and additional of several variables including minor additional choices for patient residence at time of hospitalization, pregnancy, acute signs/symptoms at admission, bacterial pathogens, and diagnosis. Select questions about date of onset of acute condition leading to hospitalization, treatment, and sign/symptoms were removed. Burden hours have remained unchanged for these changes.

### **HAIC:**

## **6. 2019 MuGSI Case Report Form for Carbapenem-resistant Enterobacteriaceae (CRE) and *Acinetobacter baumannii* (CRAB)**

For the 2019 Carbapenem Resistant Enterobacteriaceae (CRE)/ Carbapenem Resistant *A. baumannii* (CRAB) Multi-site Gram-Negative Surveillance Initiative (MuGSI) Case Report Form (CRF), we are proposing the following changes: 1) we are requesting the addition of ten antimicrobial agents to the susceptibility table (three of these antimicrobials were added for harmonization purposes between this CRF and the ESBL CRF, we expect improved consistency will reduce burden among reviewers); 2) we reworded the questions related to carbapenemase testing to streamline data collection and to make data collection more intuitive and more efficient; 3) we added one new question related to CRAB cases; 4) we have changed the language of many of the existing questions so that it is the same for all the population based surveillance activities for HAIC, and we expect that this will add efficiency in completing these questions and reduce burden; 5) we have also reordered the questions based on feedback from the EIP sites, again in an effort to make the completion of the form more efficient and to reduce the time it will take to complete; 6) we have modified the way substance use is collected. The language changes, listed above, were made in conjunction with all other HAIC pathogen groups to standardize the way questions are asked across all HAIC pathogens. In some instances, this resulted in

minor modifications to the question wording and response options, including the order in which the responses are presented. Harmonization efforts have also resulted in moving questions from one section of the CRF to another. In several questions, we have added additional checkboxes; this includes 22 checkboxes in the underlying conditions section. The overall goal of these harmonization efforts is to simplify the form for respondents and to reduce the time it will take to complete the form.

We have modified the way substance use is collected. These data elements were collecting in a more general way, on previously approved HAIC data collection forms. The substance use questions are important to track the impact of the opioid epidemic on the disease burden for MuGSI pathogens. Information on substance use is already collected for other EIP pathogens, outside of the HAIC program.

The requested changes will have minimal impact on the burden of data collection and are anticipated to have a small impact on the time expected to complete the case report form. We are anticipating a 5 minute increase.

#### **7. 2019 Multi-site Gram-Negative Surveillance Initiative (MuGSI)- Extended-Spectrum Beta-Lactamase-Producing Enterobacteriaceae (ESBL)**

For the 2019 Extended-Spectrum Beta-Lactamase (ESBL)-Producing Enterobacteriaceae Multi-site Gram-Negative Surveillance Initiative (MuGSI) Case Report Form (CRF), we are requesting the following changes: 1) the addition of two new questions to better capture information on patients' urine cultures and history of UTIs; 2) several questions were updated to align with the MuGSI CRE/CRAB CRF to harmonize between the two forms and to reduce the burden on chart abstractors (see detailed description of changes); 3) added questions to align with the MuGSI CRE/CRAB CRF (see detailed descriptions of changes); 4) removed the question 15b from the 2018 ESBL CRF; 6) we reworded the questions related to ESBL detection in clinical microbiology laboratories make the question more intuitive and thus reducing the burden it will take to complete this question, these changes were made as a result of analyzing the pilot ESBL data; 5) we have changed the language of many of the existing questions so that data collection of common questions is standardized across the population based surveillance activities for HAIC, and we expect that this will add efficiency in completing these questions and should reduce burden; 6) we have also reordered the questions based on feedback from the EIP sites, in an effort to make the completion of the form more efficient and to reduce the time it will take to complete the form; 7) we have modified the way substance use is collected.

Harmonization between this CRF and the CRE/CRAB CRF will save time and reduce burden on our chart reviewers that use these forms. The staff that complete this and the CRE/CRAB CRF in the EIP sites are the same.

Additionally, we have changed the language of many existing questions. These changes were made in conjunction with all other HAIC pathogen groups to standardize the way questions are asked across all HAIC pathogens. In some instances, this resulted in minor modifications to the question wording and response options, including the order in which the responses are presented. Harmonization efforts have also resulted in moving questions from one section of the CRF to another. In several questions, we have added additional checkboxes; this includes 22 checkboxes in the underlying conditions section. The overall goal of these harmonization efforts is to simplify the form for respondents and to reduce the time it will take to complete the form.

We have modified the way substance use is collected. These data elements were collected in a more general way, on previously approved HAIC data collection forms. The substance use questions are important to track the impact of the opioid epidemic on the disease burden for ESBL-producing pathogens. Information on substance use is already collected for other EIP pathogens, outside of the HAIC program.

The requested changes will have minimal impact on the burden of data collection and are anticipated to have a small impact on the time expected to complete the case report form. We are anticipating a 5 minute increase.

#### **8. Multi-site Gram-Negative Surveillance Initiative (MuGSI)- Carbapenem-resistant *Pseudomonas aeruginosa* (CR-PA)**

This form is being removed from the package. The removal of this form from the EIP ICR results in a decrease in burden of 2,580 hours per year. There is no longer a need for EIP to continue collecting data on Carbapenem-resistant *Pseudomonas aeruginosa* cases. Because of high case counts, sufficient medical record data has been collected.

#### **9. Invasive MRSA Infection Case Report Form**

Changes are being requested for the 2019 Methicillin-resistant *Staphylococcus aureus* (MRSA) Case Report Form: 1) the addition of susceptibility for two additional antimicrobial agents; 2) we have modified the way substance use is collected; 3) we have changed the language of many of the existing questions so that data collection of common questions is standardized across the population based surveillance activities for HAIC, and we expect that this will add efficiency in completing these questions and should reduce burden; 4) we have reordered the questions based on feedback from the EIP sites in an effort to make the completion of the form more efficient and to reduce the time it will take to complete the form.

We have changed the language of many existing questions. These changes were made in conjunction with all other HAIC pathogen groups to standardize the way questions are asked across all HAIC pathogens. In some instances, this resulted in minor modifications to the question wording and response options, including the order in which the responses are presented. Harmonization efforts have also resulted in moving questions from one section of the CRF to another. In several questions, we have added additional checkboxes; this includes 22 checkboxes in the underlying conditions section. The overall goal of these harmonization efforts is to simplify the form for respondents and to reduce the time it will take to complete the form.

We have modified the way substance use is collected. These data elements were collected in a more general way, on previously approved HAIC data collection forms. The substance use questions are important to track the impact of the opioid epidemic on the disease burden for MRSA. Information on substance use is already collected for other EIP pathogens, outside of the HAIC program.

The requested changes will have minimal impact on the burden of data collection and are anticipated to have a small impact on the time expected to complete the case report form. We are anticipating a 5 minute increase. Additionally, the estimated number of annual responses has been adjusted: from 609 to 474. The net change in burden is a 55 hour decrease.

#### **10. 2019 Invasive MSSA Infections Case Report Form**

The following changes are requested for the 2019 Methicillin-sensitive *Staphylococcus aureus* (MSSA) Case Report Form: 1) addition of susceptibility for two additional antimicrobial agents; 2) we have modified the way substance use is collected; 3) we have changed the language of many of the existing questions so that data collection of common questions is standardized across the population based surveillance activities for HAIC, and we expect that this will add efficiency in completing these questions and should reduce burden; 4) we have reordered the questions based on feedback from the EIP sites in an effort to make the completion of the form more efficient and to reduce the time it will take to complete the form.

We have changed the language of many existing questions. These changes were made in conjunction with all other HAIC pathogen groups to standardize the way questions are asked across all HAIC pathogens. In some instances, this resulted in minor modifications to the question wording and response options, including the order in which the responses are presented. Harmonization efforts have also resulted in moving questions from one section of the CRF to another. In several questions, we have added additional checkboxes; this includes 22 checkboxes in the underlying conditions section. The overall goal of these harmonization efforts is to simplify the form for respondents and to reduce the time it will take to complete the form.

We have modified the way substance use is collected. These data elements were collected in a more general way, on previously approved HAIC data collection forms. The substance use questions are important to track the impact of the opioid epidemic on the disease burden for MSSA. Information on substance use is already collected for other EIP pathogens, outside of the HAIC program.

The requested changes will have minimal impact on the burden of data collection and are anticipated to have a small impact on the time expected to complete the case report form. We are anticipating a 5 minute increase. Additionally, the estimated number of annual responses has been adjusted: from 1,035 to 754. The net change in burden is a 308 hour decrease.

#### **11. 2019 CDI Case Report Form and Treatment Form**

Changes are requested for the 2019 CDI Case Report Form and Treatment Form: 1) we removed the audit question; 2) we have added a question to track substance use; 3) we have changed the language of many of the existing questions so that data collection of common questions is standardized across the population based surveillance activities for HAIC, and we expect that this will add efficiency in completing these questions and should reduce burden; 4) we have also reordered the questions based on feedback from the EIP sites, again in an effort to make the completion of the form more efficient and to reduce the time it will take to complete the form.

The language changes, listed above, were made in conjunction with all other HAIC pathogen groups to standardize the way questions are asked across all HAIC pathogens. In some instances, this resulted in minor modifications to the question wording and response options, including the order in which the responses are presented. Harmonization efforts have also resulted in moving questions from one section of the CRF to another. The overall goal of these harmonization efforts is to simplify the form for respondents and to reduce the time it will take to complete the form.

We have added a new question to track substance use. The substance use questions are important to track the impact of the opioid epidemic on the disease burden for CDI. Information on substance use is already collected, but in a more general way on previously approved HAIC data collection forms.

The requested changes will have minimal impact on the burden of data collection and are anticipated to have a small impact on the time expected to complete the case report form. We are anticipating a 5 minute increase.

## 12. 2019 HAIC Candidemia Case Report

For the 2019 Candidemia case report form (CRF), we have added three new questions and deleted two. The changes were made based on feedback from sites about the usefulness of certain questions and the need to capture different data based on the changing epidemiology of candidemia in the United States. we have changed the language of many of the existing questions so that data collection of common questions is standardized across the population based surveillance activities for HAIC, and we expect that this will add efficiency in completing these questions and should reduce burden; 3) we have also reordered the questions based on feedback from the EIP sites, again in an effort to make the completion of the form more efficient and to reduce the time it will take to complete the form; 4) we have modified the way substance use is collected.

The language changes, listed above, were made in conjunction with all other HAIC pathogen groups to standardize the way questions are asked across all HAIC pathogens. In some instances, this resulted in minor modifications to the question wording and response options, including the order in which the responses are presented. Harmonization efforts have also resulted in moving questions from one section of the CRF to another. In several questions, we have added additional. The overall goal of these harmonization efforts is to simplify the form for respondents and to reduce the time it will take to complete the form.

We have modified the way substance use is collected. The substance use questions are important to track the impact of the opioid epidemic on the disease burden for candida. Information on substance use was already collected, this modified question is now harmonized with the other HAIC data collections.

The requested changes will have no impact on the burden of data collection.

Justification for changes: The changes made to the HAIC forms under this non-substantive request will aid in improving surveillance efficiency and data quality to clarify the burden of disease and possible risk factors for disease. This information can be used to inform strategies for preventing disease and negative outcomes. Specifically, changes were made for clarification purposes, to assist data collectors in capturing data in a standardized fashion to improve accuracy.

## Cross walk - 2019 form changes

### ABCs:

#### 1. 2019 ABCs Case Report Form

Current Form	Proposed changes
	Added 3. Patient I.D.
	T1 – Test Type Options: 1=PCR, 2=Culture, 3=Antigen, 4=Immunohistochemistry, 5=Latex Agglutination, 7=Other, 9=Unknown
3b. Date first positive culture collected	T2 – Date of first positive specimen collection



3c. Date first positive Culture Independent Diagnostic Test (CIDT, e.g. PCR) COLLECTED	
3d. Type of CIDT: <input type="checkbox"/> Biofire Meningitis Panel <input type="checkbox"/> Filmarray BCID <input type="checkbox"/> Verigene BCT <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	T3 – Test method (non-culture) Options: 1=Biofire FilmArray M/E Panel, 2=other, 3=Biofire Filmarray Blood Culture ID (BCID) Panel, 4=Verigene Gram + Blood Culture Test (BCT), 5=Bruker MALDI Biotyper CA System, 6=BD Directigen Meningitis Combo Test Kit, 7=ThermoFisher Wellcogen Bacterial Antigen Rapid, 8=Alere BinaxNOW Antigen Card, 9=Unknown
13. Sterile Sites from which organism isolated: <input type="checkbox"/> CSF <input type="checkbox"/> Blood <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Bone <input type="checkbox"/> Pericardial Fluid <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Joint <input type="checkbox"/> Muscle/Fascia/Tendon <input type="checkbox"/> Internal Body Site (specify) _____ <input type="checkbox"/> Other normally sterile site (specify) _____	T4 – Site from which organism isolated Options: 1=Amniotic fluid, 2=Blood, 3=Bone, 4=Brain, 5=CSF, 6=Heart, 7=Other Sterile Site, 8=Joint, 9=unknown, 10=Kidney, 11=Liver, 12=Lung, 13=Lymph node, 14=Middle ear, 15=Muscle/Fascia/Tendon, 16=Ovary, 17=Pancreas, 18=Pericardial Fluid, 19=Peritoneal Fluid, 20=Placenta, 21=Pleural fluid, 22=Respiratory secretion, 23=Sinus, 24=Spleen 25=Sputum, 26=Vitreous, 27=Wound, 28=Unknown
13b. CIDT STERILE SITE FROM WHICH ORGANISM WAS DETECTED: <input type="checkbox"/> CSF <input type="checkbox"/> Blood <input type="checkbox"/> Other, _____	
14. Other sites from which organism isolated: <input type="checkbox"/> Wound <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Placenta <input type="checkbox"/> Middle ear <input type="checkbox"/> Sinus	
Q12a. Bacterial Species isolated from any normally sterile site: <input type="checkbox"/> Neisseria meningitidis <input type="checkbox"/> Haemophilus influenzae <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Group A Streptococcus <input type="checkbox"/> Streptococcus pneumoniae	T5- Bacterial species isolated*: Options: 1=Neisseria meningitidis, 2=Haemophilus influenzae, 3=Group B Streptococcus, 5=Group A Streptococcus 6=Streptococcus pneumoniae
Q12b. Other bacterial species isolated from any normally sterile site: _____	* For other bacterial pathogens (i.e. non-ABCs) write-in pathogen name
3a. Was a culture performed? 1 <input type="checkbox"/> Yes, Positive 2 <input type="checkbox"/> Yes, Negative 3 <input type="checkbox"/> No	T6 – Test Result Options: 1=Positive, 0=Negative, 9=Indeterminant
15. Is Isolate available: <input type="checkbox"/> Yes <input type="checkbox"/> No	T7- Isolate/Specimen Available? Options: 1=Yes, 2=No
15b. If Isolate Not available, why not? <input type="checkbox"/> N/A at hospital lab <input type="checkbox"/> N/A at state lab <input type="checkbox"/> Hospital refuses <input type="checkbox"/> Isolate discrepancy (2x) <input type="checkbox"/> No DNA (non-viable)	T8- If isolate/specimen not available, why not? Options: 1=N/A at Hospital Lab 2=N/A at State Lab, 3=Hospital refuses, 4=Isolate Discrepancy (2x), 5=No DNA (non-viable)
22a. If survived, patient discharged to: <input type="checkbox"/> Home <input type="checkbox"/> LTC/SNF <input type="checkbox"/> LTACH <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify _____ If discharged to LTC/SNF or LTACH, list Facility ID _____	Added checkbox, 'Left AMA' 22a. If survived, patient discharged to: <input type="checkbox"/> Home <input type="checkbox"/> LTC/SNF <input type="checkbox"/> LTACH <input type="checkbox"/> Left AMA <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify _____ If discharged to LTC/SNF or LTACH, list Facility ID _____
27. Underlying causes or prior illnesses	27. Added Checkbox for lab test, HbA1C _____ % and Date collected ___/___/_____ For diabetic patients only
27c. Smoking: <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Tobacco <input type="checkbox"/> E-Cigarettes <input type="checkbox"/> Marijuana	Changed 'E-cigarette' option to 'E-nicotine delivery system' 27c. Smoking: <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Tobacco <input type="checkbox"/> E-Nicotine Delivery System <input type="checkbox"/> Marijuana
27d. Other substance abuse, current <input type="checkbox"/> None <input type="checkbox"/> Unknown If yes, check all that apply: _____ mode of delivery <input type="checkbox"/> Illicit opioid <input type="checkbox"/> IDU <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk <input type="checkbox"/> Prescription Opioid <input type="checkbox"/> IDU <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk <input type="checkbox"/> Stimulant <input type="checkbox"/> IDU <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk <input type="checkbox"/> Other _____ <input type="checkbox"/> IDU <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk <input type="checkbox"/> Unknown Substance <input type="checkbox"/> IDU <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk	Added Documented use disorder option for all substance categories and added skin-popping option for mode of delivery. Also, changed substance categories for 'illicit opioid', 'prescription opioid', and 'stimulant'. Added 'Marijuana/cannabinoid' substance category. 27d. Other substances <input type="checkbox"/> None <input type="checkbox"/> Unknown _____ Documented Use disorder _____ mode of delivery <input type="checkbox"/> Marijuana/Cannabinoid (other than smoking) <input type="checkbox"/> DUD or Abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin Popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk

	<input type="checkbox"/> Opioid, DEA Schedule I <input type="checkbox"/> DUD or Abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin Popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk <input type="checkbox"/> Opioid, DEA Schedule II- IV <input type="checkbox"/> DUD or Abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin Popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk <input type="checkbox"/> Cocain or methamphetamine <input type="checkbox"/> DUD or Abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin Popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk <input type="checkbox"/> Other _____ <input type="checkbox"/> DUD or Abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin Popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk <input type="checkbox"/> Unknown Substance <input type="checkbox"/> DUD or Abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin Popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unk
28c. Were records obtained to verify vaccination history? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the source of the information? <input type="checkbox"/> Vaccine Registry <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Other (specify) _____	Added 'Medical chart' option below 28c. Were records obtained to verify vaccination history? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the source of the information? <input type="checkbox"/> Medical Chart <input type="checkbox"/> Vaccine Registry <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Other (specify) _____

## 2. 2019 ABCs *H. influenzae* Neonatal Sepsis Expanded Surveillance Form

<u>Current Form</u>	<u>Proposed Changes</u>
Indicate type of HiNSES case: <input type="checkbox"/> Neonatal: infant (sterile isolates only) – complete #1-10, 11-31	Updated instructions at top of form to clarify information to be collected. Indicate type of HiNSES case: <input type="checkbox"/> Neonatal: infant (sterile isolates only) – complete #1-31
Indicate type of HiNSES case: <input type="checkbox"/> Other maternal cases (specify) <input type="checkbox"/> Fetal death Hi isolated from placenta/amniotic fluid <input type="checkbox"/> Stillbirth – complete #1-3, 12-31 <input type="checkbox"/> Spontaneous abortion – complete #1-2b, 12-18, 28-31	Updated instructions at top of form to clarify information to be collected. Indicate type of HiNSES case: <input type="checkbox"/> Fetal cases (any gestational age –specify isolate/outcome): <input type="checkbox"/> Hi from sterile site in stillbirth – complete #1-3, 12-31 <input type="checkbox"/> Fetal death Hi isolated from placenta/amniotic fluid <input type="checkbox"/> Stillbirth – complete #1-3, 12-31 <input type="checkbox"/> Spontaneous abortion – complete #1-2b, 12-18, 28-31
29. During the intrapartum period or in the week prior to spontaneous abortion did the mother have any of the following symptoms or diagnoses? (check all that apply)  <input type="checkbox"/> Unknown <input type="checkbox"/> Uterine Tenderness <input type="checkbox"/> Foul smelling amniotic fluid <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Maternal tachycardia (>100 beats/min) <input type="checkbox"/> Fetal tachycardia (>160 beats/min) <input type="checkbox"/> Intrapartum fever (>=100.4 F/38 C) <input type="checkbox"/> Maternal WBC >20 or 20,000	Added 'none listed' option 29. During the intrapartum period or in the week prior to spontaneous abortion did the mother have any of the following symptoms or diagnoses? (check all that apply)  <input type="checkbox"/> Unknown <input type="checkbox"/> None Listed <input type="checkbox"/> Uterine Tenderness <input type="checkbox"/> Foul smelling amniotic fluid <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Maternal tachycardia (>100 beats/min) <input type="checkbox"/> Fetal tachycardia (>160 beats/min) <input type="checkbox"/> Intrapartum fever (>=100.4 F/38 C) <input type="checkbox"/> Maternal WBC >20 or 20,000

## 3. 2019 Neonatal Infection Expanded Tracking Form

<u>Current Form</u>	<u>Proposed Changes</u>
35. Neonatal infection Expanded Form Tracking Status: 1 <input type="checkbox"/> Complete, 2 <input type="checkbox"/> Partial, 2 <input type="checkbox"/> Chart Unavailable, 2 <input type="checkbox"/> Edited & Corrected	Two wording changes: Option 2: “Partial” changed to “Incomplete”, Option 4: “after 3 requests” added 35. Neonatal infection Expanded Form Tracking Status: 1 <input type="checkbox"/> Complete, 2

#### 4. Non-Invasive Pneumococcal Pneumonia (SNiPP)– Form Discontinued

#### FluSurv-NET

#### 5. Influenza Hospitalization Surveillance Network Case Report Form

<u>Question on 2017-18 Form</u>	<u>Question on 2018-19 Form</u>
<p><b>C14. Where did patient reside at the time of hospitalization?</b></p> <ul style="list-style-type: none"> <li>▪ Private Residence</li> <li>▪ Homeless/Shelter</li> <li>▪ Nursing home/Skilled Nursing Facility</li> <li>▪ Alcohol/Drug Abuse Treatment</li> <li>▪ Hospitalized at birth</li> <li>▪ Rehabilitation facility</li> <li>▪ Jail</li> <li>▪ Hospice</li> <li>▪ Assisted living/Residential care</li> <li>▪ LTACH</li> <li>▪ Group home/Retire</li> <li>▪ Mental hospital</li> <li>▪ Unknown</li> <li>▪ Other long term care facility</li> <li>▪ Other, specify</li> </ul>	<p><b>C14. Where did patient reside at the time of hospitalization?</b></p> <ul style="list-style-type: none"> <li>▪ Private Residence</li> <li>▪ Home with Services</li> <li>▪ Homeless/Shelter</li> <li>▪ Nursing home/Skilled Nursing Facility</li> <li>▪ Alcohol/Drug Abuse Treatment</li> <li>▪ Hospitalized at birth</li> <li>▪ Rehabilitation facility</li> <li>▪ Corrections facility</li> <li>▪ Hospice</li> <li>▪ Assisted living/Residential care</li> <li>▪ LTACH</li> <li>▪ Group home/Retire</li> <li>▪ Psychiatric facility</li> <li>▪ Unknown</li> <li>▪ Other long term care facility</li> <li>▪ Other, specify</li> </ul>
<p><b>E1. Date of onset of acute condition resulting in current hospitalization</b></p>	<p>N/A (Question removed)</p>
<p><b>E11m. Did patient have any of the following pre-existing medical conditions?</b> If pregnant, specify gestational age in weeks</p>	<p><b>E10m. Did patient have any of the following pre-existing medical conditions?</b></p> <ul style="list-style-type: none"> <li>▪ Total # of pregnancies to date</li> <li>▪ Total # of pregnancies to date that resulted in a live birth</li> <li>▪ Specify total # of fetuses for current pregnancy</li> <li>▪ Specify gestation age in weeks</li> <li>▪ If gestational age in weeks unknown, specify trimester of pregnancy</li> </ul>
<p><b>E2. Acute signs/symptoms present at admission (began or worsened within 2 weeks prior to admission)</b></p> <ul style="list-style-type: none"> <li>▪ Altered mental status/confusion</li> <li>▪ Cough*</li> <li>▪ Headache</li> <li>▪ Seizures</li> <li>▪ Wheezing*</li> <li>▪ Chest pain</li> <li>▪ Diarrhea</li> </ul>	<p><b>E1. Acute signs/symptoms present at admission (began or worsened within 2 weeks prior to admission)</b></p> <ul style="list-style-type: none"> <li>▪ Altered mental status/confusion</li> <li>▪ Cough*</li> <li>▪ Seizures</li> <li>▪ Wheezing*</li> <li>▪ Shortness of breath/respiratory distress*</li> <li>▪ Congested/runny nose*</li> </ul>

<ul style="list-style-type: none"> <li>▪ Myalgia/muscle aches</li> <li>▪ Shortness of breath/respiratory distress*</li> <li>▪ Other, non-respiratory</li> <li>▪ Congested/runny nose*</li> <li>▪ Fatigue/weakness</li> <li>▪ Nausea/vomiting</li> <li>▪ Sore throat*</li> <li>▪ Conjunctivitis/pink eye</li> <li>▪ Fever/chills</li> <li>▪ Rash</li> <li>▪ URI/ILI*</li> <li>▪ No signs/symptoms documented</li> </ul>	<ul style="list-style-type: none"> <li>▪ Sore throat*</li> <li>▪ Fever/chills</li> <li>▪ URI/ILI*</li> <li>▪ No signs/symptoms documented</li> </ul>
<b>F1a. Number of ICU Admissions:</b> _____	N/A (Question removed)
<b>G3a. If yes, specify pathogen</b>	<b>G3a. If yes, specify pathogen</b> Aspergillus (fungus)
<b>H1. Was patient tested for any of the following viral respiratory pathogens within 3 days of admission?</b>	<b>H1. Was patient tested for any viral respiratory pathogens within 14 days prior to or within 3 days after admission?</b>
<b>I2b-I4b. Method of Administration:</b> Oral Intravenous (IV) Inhaled Unknown	N/A (question removed)
<b>I2c. End Date:</b> _____	<b>I2c. End Date:</b> _____ OR Total Duration (days)
<b>I2e-14e. Dose</b> _____ Dose Unknown	N/A (question removed)
<b>I2f-14f: Frequency</b> _____ Frequency Unknown	N/A (question removed)
<b>K1. Did the patient have any of the following new diagnoses at discharge? (check all that apply)</b> <ul style="list-style-type: none"> <li>▪ Acute encephalopathy/encephalitis</li> <li>▪ Acute myocardial infarction</li> <li>▪ Acute Myocarditis</li> <li>▪ Acute renal failure</li> <li>▪ Acute respiratory distress syndrome (ARDS)</li> <li>▪ Acute respiratory failure</li> <li>▪ Asthma exacerbation</li> <li>▪ Bacteremia</li> <li>▪ Bronchiolitis</li> <li>▪ Congestive heart failure</li> <li>▪ COPD exacerbation</li> <li>▪ Diabetic Ketoacidosis</li> <li>▪ Guillain-Barre syndrome</li> <li>▪ Hemophagocytic syndrome</li> <li>▪ Reyes syndrome</li> <li>▪ Rhabdomyolysis</li> <li>▪ Pneumonia</li> <li>▪ Sepsis</li> <li>▪ Seizures</li> <li>▪ Stroke (CVA)</li> </ul>	<b>K1. Did the patient have any of the following new diagnoses at discharge? (check all that apply)</b> <ul style="list-style-type: none"> <li>▪ Acute encephalopathy/encephalitis</li> <li>▪ Acute myocardial infarction</li> <li>▪ Acute Myocarditis</li> <li>▪ Acute renal failure</li> <li>▪ Acute respiratory distress syndrome (ARDS)</li> <li>▪ Acute respiratory failure</li> <li>▪ Asthma exacerbation</li> <li>▪ Bacteremia</li> <li>▪ Bronchiolitis</li> <li>▪ Congestive heart failure</li> <li>▪ COPD exacerbation</li> <li>▪ Diabetic Ketoacidosis</li> <li>▪ Guillain-Barre syndrome</li> <li>▪ Hemophagocytic syndrome</li> <li>▪ Invasive pulmonary aspergillosis</li> <li>▪ Reyes syndrome</li> <li>▪ Rhabdomyolysis</li> <li>▪ Pneumonia</li> <li>▪ Sepsis</li> </ul>

<ul style="list-style-type: none"> <li>▪ No discharge summary available</li> </ul>	<ul style="list-style-type: none"> <li>▪ Seizures</li> <li>▪ Stroke (CVA)</li> <li>▪ No discharge summary available</li> </ul>
<b>K3a. If patient was pregnant on admission but not longer pregnant at discharge, indicate pregnancy outcome at discharge.</b> <ul style="list-style-type: none"> <li>▪ Miscarriage</li> <li>▪ Ill newborn</li> <li>▪ Newborn died</li> <li>▪ Healthy newborn</li> <li>▪ Abortion</li> <li>▪ Unknown</li> </ul>	<b>K3a. If patient was pregnant on admission but not longer pregnant at discharge, indicate pregnancy outcome at discharge.</b> <ul style="list-style-type: none"> <li>▪ Miscarriage (intrauterine death at &lt;22 weeks GA)</li> <li>▪ Stillbirth (intrauterine death at ≥22 weeks GA)</li> <li>▪ Ill newborn</li> <li>▪ Newborn died</li> <li>▪ Healthy newborn</li> <li>▪ Abortion</li> <li>▪ Unknown</li> </ul>
K3b. N/A	<b>K3b. If no longer pregnant, indicate date of delivery or end of pregnancy: _____</b>

**HAIC**

**6. 2019 MuGSI Case Report Form for Carbapenem-resistant Enterobacteriaceae (CRE) and *Acinetobacter baumannii* (CRAB)**

Question on 2018 form	Question on 2019 form
24. Date reported to EIP site: □□/□□/□□□□	DATE REPORTED TO EIP SITE: ____ - ____ - _____
Title: 2018 Multi-site Gram-Negative Surveillance Initiative (MuGSI) Healthcare Associated Infection Community Interface (HAIC) Case Report	Title: 2019 Carbapenem Resistant Enterobacteriaceae (CRE)/ Carbapenem Resistant <i>A. baumannii</i> (CRAB) Multi-site Gram-Negative Surveillance Initiative (MuGSI) Healthcare Associated Infection Community Interface (HAIC) Case Report
4a. LABORATORY ID WHERE CULTURE IDENTIFIED: _____	4a. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED: _____
6. DATE OF BIRTH: □□/□□/□□□□	5. DATE OF BIRTH: ____ - ____ - _____
7a. AGE: □□□	6. AGE ____ _ • Days • Mos. • Years
7b. Is age in day/mo/yr? • Days • Mos. • Years	
8a. Sex: • Male • Female	7. SEX AT BIRTH: • Male • Female • Unknown • Check if transgender
8b. ETHNIC ORIGIN: • Hispanic or Latino • Not Hispanic or Latino • Unknown	8a. ETHNIC ORIGIN: • Hispanic or Latino • Not Hispanic or Latino • Unknown

<p>8c. RACE: (Check all that apply)</p> <ul style="list-style-type: none"> <li>• White</li> <li>• Black or African American</li> <li>• American Indian or Alaska Native</li> <li>• Asian</li> <li>• Native Hawaiian or Other Pacific Islander</li> <li>• Unknown</li> </ul>	<p>8b. RACE: (Check all that apply)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native</li> <li>• Asian</li> <li>• Black or African American</li> <li>• Native Hawaiian or Other Pacific Islander</li> <li>• White</li> <li>• Unknown</li> </ul>
<p>10a. DATE OF INITIAL CULTURE □□/□□/□□□□</p>	<p>9. DATE OF INCIDENT SPECIMEN COLLECTION (DISC): ____ - ____ - _____</p>
<p>13a. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE:</p> <p>Carbapenem-resistant:</p> <p><input type="checkbox"/> <i>Enterobacteriaceae</i> (CRE)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Escherichia coli</i></li> <li><input type="checkbox"/> <i>Enterobacter cloacae</i></li> <li><input type="checkbox"/> <i>Enterobacter aerogenes</i></li> <li><input type="checkbox"/> <i>Klebsiella pneumoniae</i></li> <li><input type="checkbox"/> <i>Klebsiella oxytoca</i></li> <li><input type="checkbox"/> <i>A. baumannii</i> (CRAB)</li> </ul>	<p>10. ORGANISM:</p> <p>Carbapenem-resistant:</p> <p><input type="checkbox"/> <i>Enterobacteriaceae</i> (CRE)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Escherichia coli</i></li> <li><input type="checkbox"/> <i>Enterobacter cloacae</i></li> <li><input type="checkbox"/> <i>Klebsiella aerogenes</i></li> <li><input type="checkbox"/> <i>Klebsiella pneumoniae</i></li> <li><input type="checkbox"/> <i>Klebsiella oxytoca</i></li> <li><input type="checkbox"/> <i>A. baumannii</i> (CRAB)</li> </ul>
<p>14. INITIAL CULTURE SITE:</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• CSF</li> <li>• Pleural fluid</li> <li>• Peritoneal fluid</li> <li>• Pericardial fluid</li> <li>• Joint/Synovial fluid</li> <li>• Bone</li> <li>• Urine</li> <li>• Other normally sterile site _____</li> </ul>	<p>11. Incident specimen collection site (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• Bone</li> <li>• CSF</li> <li>• Internal body site (specify): _____</li> <li>• Joint/Synovial fluid</li> <li>• Muscle</li> <li>• Pericardial fluid</li> <li>• Peritoneal fluid</li> <li>• Pleural fluid</li> <li>• Urine</li> <li>• Other normally sterile site (specify): _____</li> </ul>
<p>10b. LOCATION OF CULTURE COLLECTION:</p> <p><b>Hospital Inpatient</b></p> <ul style="list-style-type: none"> <li>• ICU</li> <li>• Surgery/OR</li> <li>• Radiology</li> <li>• Other Unit</li> </ul> <p>• Emergency Room</p> <p><b>Outpatient</b></p> <ul style="list-style-type: none"> <li>• Clinic/Doctors Office</li> <li>• Surgery</li> <li>• Other outpatient</li> <li>• Dialysis center</li> </ul> <ul style="list-style-type: none"> <li>• Observational/clinical decision unit</li> <li>• LTCF Facility ID: _____</li> <li>• LTACH Facility ID: _____</li> <li>• Autopsy</li> <li>• Unknown</li> </ul>	<p>12. LOCATION OF SPECIMEN COLLECTION:</p> <ul style="list-style-type: none"> <li>• <b>Outpatient</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Emergency room</li> <li>• Clinic/Doctor's office</li> <li>• Dialysis center</li> <li>• Surgery</li> <li>• Observational/clinical decision unit</li> <li>• Other outpatient</li> </ul> <ul style="list-style-type: none"> <li>• <b>Inpatient</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• ICU</li> <li>• OR</li> <li>• Radiology</li> <li>• Other inpatient</li> </ul> <ul style="list-style-type: none"> <li>• <b>LTCF</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• <b>LTACH</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• <b>Autopsy</b></li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Other (specify):</b> _____</li> <li>• <b>Unknown</b></li> </ul>
<p>5. Where was the patient located on the 4th calendar day prior to the date of initial culture?</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTCF Facility ID: _____</li> <li>• LTACH Facility ID: _____</li> <li>• Homeless</li> <li>• Incarcerated</li> <li>• Hospital inpatient Was patient transferred from this hospital? • Yes • No • Unknown Facility ID: _____</li> <li>• Other (specify): _____</li> <li>• Unknown</li> </ul>	<p>13. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC?</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTCF Facility ID: _____</li> <li>• Hospital inpatient Facility ID: _____ Was patient transferred from this hospital? • Yes • No • Unknown</li> <li>• LTACH Facility ID: _____</li> <li>• Homeless</li> <li>• Incarcerated</li> <li>• Other (specify): _____</li> <li>• Unknown</li> </ul>
<p>9. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>If yes: Date of admission □□/□□/□□□□</p> <p>Date of discharge □□/□□/□□□□</p>	<p>14. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER THE DISC?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>IF YES, DATE OF ADMISSION: ____ - ____ - _____</p>
<p>11a. Was the patient in the ICU in the 7 days prior to their initial culture?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul>	<p>15a. WAS THE PATIENT IN AN ICU IN THE 7 DAYS BEFORE THE DISC?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>IF YES, DATE OF ICU ADMISSION: ____ - ____ - _____ OR <input type="checkbox"/> Date unknown</p>
<p>11b. Was the patient in the ICU on the date of or in the 7 days after the initial culture?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul>	<p>15b. WAS THE PATIENT IN AN ICU ON THE DAY OF INCIDENT SPECIMEN COLLECTION OR IN THE 6 DAYS AFTER THE DISC?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>IF YES, DATE OF ICU ADMISSION: ____ - ____ - _____ OR <input type="checkbox"/> Date unknown</p>
<p>12. PATIENT OUTCOME:</p> <ul style="list-style-type: none"> <li>• Survived</li> <li>• Died</li> <li>• Unknown</li> </ul> <p>If survived, transferred to:</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTCF Facility ID: _____</li> <li>• LTACH Facility ID: _____</li> <li>• Unknown</li> <li>• Other (specify): _____</li> </ul> <p>If died, date of death: □□/□□/□□□□</p> <p>Was the organism cultured from a normally sterile site or urine, ≤ calendar day 7 before death?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul>	<p>16. PATIENT OUTCOME:</p> <ul style="list-style-type: none"> <li>• Survived Date of discharge: ____ - ____ - _____ OR</li> <li>• Date unknown</li> <li>• Left against medical advice (AMA)</li> </ul> <p>If survived, discharged to:</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTCF Facility ID: _____</li> <li>• LTACH Facility ID: _____</li> <li>• Other (specify): _____</li> <li>• Unknown</li> </ul> <ul style="list-style-type: none"> <li>• Died Date of death: ____ - ____ - _____</li> </ul> <p>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?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul>

<p>19. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S) (check all that apply):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Unknown</li> <li><input type="checkbox"/> Abscess, not skin</li> <li><input type="checkbox"/> AV fistula/graft infection</li> <li><input type="checkbox"/> Bacteremia</li> <li><input type="checkbox"/> Bursitis</li> <li><input type="checkbox"/> Catheter site infection (CVC)</li> <li><input type="checkbox"/> Cellulitis</li> <li><input type="checkbox"/> Chronic ulcer/wound (not decubitus)</li> <li><input type="checkbox"/> Decubitus/pressure ulcer</li> <li><input type="checkbox"/> Empyema</li> <li><input type="checkbox"/> Endocarditis</li> <li><input type="checkbox"/> Epidural Abscess</li> <li><input type="checkbox"/> Meningitis</li> <li><input type="checkbox"/> Osteomyelitis</li> <li><input type="checkbox"/> Peritonitis</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Pyelonephritis</li> <li><input type="checkbox"/> Septic arthritis</li> <li><input type="checkbox"/> Septic emboli</li> <li><input type="checkbox"/> Septic shock</li> <li><input type="checkbox"/> Skin abscess</li> <li><input type="checkbox"/> Surgical incision infection</li> <li><input type="checkbox"/> Surgical site infection (internal)</li> <li><input type="checkbox"/> Traumatic wound</li> <li><input type="checkbox"/> Urinary tract infection</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p>17. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply)</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> <li><input type="checkbox"/> Abscess, not skin</li> <li><input type="checkbox"/> AV fistula/graft infection</li> <li><input type="checkbox"/> Bacteremia</li> <li><input type="checkbox"/> Bursitis</li> <li><input type="checkbox"/> Catheter site infection (CVC)</li> <li><input type="checkbox"/> Cellulitis</li> <li><input type="checkbox"/> Chronic ulcer/wound (not decubitus)</li> <li><input type="checkbox"/> Decubitus/pressure ulcer</li> <li><input type="checkbox"/> Empyema</li> <li><input type="checkbox"/> Endocarditis</li> <li><input type="checkbox"/> Epidural Abscess</li> <li><input type="checkbox"/> Meningitis</li> <li><input type="checkbox"/> Osteomyelitis</li> <li><input type="checkbox"/> Peritonitis</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Pyelonephritis</li> <li><input type="checkbox"/> Septic arthritis</li> <li><input type="checkbox"/> Septic emboli</li> <li><input type="checkbox"/> Septic shock</li> <li><input type="checkbox"/> Skin abscess</li> <li><input type="checkbox"/> Surgical incision infection</li> <li><input type="checkbox"/> Surgical site infection (internal)</li> <li><input type="checkbox"/> Traumatic wound</li> <li><input type="checkbox"/> Urinary tract infection</li> <li><input type="checkbox"/> Other (specify): _____</li> </ul>		
<p>20. UNDERLYING CONDITIONS (check all that apply):</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> <li><input type="checkbox"/> AIDS/CD4 count &lt; 200</li> <li><input type="checkbox"/> Alcohol abuse</li> <li><input type="checkbox"/> Chronic Liver Disease</li> <li><input type="checkbox"/> Chronic Pulmonary Disease</li> <li><input type="checkbox"/> Chronic Renal Insufficiency</li> <li><input type="checkbox"/> Chronic Skin Breakdown</li> <li><input type="checkbox"/> Congestive Heart Failure</li> <li><input type="checkbox"/> Connective Tissue Disease</li> <li><input type="checkbox"/> Current Smoker</li> <li><input type="checkbox"/> CVA/Stroke</li> <li><input type="checkbox"/> Cystic Fibrosis</li> <li><input type="checkbox"/> Decubitus/Pressure Ulcer</li> <li><input type="checkbox"/> Dementia/Chronic Cognitive Deficit</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Hemiplegia/Paraplegia</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> Hematologic Malignancy</li> <li><input type="checkbox"/> IVDU</li> <li><input type="checkbox"/> Liver failure</li> <li><input type="checkbox"/> Metastatic Solid Tumor</li> </ul>	<p>18. UNDERLYING CONDITIONS: (Check all that apply)</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> </ul> <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 50%;"> <p><b>CHRONIC LUNG DISEASE</b></p> <ul style="list-style-type: none"> <li>• Cystic fibrosis</li> <li>• Chronic pulmonary disease</li> </ul> <p><b>CHRONIC METABOLIC DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diabetes mellitus <ul style="list-style-type: none"> <li>• with chronic complications</li> </ul> </li> </ul> <p><b>CARDIOVASCULAR DISEASE</b></p> <ul style="list-style-type: none"> <li>• CVA/Stroke/TIA</li> <li>• Congenital heart disease</li> <li>• Congestive heart failure</li> <li>• Myocardial infarction</li> <li>• Peripheral vascular disease (PVD)</li> </ul> <p><b>GASTROINTESTINAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diverticular disease</li> <li>• Inflammatory Bowel disease</li> <li>• Peptic ulcer disease</li> <li>• Short gut syndrome</li> </ul> </td> <td style="vertical-align: top; width: 50%;"> <p><b>NEUROLOGIC CONDITION</b></p> <ul style="list-style-type: none"> <li>• Cerebral palsy</li> <li>• Chronic cognitive deficit</li> <li>• Dementia</li> <li>• Epilepsy/seizure/ seizure disorder</li> <li>• Multiple sclerosis</li> <li>• Neuropathy</li> <li>• Parkinson's Disease</li> <li>• Other specify: _____</li> </ul> <p><b>PLEGIAS/PARALYSIS</b></p> <ul style="list-style-type: none"> <li>• Hemiplegia</li> <li>• Paraplegia</li> <li>• Quadriplegia</li> </ul> <p><b>RENAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Chronic kidney disease</li> <li>Lowest serum creatinine: _____mg/Dl</li> </ul> <p><b>SKIN CONDITION</b></p> <ul style="list-style-type: none"> <li>• Burn</li> <li>• Decubitus/pressure ulcer</li> </ul> </td> </tr> </table>	<p><b>CHRONIC LUNG DISEASE</b></p> <ul style="list-style-type: none"> <li>• Cystic fibrosis</li> <li>• Chronic pulmonary disease</li> </ul> <p><b>CHRONIC METABOLIC DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diabetes mellitus <ul style="list-style-type: none"> <li>• with chronic complications</li> </ul> </li> </ul> <p><b>CARDIOVASCULAR DISEASE</b></p> <ul style="list-style-type: none"> <li>• CVA/Stroke/TIA</li> <li>• Congenital heart disease</li> <li>• Congestive heart failure</li> <li>• Myocardial infarction</li> <li>• Peripheral vascular disease (PVD)</li> </ul> <p><b>GASTROINTESTINAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diverticular disease</li> <li>• Inflammatory Bowel disease</li> <li>• Peptic ulcer disease</li> <li>• Short gut syndrome</li> </ul>	<p><b>NEUROLOGIC CONDITION</b></p> <ul style="list-style-type: none"> <li>• Cerebral palsy</li> <li>• Chronic cognitive deficit</li> <li>• Dementia</li> <li>• Epilepsy/seizure/ seizure disorder</li> <li>• Multiple sclerosis</li> <li>• Neuropathy</li> <li>• Parkinson's Disease</li> <li>• Other specify: _____</li> </ul> <p><b>PLEGIAS/PARALYSIS</b></p> <ul style="list-style-type: none"> <li>• Hemiplegia</li> <li>• Paraplegia</li> <li>• Quadriplegia</li> </ul> <p><b>RENAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Chronic kidney disease</li> <li>Lowest serum creatinine: _____mg/Dl</li> </ul> <p><b>SKIN CONDITION</b></p> <ul style="list-style-type: none"> <li>• Burn</li> <li>• Decubitus/pressure ulcer</li> </ul>
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<ul style="list-style-type: none"> <li><input type="checkbox"/> Myocardial Infarct</li> <li><input type="checkbox"/> Neurological Problems</li> <li><input type="checkbox"/> Obesity or Morbid Obesity</li> <li><input type="checkbox"/> Peptic Ulcer Disease</li> <li><input type="checkbox"/> Peripheral Vascular Disease (PVD)</li> <li><input type="checkbox"/> Premature Birth</li> <li><input type="checkbox"/> Solid Tumor (non metastatic)</li> <li><input type="checkbox"/> Spina bifida</li> <li><input type="checkbox"/> Transplant Recipient</li> <li><input type="checkbox"/> Urinary Tract Problems/Abnormalities</li> </ul>	<p><b>IMMUNOCOMPROMISED CONDITION</b></p> <ul style="list-style-type: none"> <li>• HIV infection <ul style="list-style-type: none"> <li>• AIDS/CD4 count &lt;200</li> </ul> </li> <li>• Primary immunodeficiency</li> <li>• Transplant, hematopoietic stem cell</li> <li>• Transplant, solid organ</li> </ul> <p><b>LIVER DISEASE</b></p> <ul style="list-style-type: none"> <li>• Chronic liver disease <ul style="list-style-type: none"> <li>• Ascites</li> <li>• Cirrhosis</li> <li>• Hepatic encephalopathy</li> <li>• Variceal bleeding</li> </ul> </li> <li><input type="checkbox"/> Hepatitis C <ul style="list-style-type: none"> <li>• Treated, in SVR</li> <li>• Current, chronic</li> </ul> </li> </ul> <p><b>MALIGNANCY</b></p> <ul style="list-style-type: none"> <li>• Malignancy, hematologic</li> <li>• Malignancy, solid organ (non-metastatic)</li> <li>• Malignancy, solid organ (metastatic)</li> </ul> <ul style="list-style-type: none"> <li>• Surgical wound</li> <li>• Other chronic ulcer or chronic wound</li> </ul> <p><b>OTHER</b></p> <ul style="list-style-type: none"> <li>• Connective tissue disease</li> <li>• Obesity or morbid obesity</li> <li>• Pregnant</li> </ul> <p><b>MuGSI CONDITIONS</b></p> <ul style="list-style-type: none"> <li>• Urinary tract problems/abnormalities</li> <li>• Premature birth</li> <li>• Spina bifida</li> </ul>
<p>20. UNDERLYING CONDITIONS (check all that apply):</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> <li><input type="checkbox"/> AIDS/CD4 count &lt; 200</li> <li><input type="checkbox"/> Alcohol abuse</li> <li><input type="checkbox"/> Chronic Liver Disease</li> <li><input type="checkbox"/> Chronic Pulmonary Disease</li> <li><input type="checkbox"/> Chronic Renal Insufficiency</li> <li><input type="checkbox"/> Chronic Skin Breakdown</li> <li><input type="checkbox"/> Congestive Heart Failure</li> <li><input type="checkbox"/> Connective Tissue Disease</li> <li><input type="checkbox"/> Current Smoker</li> <li><input type="checkbox"/> CVA/Stroke</li> <li><input type="checkbox"/> Cystic Fibrosis</li> <li><input type="checkbox"/> Decubitus/Pressure Ulcer</li> <li><input type="checkbox"/> Dementia/Chronic Cognitive Deficit</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Hemiplegia/Paraplegia</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> Hematologic Malignancy</li> <li><input type="checkbox"/> IVDU</li> <li><input type="checkbox"/> Liver failure</li> <li><input type="checkbox"/> Metastatic Solid Tumor</li> <li><input type="checkbox"/> Myocardial Infarct</li> <li><input type="checkbox"/> Neurological Problems</li> <li><input type="checkbox"/> Obesity or Morbid Obesity</li> <li><input type="checkbox"/> Peptic Ulcer Disease</li> <li><input type="checkbox"/> Peripheral Vascular Disease (PVD)</li> <li><input type="checkbox"/> Premature Birth</li> <li><input type="checkbox"/> Solid Tumor (non metastatic)</li> <li><input type="checkbox"/> Spina bifida</li> </ul>	<p>19. SUBSTANCE USE, CURRENT</p> <p>SMOKING (Check all that apply):</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> <li>• Tobacco</li> <li>• E-nicotine delivery system</li> <li>• Marijuana</li> </ul> <p>ALCOHOL ABUSE:</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Unknown</li> </ul> <p>OTHER SUBSTANCES: (Check all that apply)</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> </ul> <p style="text-align: right;"><u>DOCUMENTED USE DISORDER (DUD)/ABUSE:</u></p> <p><u>MODE OF DELIVERY:</u> (Check all that apply)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Marijuana/cannabinoid (other than smoking) <input type="checkbox"/> DUD or abuse</li> <li><input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</li> <li><input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin) <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</li> <li><input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone) <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</li> <li><input type="checkbox"/> Cocaine or methamphetamine <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</li> </ul>

<input type="checkbox"/> Transplant Recipient <input type="checkbox"/> Urinary Tract Problems/Abnormalities	<input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> Unknown substance <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown  <p>Some of the data in this section was formerly collected in the underlying conditions section (IVDU [changed to injection drug user], Current smoker [changed to smoking], Alcohol Abuse (see highlighted conditions in the prior column). The collection of more information for other drug use is new.</p> <p>There are six new check boxes that allow other drug use to be captured in more detail. These questions focus on type of drug and mode of delivery.</p>
<p>21. RISK FACTORS OF INTEREST (check all that apply):</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> <li>• Culture collected ≥ calendar day 3 after hospital admission</li> <li>• Hospitalized within year before date of initial culture: If yes, enter mo/yr <input type="checkbox"/><input type="checkbox"/>/<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> OR • Unknown If known, prior hospital ID: _____</li> <li>• Surgery within year before date of initial culture</li> <li>• Current chronic dialysis: <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Unknown Hemodialysis Access: <input type="checkbox"/> AV fistula/graft <input type="checkbox"/> CVC <input type="checkbox"/> Unknown</li> <li>• Residence in LTCF within year before date of initial culture If known, facility ID: _____</li> <li>• Admitted to a LTACH within year before initial culture date If known, facility ID: _____</li> <li>• Central venous catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture</li> <li>• Urinary catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture If checked, indicate all that apply:           <ul style="list-style-type: none"> <li>• Indwelling Urethral Catheter</li> <li>• Suprapubic Catheter</li> <li>• Condom Catheter</li> </ul> </li> </ul>	<p>20. RISK FACTORS: (Check all that apply)</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> </ul> <p>WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No (please note, this field is auto calculated in the data management system (DMS), therefore, the user does not ever complete this filed and there is not burden associated with its collection. It is on the paper form because our users want to continue to view this in the DMS)</li> </ul> <p>Previous hospitalization in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Unknown</li> </ul> <p>If yes, date of discharge closed to DISC:    ____ - ____ - ____ - ____    Facility ID: _____    OR, Date Unknown •</p> <p>Overnight stay in LTCF in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Unknown</li> </ul> <p>Facility ID: _____</p> <p>Overnight stay in LTACH in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Unknown</li> </ul> <p>Facility ID: _____</p> <p>Surgery in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Unknown</li> </ul> <p>CURRENT CHRONIC DIALYSIS:    IF YES, TYPE:  <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Unknown    IF HEMODIALYSIS, TYPE OF VASCULAR ACCESS:  <input type="checkbox"/> AV fistula/graft <input type="checkbox"/> Hemodialysis central line <input type="checkbox"/> Unknown</p> <p>CENTRAL LINE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:</p>

<p>• Other: _____</p> <p>• Any OTHER indwelling device in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture If checked, indicate all that apply:</p> <ul style="list-style-type: none"> <li>• ET/NT Tube</li> <li>• Gastrostomy Tube</li> <li>• NG Tube</li> <li>• Tracheostomy</li> <li>• Nephrostomy Tube</li> <li>• Other: _____</li> </ul> <p>• Patient traveled internationally in the two months prior to the date of initial culture.</p> <p><b>Country:</b> _____, _____, _____</p> <p>• Patient was hospitalized while visiting country(ies) listed above</p>	<p>• Yes • No • Unknown Check here if central line in place for &gt; 2 calendar days: <input type="checkbox"/></p> <p>URINARY CATHETER IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:</p> <p>• Yes • No • Unknown IF YES, CHECK ALL THAT APPLY:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Indwelling Urethral Catheter</li> <li><input type="checkbox"/> Suprapubic Catheter</li> <li><input type="checkbox"/> Condom Catheter</li> <li><input type="checkbox"/> Other (specify): _____</li> </ul> <p>ANY OTHER INDWELLING DEVICE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:</p> <p>• Yes • No • Unknown IF YES, CHECK ALL THAT APPLY:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> ET/NT Tube    <input type="checkbox"/> Gastrostomy Tube    <input type="checkbox"/> NG Tube</li> <li><input type="checkbox"/> Tracheostomy    <input type="checkbox"/> Nephrostomy Tube    <input type="checkbox"/> Other (specify): _____</li> </ul> <p>PATIENT TRAVELED INTERNATIONALLY IN THE YEAR BEFORE DISC:</p> <p>• Yes • No • Unknown COUNTRY: _____, _____, _____</p> <p>PATIENT HOSPITALIZED WHILE VISITING COUNTRY(IES) ABOVE:</p> <p>• Yes • No • Unknown</p>
<p>8d. WEIGHT: _____ lbs _____ oz OR _____ kg <input type="checkbox"/> Unknown</p>	<p>21a. WEIGHT: _____ lbs. _____ oz. OR _____ kg    <input type="checkbox"/> Unknown</p>
<p>8e. HEIGHT: _____ ft _____ in OR _____ cm <input type="checkbox"/> Unknown</p>	<p>21b. HEIGHT: _____ ft. _____ in. OR _____ cm    <input type="checkbox"/> Unknown</p>
<p>8f. BMI (Record only if ht and/or wt is not available): _____ <input type="checkbox"/> Unknown</p>	<p>21c. BMI: _____ <input type="checkbox"/> Unknown</p>
<p>URINE Cultures ONLY: 14a. Was the urine collected through an indwelling urethral catheter? • Yes • No • Unknown</p>	<p>URINE CULTURES ONLY: 22a. WAS THE URINE COLLECTED THROUGH AN INDWELLING URETHRAL CATHETER? • Yes • No • Unknown</p>
<p>URINE Cultures ONLY: 14b. Record the colony count _____</p>	<p>URINE CULTURES ONLY: 22b. RECORD THE COLONY COUNT: _____</p>
<p>URINE Cultures ONLY: 14c. Signs and Symptoms associated with urine culture. Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before through the 2 calendar days after the date of initial culture. Then go to question 14d.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Costovertebral angle pain or tenderness</li> <li><input type="checkbox"/> Dysuria</li> </ul>	<p>URINE CULTURES ONLY: 22c. SIGNS AND SYMPTOMS ASSOCIATED WITH URINE CULTURE Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before through the 2 calendar days after the DISC.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Costovertebral angle pain or tenderness</li> <li><input type="checkbox"/> Dysuria</li> <li><input type="checkbox"/> Fever [temperature <math>\geq</math> 100.4 °F (38 °C)]</li> </ul>

<input type="checkbox"/> Fever [temperature $\geq$ 100.4 °F (38 °C)] <input type="checkbox"/> Unknown <input type="checkbox"/> Frequency <input type="checkbox"/> Suprapubic tenderness <input type="checkbox"/> Urgency  Symptoms for patients $\leq$ 1 year of age only: <input type="checkbox"/> Apnea <input type="checkbox"/> Bradycardia <input type="checkbox"/> Lethargy <input type="checkbox"/> Vomiting	<input type="checkbox"/> Unknown <input type="checkbox"/> Frequency <input type="checkbox"/> Suprapubic tenderness <input type="checkbox"/> Urgency  Symptoms for patients $\leq$ 1 year of age only: <input type="checkbox"/> Apnea <input type="checkbox"/> Bradycardia <input type="checkbox"/> Lethargy <input type="checkbox"/> Vomiting																				
URINE Cultures ONLY: 14d. Was a blood culture positive in the 3 calendar days before through the 3 calendar days after the initial urine culture for the same MuGSI organism? • Yes • No • Unknown	URINE CULTURES ONLY: 22d. WAS A BLOOD CULTURE POSITIVE IN THE 3 CALENDAR DAYS BEFORE THROUGH THE 3 CALENDAR DAYS AFTER THE DISC FOR THE SAME MuGSI ORGANISM? • Yes • No • Unknown																				
13b. Was the initial culture polymicrobial?  • Yes • No • Unknown	23. WAS THE INCIDENT SPECIMEN POLYMICROBIAL? • Yes • No • Unknown																				
13c. Was the initial isolate tested for carbapenemase?  • Yes • No • Laboratory not testing • Unknown  If yes, what testing method was used (check all that apply): • Automated Molecular Assay (specify): _____ • CarbaNP • PCR • E Test • Modified Hodge Test (MHT) • Other (specify): _____ • Unknown  If tested, what was the testing result? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown	24a. WAS THE INCIDENT SPECIMEN TESTED FOR CARBAPENEMASE? • Yes • No • Laboratory not testing • Unknown  24b. IF YES, WHAT TESTING METHOD WAS USED? (Check all that apply): Non-Molecular Tests <input type="checkbox"/> CarbaNP <input type="checkbox"/> Carbapenemase Inactivation Method (CIM) <input type="checkbox"/> Disk Diffusion/ROSCO Disk <input type="checkbox"/> E-test <input type="checkbox"/> Modified Carbapenemase Inactivation Method (mCIM) <input type="checkbox"/> Modified Hodge Test (MHT) <input type="checkbox"/> RAPIDEC <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown  Molecular Tests <input type="checkbox"/> Automated Molecular Assay <input type="checkbox"/> Carba-R <input type="checkbox"/> Check Points <input type="checkbox"/> MALDI-TOF MS <input type="checkbox"/> Next Generation Nucleic Acid Sequencing <input type="checkbox"/> PCR <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown  24c. IF TESTED, WHAT WAS THE TESTING RESULT? Non-Molecular Test Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown Molecular Test Results: <table border="1" data-bbox="743 1791 1528 1917"> <tr> <td><input type="checkbox"/> NDM</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td><input type="checkbox"/> Ind</td> <td><input type="checkbox"/> Unk</td> </tr> <tr> <td><input type="checkbox"/> KPC</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td><input type="checkbox"/> Ind</td> <td><input type="checkbox"/> Unk</td> </tr> <tr> <td><input type="checkbox"/> OXA</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td><input type="checkbox"/> Ind</td> <td><input type="checkbox"/> Unk</td> </tr> <tr> <td><input type="checkbox"/> OXA-48</td> <td><input type="checkbox"/> Pos</td> <td><input type="checkbox"/> Neg</td> <td><input type="checkbox"/> Ind</td> <td><input type="checkbox"/> Unk</td> </tr> </table>	<input type="checkbox"/> NDM	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Ind	<input type="checkbox"/> Unk	<input type="checkbox"/> KPC	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Ind	<input type="checkbox"/> Unk	<input type="checkbox"/> OXA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Ind	<input type="checkbox"/> Unk	<input type="checkbox"/> OXA-48	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Ind	<input type="checkbox"/> Unk
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<p>15. Was the same organism (Q13a) cultured from a different sterile site or urine in the 30 days after the date of initial culture (of this current episode)?</p> <p>• Yes • No • Unknown</p> <p>IF YES, SOURCE: (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• CSF</li> <li>• Pleural fluid</li> <li>• Pericardial fluid</li> <li>• Peritoneal fluid</li> <li>• Joint/Synovial fluid</li> <li>• Bone</li> <li>• Urine</li> <li>• Other normally sterile site _____</li> </ul>	<p>25. WAS THE SAME ORGANISM (Q10) CULTURED FROM A DIFFERENT STERILE SITE OR URINE IN THE 30 DAYS AFTER THE DISC?</p> <p>• Yes • No • Unknown</p> <p>IF YES, SOURCE: (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• Bone</li> <li>• CSF</li> <li>• Internal body site (specify): _____</li> <li>• Joint/Synovial fluid</li> <li>• Muscle</li> <li>• Pericardial fluid</li> <li>• Peritoneal fluid</li> <li>• Pleural fluid</li> <li>• Urine</li> <li>• Other normally sterile site (specify): _____</li> </ul>																								
<p>16. Enterobacteriaceae ONLY:</p> <p>Were cultures of sterile site(s) or urine positive in the 30 days prior to the date of initial culture, for a DIFFERENT organism (Q13a)?</p> <p>• Yes • No • Unknown • N/A</p> <p>IF YES, SOURCE: (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• CSF</li> <li>• Pleural fluid</li> <li>• Pericardial fluid</li> <li>• Peritoneal fluid</li> <li>• Joint/Synovial fluid</li> <li>• Bone</li> <li>• Urine</li> <li>• Other normally sterile site _____</li> </ul> <p>If yes, indicate organism type and associated State ID for the incident closest to the date of initial culture:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;">Organism</th> <th style="width:30%;">State ID</th> </tr> </thead> <tbody> <tr><td><i>Escherichia coli</i></td><td></td></tr> <tr><td><i>Enterobacter cloacae</i></td><td></td></tr> <tr><td><i>Enterobacter aerogenes</i></td><td></td></tr> <tr><td><i>Klebsiella pneumoniae</i></td><td></td></tr> <tr><td><i>Klebsiella oxytoca</i></td><td></td></tr> </tbody> </table>	Organism	State ID	<i>Escherichia coli</i>		<i>Enterobacter cloacae</i>		<i>Enterobacter aerogenes</i>		<i>Klebsiella pneumoniae</i>		<i>Klebsiella oxytoca</i>		<p>26. ENTEROBACTERIACEAE ONLY: WERE CULTURES OF STERILE SITE(S) OR URINE POSITIVE IN THE 30 DAYS BEFORE THE DISC, FOR A DIFFERENT ORGANISM (Q10)?</p> <p>• Yes • No • Unknown • N/A</p> <p>IF YES, SOURCE: (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• Bone</li> <li>• CSF</li> <li>• Internal body site (specify): _____</li> <li>• Joint/Synovial fluid</li> <li>• Muscle</li> <li>• Pericardial fluid</li> <li>• Peritoneal fluid</li> <li>• Pleural fluid</li> <li>• Urine</li> <li>• Other normally sterile site (specify): _____</li> </ul> <p>IF YES, INDICATE ORGANISM TYPE AND ASSOCIATED STATE ID FOR THE INCIDENT CLOSEST TO THE DISC:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;">Organism</th> <th style="width:30%;">State ID</th> </tr> </thead> <tbody> <tr><td><i>Escherichia coli</i></td><td></td></tr> <tr><td><i>Enterobacter cloacae</i></td><td></td></tr> <tr><td><i>Klebsiella aerogenes</i></td><td></td></tr> <tr><td><i>Klebsiella pneumoniae</i></td><td></td></tr> <tr><td><i>Klebsiella oxytoca</i></td><td></td></tr> </tbody> </table>	Organism	State ID	<i>Escherichia coli</i>		<i>Enterobacter cloacae</i>		<i>Klebsiella aerogenes</i>		<i>Klebsiella pneumoniae</i>		<i>Klebsiella oxytoca</i>	
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<p>16a. A. baumannii Cultures ONLY:</p> <p>Were cultures of OTHER sterile site(s) or urine positive in the 30 days prior to the date of initial culture, for another A. baumannii?</p> <p>• Yes • No • Unknown • N/A</p> <p>• Yes • No • Unknown • N/A</p> <p>IF YES, SOURCE: (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• CSF</li> </ul>	<p>27a. A. BAUMANNII CULTURES ONLY:</p> <p>WERE CULTURES OF OTHER STERILE SITE(S) OR URINE POSITIVE IN THE 30 DAYS BEFORE THE DISC, FOR ANOTHER A. BAUMANNII?</p> <p>• Yes • No • Unknown • N/A</p> <p>IF YES, SOURCE: (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• Bone</li> <li>• CSF</li> <li>• Internal body site (specify): _____</li> </ul>																								

<ul style="list-style-type: none"> <li>• Pleural fluid</li> <li>• Pericardial fluid</li> <li>• Peritoneal fluid</li> <li>• Joint/Synovial fluid</li> <li>• Bone</li> <li>• Urine</li> <li>• Other normally sterile site _____</li> </ul> <p>If yes, State ID for the organism closest to the date of initial culture: _____</p>	<ul style="list-style-type: none"> <li>• Joint/Synovial fluid</li> <li>• Muscle</li> <li>• Pericardial fluid</li> <li>• Peritoneal fluid</li> <li>• Pleural fluid</li> <li>• Urine</li> <li>• Other normally sterile site (specify): _____</li> </ul> <p>IF YES, STATE ID FOR THE INCIDENT CLOSEST TO THE DISC: _____</p>
<p>16b. <i>A. baumannii</i> Cultures ONLY: Did the patient have a sputum culture positive for CRAB in the 30 days prior to the date of culture (Day 1)?</p> <p>• Yes • No • Unknown • N/A</p>	<p>27b. A. BAUMANNII CULTURES ONLY: DID THE PATIENT HAVE A SPUTUM CULTURE POSITIVE FOR CRAB IN THE 30 DAYS BEFORE THE DISC?</p> <p>• Yes • No • Unknown • N/A</p>
	<p>27c. A. BAUMANNII CULTURES ONLY: RISK FACTORS IN THE 7 DAYS BEFORE THE DISC:</p> <p><input type="checkbox"/> Non-invasive positive pressure ventilation (CPAP or BiPAP) at any time in the 7 calendar days before the DISC</p> <p><input type="checkbox"/> Nebulizer treatment at any time in the 7 calendar days before the DISC</p> <p><input type="checkbox"/> Mechanical ventilation at any time in the 7 calendar days before the DISC</p>
<p>17a. Was this patient positive for the SAME organism in the year prior to the date of the initial culture (Q10a):</p> <p>• Yes • No (GO TO Q17c) • Unknown (GO TO Q17c)</p>	<p>28a. WAS THE PATIENT POSITIVE FOR THE SAME ORGANISM IN THE YEAR BEFORE THE DISC?</p> <p>• Yes • No • Unknown</p>
<p>17b. If yes, specify date of culture and State ID for the first positive culture in the year prior:</p> <p>□□/□□/□□□□ State ID: _____</p>	<p>28b. IF YES, SPECIFY DATE OF CULTURE AND STATE ID FOR THE FIRST POSITIVE CULTURE IN THE YEAR BEFORE:</p> <p>DATE OF CULTURE: ____ - ____ - ____ STATE ID: _____</p>
<p>17c. Enterobacteriaceae ONLY: Was this patient positive for a MuGSI Enterobacteriaceae in the year prior to the date of initial culture (Q10a)?</p> <p>• Yes • No (GO TO Q18) • Unknown (GO TO Q18) • NA (GO TO Q18)</p>	<p>29a. ENTEROBACTERIACEAE ONLY: WAS THE PATIENT POSITIVE FOR A MuGSI ENTEROBACTERIACEAE IN THE YEAR BEFORE THE DISC?</p> <p>• Yes • No • Unknown • N/A</p>
<p>17d. If yes, specify organism, date of culture and State ID for the first positive Enterobacteriaceae culture in the year prior to the date of initial culture (Q10a):</p> <p>Carbapenem-resistant Enterobacteriaceae (CRE):</p> <p><input type="checkbox"/> <i>Escherichia coli</i></p> <p><input type="checkbox"/> <i>Enterobacter cloacae</i></p> <p><input type="checkbox"/> <i>Enterobacter aerogenes</i></p> <p><input type="checkbox"/> <i>Klebsiella pneumoniae</i></p> <p><input type="checkbox"/> <i>Klebsiella oxytoca</i></p> <p>Date of Culture: _____</p>	<p>29b. IF YES, SPECIFY ORGANISM, DATE OF CULTURE, AND STATE ID FOR THE FIRST POSITIVE ENTEROBACTERIACEAE CULTURE IN THE YEAR BEFORE THE DISC:</p> <p>Carbapenem-resistant Enterobacteriaceae (CRE):</p> <p><input type="checkbox"/> <i>Escherichia coli</i></p> <p><input type="checkbox"/> <i>Enterobacter cloacae</i></p> <p><input type="checkbox"/> <i>Klebsiella aerogenes</i></p> <p><input type="checkbox"/> <i>Klebsiella pneumoniae</i></p> <p><input type="checkbox"/> <i>Klebsiella oxytoca</i></p> <p>DATE OF CULTURE: ____ - ____ - ____</p>

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> State ID: _____	STATE ID: _____
18. Susceptibility Results: (please complete the table below based on the information found in the indicated data source). Shaded antibiotics are required to have the MIC entered into the MuGSI-CM system, if available.	30. SUSCEPTIBILITY RESULTS: Please complete the table below based on the information found in the indicated data source. Shaded antibiotics are required to have the MIC entered into the MuGSI-CM system, if available.  Add option to collect ten additional drug susceptibilities: <input type="checkbox"/> Meropenem-vaborbactam <input type="checkbox"/> Minocycline <input type="checkbox"/> Doxycycline <input type="checkbox"/> Plazomicin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Rifampin\ <input type="checkbox"/> Ceftazidime/Avibactam <input type="checkbox"/> Ceftolozane/Tazobactam <input type="checkbox"/> Fosfomycin <input type="checkbox"/> Imipenem-relebactam
22. Was case first identified through audit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	31a. WAS CASE FIRST IDENTIFIED THROUGH AUDIT? <input type="checkbox"/> Yes <input type="checkbox"/> No
23. CRF status: <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Chart unavailable	31b. CRF STATUS: <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Chart unavailable after 3 requests
25. SO initials: _____	31c. SO INITIALS: _____
26. Comments: _____ _____	31d. COMMENTS: _____ _____

**7. 2019 Multi-site Gram-Negative Surveillance Initiative (MuGSI)- Extended-Spectrum Beta-Lactamase-Producing Enterobacteriaceae (ESBL)**

Question on 2018 form	Question on 2019 form
21. Date reported to EIP site: ____ - ____ - ____	DATE REPORTED TO EIP SITE: ____ - ____ - ____
Title: Pilot Assessment: Feasibility of Conducting Surveillance for Extended-Spectrum Beta-Lactamase-Producing Enterobacteriaceae Multi-site Gram-Negative Surveillance Initiative (MuGSI) Healthcare Associated Infection Community Interface (HAIC) Case Report	Title: 2019 Extended-Spectrum Beta-Lactamase (ESBL)-Producing Enterobacteriaceae Multi-site Gram-Negative Surveillance Initiative (MuGSI) Healthcare Associated Infection Community Interface (HAIC) Case Report
4a. LABORATORY ID WHERE CULTURE IDENTIFIED: _____	4a. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED: _____

6. DATE OF BIRTH: ____ - ____ - _____	5. DATE OF BIRTH: ____ - ____ - _____
7a. AGE: _____	6. AGE _____
7b. Is age in day/mo/yr? • Days • Mos. • Years	• Days • Mos. • Years
8a. Sex: • Male • Female • Unknown	7. SEX AT BIRTH: • Male • Female • Unknown • Check if transgender
8b. ETHNIC ORIGIN: • Hispanic or Latino • Not Hispanic or Latino • Unknown	8a. ETHNIC ORIGIN: • Hispanic or Latino • Not Hispanic or Latino • Unknown
8c. RACE: (Check all that apply) • White • Black or African American • American Indian or Alaska Native • Asian • Native Hawaiian or Other Pacific Islander • Unknown	8b. RACE: (Check all that apply) • American Indian or Alaska Native • Asian • Black or African American • Native Hawaiian or Other Pacific Islander • White • Unknown
10a. DATE OF INITIAL CULTURE ____ - ____ - _____	9. DATE OF INCIDENT SPECIMEN COLLECTION (DISC): ____ - ____ - _____
13a. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE:  Extended-Spectrum Cephalosporin-resistant: <input type="checkbox"/> <i>Escherichia coli</i> <input type="checkbox"/> <i>Klebsiella pneumoniae</i> <input type="checkbox"/> <i>Klebsiella oxytoca</i>	10. ORGANISM:  Extended-Spectrum Cephalosporin-resistant: <input type="checkbox"/> <i>Escherichia coli</i> <input type="checkbox"/> <i>Klebsiella pneumoniae</i> <input type="checkbox"/> <i>Klebsiella oxytoca</i>
14. INITIAL CULTURE SITE: <input type="checkbox"/> Blood <input type="checkbox"/> Bone <input type="checkbox"/> Brain <input type="checkbox"/> CSF <input type="checkbox"/> Heart <input type="checkbox"/> Joint/Synovial fluid <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Lymph node <input type="checkbox"/> Ovary <input type="checkbox"/> Pancreas <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Spleen <input type="checkbox"/> Urine <input type="checkbox"/> Vascular tissue	11. Incident specimen collection site (check all that apply) • Blood • Bone • CSF • Internal body site (specify): _____ • Joint/Synovial fluid • Muscle • Pericardial fluid • Peritoneal fluid • Pleural fluid • Urine • Other normally sterile site (specify): _____



<ul style="list-style-type: none"> <li><input type="checkbox"/> Vitreous</li> <li><input type="checkbox"/> Other fluid (sterile)</li> <li><input type="checkbox"/> Deep tissue</li> <li><input type="checkbox"/> Other normally sterile site _____</li> </ul>	
<p>10b. LOCATION OF CULTURE COLLECTION:</p> <ul style="list-style-type: none"> <li>• Hospital Inpatient</li> <li>• Emergency Room</li> <li>• LTCF Facility ID: _____</li> <li>• LTACH Facility ID: _____</li> <li>• Unknown</li> <li>• Other (specify): _____</li> </ul> <p>Outpatient:</p> <ul style="list-style-type: none"> <li>• Clinic/Doctor's Office</li> <li>• Surgery</li> <li>• Other Outpatient</li> <li>• Dialysis Center</li> </ul>	<p>12. LOCATION OF SPECIMEN COLLECTION:</p> <ul style="list-style-type: none"> <li>• <b>Outpatient</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Emergency room</li> <li>• Clinic/Doctor's office</li> <li>• Dialysis center</li> <li>• Surgery</li> <li>• Observational/clinical decision unit</li> <li>• Other outpatient</li> </ul> <ul style="list-style-type: none"> <li>• <b>Inpatient</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• ICU</li> <li>• OR</li> <li>• Radiology</li> <li>• Other inpatient</li> </ul> <ul style="list-style-type: none"> <li>• <b>LTCF</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• <b>LTACH</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• <b>Autopsy</b></li> <li>• <b>Other (specify):</b> _____</li> <li>• <b>Unknown</b></li> </ul>
<p>5. Where was the patient located on the 4th calendar day prior to the date of initial culture?</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTCF Facility ID: _____</li> <li>• LTACH Facility ID: _____</li> <li>• Homeless</li> <li>• Incarcerated</li> <li>• Hospital inpatient</li> </ul> <p>Was patient transferred from this hospital?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Other (specify): _____</li> <li>• Unknown</li> </ul>	<p>13. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC?</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTCF Facility ID: _____</li> <li>• Hospital inpatient Facility ID: _____</li> <li>• LTACH Facility ID: _____</li> <li>• Homeless</li> <li>• Incarcerated</li> <li>• Other (specify): _____</li> <li>• Unknown</li> </ul> <p>Was patient transferred from this hospital?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul>
<p>9. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>If yes: Date of admission</p> <p>_____ - _____ - _____</p> <p>Date of discharge</p> <p>_____ - _____ - _____</p>	<p>14. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER THE DISC?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>IF YES, DATE OF ADMISSION:</p> <p>_____ - _____ - _____</p>
<p>11a. Was the patient in the ICU in the 7 days prior to their initial culture?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul>	<p>15a. WAS THE PATIENT IN AN ICU IN THE 7 DAYS BEFORE THE DISC?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>IF YES, DATE OF ICU ADMISSION:</p> <p>_____ - _____ - _____ OR <input type="checkbox"/> Date unknown</p>

<p>11b. Was the patient in the ICU on the date of or in the 7 days after the initial culture?  • Yes • No • Unknown</p>	<p>15b. WAS THE PATIENT IN AN ICU ON THE DAY OF INCIDENT SPECIMEN COLLECTION OR IN THE 6 DAYS AFTER THE DISC?  • Yes • No • Unknown  IF YES, DATE OF ICU ADMISSION:  _____ - _____ - _____ OR <input type="checkbox"/> Date unknown</p>
<p>12. PATIENT OUTCOME:  • Survived  • Died  • Unknown</p> <p>If survived, transferred to:</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTCF Facility ID: _____</li> <li>• LTACH Facility ID: _____</li> <li>• Unknown</li> <li>• Other (specify): _____</li> </ul> <p>If died, date of death:  _____ - _____ - _____</p>	<p>16. PATIENT OUTCOME:  • Survived  Date of discharge: _____ - _____ - _____ OR  • Date unknown  • Left against medical advice (AMA)</p> <p>If survived, discharged to:</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• Other</li> <li>• LTCF Facility ID: _____ (specify): _____</li> <li>• LTACH Facility ID: _____</li> <li>• Unknown</li> </ul> <p>• Died  Date of death: _____ - _____ - _____</p> <p>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?  • Yes • No • Unknown</p>
<p>16. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S) (check all that apply):  • None  • Unknown  <input type="checkbox"/> Abscess, not skin  <input type="checkbox"/> Appendicitis  <input type="checkbox"/> AV fistula/graft infection  <input type="checkbox"/> Bacteremia  <input type="checkbox"/> Catheter site infection (CVC)  <input type="checkbox"/> Cholangitis  <input type="checkbox"/> Chronic ulcer/wound (not decubitus)  <input type="checkbox"/> Decubitus/pressure ulcer  <input type="checkbox"/> Diverticulitis  <input type="checkbox"/> Empyema  <input type="checkbox"/> Endocarditis  <input type="checkbox"/> Epididymitis  <input type="checkbox"/> Epidural Abscess  <input type="checkbox"/> Meningitis  <input type="checkbox"/> Osteomyelitis  <input type="checkbox"/> Peritonitis  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Prostatitis  <input type="checkbox"/> Pyelonephritis  <input type="checkbox"/> Septic arthritis  <input type="checkbox"/> Surgical incision infection  <input type="checkbox"/> Surgical site infection (internal)  <input type="checkbox"/> Traumatic wound  <input type="checkbox"/> Urinary tract infection  <input type="checkbox"/> Other (specify): _____</p>	<p>17. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply)  • None  • Unknown  <input type="checkbox"/> Abscess, not skin  <input type="checkbox"/> AV fistula/graft infection  <input type="checkbox"/> Bacteremia  <input type="checkbox"/> Bursitis  <input type="checkbox"/> Catheter site infection (CVC)  <input type="checkbox"/> Cellulitis  <input type="checkbox"/> Chronic ulcer/wound (not decubitus)  <input type="checkbox"/> Decubitus/pressure ulcer  <input type="checkbox"/> Empyema  <input type="checkbox"/> Endocarditis  <input type="checkbox"/> Epidural Abscess  <input type="checkbox"/> Meningitis  <input type="checkbox"/> Osteomyelitis  <input type="checkbox"/> Peritonitis  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Pyelonephritis  <input type="checkbox"/> Septic arthritis  <input type="checkbox"/> Septic emboli  <input type="checkbox"/> Septic shock  <input type="checkbox"/> Skin abscess  <input type="checkbox"/> Surgical incision infection  <input type="checkbox"/> Surgical site infection (internal)  <input type="checkbox"/> Traumatic wound  <input type="checkbox"/> Urinary tract infection  <input type="checkbox"/> Other (specify): _____</p>

	Five types of infections were removed from this question.
NEW QUESTION	18. RECURRENT UTI <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
27. UNDERLYING CONDITIONS (check all that apply): • None • Unknown <input type="checkbox"/> AIDS/CD4 count < 200 <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Chronic Pulmonary Disease <input type="checkbox"/> Chronic Renal Insufficiency <input type="checkbox"/> Chronic Skin Breakdown <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Connective Tissue Disease <input type="checkbox"/> Current Smoker <input type="checkbox"/> CVA/Stroke <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Decubitus/Pressure Ulcer <input type="checkbox"/> Dementia/Chronic Cognitive Deficit <input type="checkbox"/> Diabetes <input type="checkbox"/> Hemiplegia/Paraplegia <input type="checkbox"/> HIV <input type="checkbox"/> Hematologic Malignancy <input type="checkbox"/> IVDU <input type="checkbox"/> Liver failure <input type="checkbox"/> Metastatic Solid Tumor <input type="checkbox"/> Myocardial Infarct <input type="checkbox"/> Neurological Problems <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Peripheral Vascular Disease (PVD) <input type="checkbox"/> Premature Birth <input type="checkbox"/> Solid Tumor (non metastatic) <input type="checkbox"/> Spina bifida <input type="checkbox"/> Transplant Recipient <input type="checkbox"/> Urinary Tract Problems/Abnormalities	19. UNDERLYING CONDITIONS: (Check all that apply) • None • Unknown <b>CHRONIC LUNG DISEASE</b> • Cystic fibrosis • Chronic pulmonary disease <b>CHRONIC METABOLIC DISEASE</b> • Diabetes mellitus • with chronic complications <b>CARDIOVASCULAR DISEASE</b> • CVA/Stroke/TIA • Congenital heart disease • Congestive heart failure • Myocardial infarction • Peripheral vascular disease (PVD) <b>GASTROINTESTINAL DISEASE</b> • Diverticular disease • Inflammatory Bowel disease • Peptic ulcer disease • Short gut syndrome <b>IMMUNOCOMPROMISED CONDITION</b> • HIV infection • AIDS/CD4 count <200 • Primary immunodeficiency • Transplant, hematopoietic stem cell • Transplant, solid organ <b>LIVER DISEASE</b> • Chronic liver disease • Ascites • Chronic hepatitis C • Cirrhosis • Hepatic encephalopathy • Variceal bleeding <input type="checkbox"/> Hepatitis C • Treated, in SVR • Current, chronic <b>MALIGNANCY</b> • Malignancy, hematologic • Malignancy, solid organ (non-metastatic) • Malignancy, solid organ (metastatic) <b>NEUROLOGIC CONDITION</b> • Cerebral palsy • Chronic cognitive deficit • Dementia • Epilepsy/seizure/ seizure disorder • Multiple sclerosis • Neuropathy • Parkinson's Disease • Other specify: _____ <b>PLEGIAS/PARALYSIS</b> • Hemiplegia • Paraplegia • Quadriplegia <b>RENAL DISEASE</b> • Chronic kidney disease Lowest serum creatinine: _____mg/Dl <b>SKIN CONDITION</b> • Burn • Decubitus/pressure ulcer • Surgical wound • Other chronic ulcer or chronic wound <b>OTHER</b> • Connective tissue disease • Obesity or morbid obesity • Pregnant <b>MuGSI CONDITIONS</b> • Urinary tract problems/abnormalities • Premature birth • Spina bifida
27. UNDERLYING CONDITIONS (check all that apply):	20. SUBSTANCE USE, CURRENT

<ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> <li><input type="checkbox"/> AIDS/CD4 count &lt; 200</li> <li><input type="checkbox"/> Alcohol abuse</li> <li><input type="checkbox"/> Chronic Liver Disease</li> <li><input type="checkbox"/> Chronic Pulmonary Disease</li> <li><input type="checkbox"/> Chronic Renal Insufficiency</li> <li><input type="checkbox"/> Chronic Skin Breakdown</li> <li><input type="checkbox"/> Congestive Heart Failure</li> <li><input type="checkbox"/> Connective Tissue Disease</li> <li><input type="checkbox"/> Current Smoker</li> <li><input type="checkbox"/> CVA/Stroke</li> <li><input type="checkbox"/> Cystic Fibrosis</li> <li><input type="checkbox"/> Decubitus/Pressure Ulcer</li> <li><input type="checkbox"/> Dementia/Chronic Cognitive Deficit</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Hemiplegia/Paraplegia</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> Hematologic Malignancy</li> <li><input type="checkbox"/> IVDU</li> <li><input type="checkbox"/> Liver failure</li> <li><input type="checkbox"/> Metastatic Solid Tumor</li> <li><input type="checkbox"/> Myocardial Infarct</li> <li><input type="checkbox"/> Neurological Problems</li> <li><input type="checkbox"/> Peptic Ulcer Disease</li> <li><input type="checkbox"/> Peripheral Vascular Disease (PVD)</li> <li><input type="checkbox"/> Premature Birth</li> <li><input type="checkbox"/> Solid Tumor (non metastatic)</li> <li><input type="checkbox"/> Spina bifida</li> <li><input type="checkbox"/> Transplant Recipient</li> <li>Urinary Tract Problems/Abnormalities</li> </ul>	<p>SMOKING (Check all that apply):</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> <li>• Tobacco</li> <li>• E-nicotine delivery system</li> <li>• Marijuana</li> </ul> <p>ALCOHOL ABUSE:</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Unknown</li> </ul> <p>OTHER SUBSTANCES: (Check all that apply)</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> </ul> <p style="text-align: right;"><u>DOCUMENTED USE</u></p> <p style="text-align: right;"><u>DISORDER (DUD)/ABUSE:</u></p> <p><u>MODE OF DELIVERY:</u> (Check all that apply)</p> <p><input type="checkbox"/> Marijuana/cannabinoid (other than smoking) <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin) <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone) <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Cocaine or methamphetamine <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Unknown substance <input type="checkbox"/> DUD or abuse <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown</p> <p>Some of the data in this section was formerly collected in the underlying conditions section (IVDU [changed to injection drug user], Current smoker [changed to smoking], Alcohol Abuse (see highlighted conditions in the prior column). The collection of more information for other drug use is new.</p> <p>There are six new check boxes that allow other drug use to be captured in more detail. These questions focus on type of drug and mode of delivery.</p>
<p>21. RISK FACTORS OF INTEREST (check all that apply):</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> </ul> <p>• Hospitalized within year before date of initial culture: If yes, enter mo/yr <input type="checkbox"/><input type="checkbox"/>/<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></p> <p>OR • Unknown</p> <p>If known, prior hospital ID: _____</p>	<p>21. RISK FACTORS: (Check all that apply)</p> <ul style="list-style-type: none"> <li>• None</li> <li>• Unknown</li> </ul> <p>WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?</p> <p>• Yes • No (please note, this field is auto calculated in the data management system (DMS), therefore, the user does not ever complete this filed and there is not burden associated with its collection. It is on</p>

<ul style="list-style-type: none"> <li>• Surgery within year before date of initial culture</li>   <li>• Current chronic dialysis:  <input type="checkbox"/> Hemodialysis   <input type="checkbox"/> Peritoneal   <input type="checkbox"/> Unknown  Hemodialysis Access:  <input type="checkbox"/> AV fistula/graft   <input type="checkbox"/> CVC   <input type="checkbox"/> Unknown</li>   <li>• Residence in LTCF within year before date of initial culture If known,  facility ID: _____</li>   <li>• Admitted to a LTACH within year before initial culture date  If known, facility ID: _____</li>   <li>• Central venous catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture</li>   <li>• Urinary catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture  If checked, indicate all that apply: <ul style="list-style-type: none"> <li>• Indwelling Urethral Catheter</li> <li>• Suprapubic Catheter</li> <li>• Condom Catheter</li> <li>• Other: _____</li> </ul> </li>   <li>• Any OTHER indwelling device in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture  If checked, indicate all that apply: <ul style="list-style-type: none"> <li>• ET/NT Tube</li> <li>• Gastrostomy Tube</li> <li>• NG Tube</li> <li>• Tracheostomy</li> <li>• Nephrostomy Tube</li> <li>• Other: _____</li> </ul> </li>   <li>• Patient traveled internationally in the two months prior to the date of initial culture.  Country: _____,  _____, _____</li>   <li>• Patient was hospitalized while visiting country(ies) listed above</li> </ul>	<p>the paper form because our users want to continue to view this in the DMS)</p> <p>Previous hospitalization in the year before DISC  • Yes • No • Unknown  If yes, date of discharge closed to DISC:  ____ - ____ - ____ - ____  Facility ID: _____  OR,   Date Unknown •</p> <p>Overnight stay in LTCF in the year before DISC  • Yes • No • Unknown  Facility ID: _____</p> <p>Overnight stay in LTACH in the year before DISC  • Yes • No • Unknown  Facility ID: _____</p> <p>Surgery in the year before DISC  • Yes • No • Unknown</p> <p>CURRENT CHRONIC DIALYSIS:  IF YES, TYPE:  <input type="checkbox"/> Hemodialysis   <input type="checkbox"/> Peritoneal   <input type="checkbox"/> Unknown  IF HEMODIALYSIS, TYPE OF VASCULAR ACCESS:  <input type="checkbox"/> AV fistula/graft   <input type="checkbox"/> Hemodialysis central line   <input type="checkbox"/> Unknown</p> <p>CENTRAL LINE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:  • Yes • No • Unknown  Check here if central line in place for &gt; 2 calendar days:   <input type="checkbox"/></p> <p>URINARY CATHETER IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:  • Yes • No • Unknown  IF YES, CHECK ALL THAT APPLY:  <input type="checkbox"/> Indwelling Urethral Catheter  <input type="checkbox"/> Suprapubic Catheter  <input type="checkbox"/> Condom Catheter  <input type="checkbox"/> Other (specify): _____</p> <p>ANY OTHER INDWELLING DEVICE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:  • Yes • No • Unknown  IF YES, CHECK ALL THAT APPLY:  <input type="checkbox"/> ET/NT Tube   <input type="checkbox"/> Gastrostomy Tube   <input type="checkbox"/> NG Tube  <input type="checkbox"/> Tracheostomy   <input type="checkbox"/> Nephrostomy Tube   <input type="checkbox"/> Other (specify): _____</p> <p>PATIENT TRAVELED INTERNATIONALLY IN THE YEAR BEFORE DISC:  • Yes • No • Unknown  COUNTRY: _____, _____, _____</p> <p>PATIENT HOSPITALIZED WHILE VISITING COUNTRY(IES)</p>
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	<p>ABOVE:  • Yes • No • Unknown</p>
NEW QUESTION	<p>22a. WEIGHT:  _____ lbs. _____ oz. OR _____ kg <input type="checkbox"/> Unknown</p>
NEW QUESTION	<p>22b. HEIGHT:  _____ ft. _____ in. OR _____ cm <input type="checkbox"/> Unknown</p>
NEW QUESTION	<p>23c. BMI:  _____ <input type="checkbox"/> Unknown</p>
NEW QUESTION	<p>URINE CULTURES ONLY:  23a. RECORD THE COLONY COUNT: _____</p>
<p>URINE Cultures ONLY:  14b. Signs and Symptoms associated with urine culture.  Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before through the 2 calendar days after the date of initial culture.  Then go to question 14d.</p> <p><input type="checkbox"/> None  <input type="checkbox"/> Costovertebral angle pain or tenderness  <input type="checkbox"/> Dysuria  <input type="checkbox"/> Fever [temperature <math>\geq</math> 100.4 °F (38 °C)]  <input type="checkbox"/> Unknown  <input type="checkbox"/> Frequency  <input type="checkbox"/> Suprapubic tenderness  <input type="checkbox"/> Urgency</p>	<p>URINE CULTURES ONLY:  23b. SIGNS AND SYMPTOMS ASSOCIATED WITH URINE CULTURE  Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before through the 2 calendar days after the DISC.</p> <p><input type="checkbox"/> None  <input type="checkbox"/> Costovertebral angle pain or tenderness  <input type="checkbox"/> Dysuria  <input type="checkbox"/> Fever [temperature <math>\geq</math> 100.4 °F (38 °C)]  <input type="checkbox"/> Unknown  <input type="checkbox"/> Frequency  <input type="checkbox"/> Suprapubic tenderness  <input type="checkbox"/> Urgency</p> <p><b>Symptoms for patients <math>\leq</math>1 year of age only:</b></p> <p><input type="checkbox"/> Apnea  <input type="checkbox"/> Bradycardia  <input type="checkbox"/> Lethargy  <input type="checkbox"/> Vomiting</p>
<p>15b. Did clinical laboratory identify isolate as ESBL producer?  • Yes • No • Unknown</p>	<p>This question was removed.</p>
NEW QUESTION	<p>24a. WAS THE INCIDENT SPECIMEN POLYMICROBIAL?  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown</p>
<p>15c. What confirmatory testing method(s) was used? (Check all that apply):</p> <p><input type="checkbox"/> Broth Microdilution (ATI)  <input type="checkbox"/> Disk Diffusion  <input type="checkbox"/> Other (Specify): _____  <input type="checkbox"/> None  <input type="checkbox"/> Unknown</p>	<p>24b. WHAT SCREENING/ CONFIRMATORY METHOD WAS USED FOR ESBL DETECTION? (Check all that apply):</p> <p><input type="checkbox"/> Broth Microdilution (ATI detection)  <input type="checkbox"/> ESBL well  <input type="checkbox"/> Expert rule (ATI flag)  <input type="checkbox"/> Broth Microdilution (Manual)  <input type="checkbox"/> Disk Diffusion  <input type="checkbox"/> E-test  <input type="checkbox"/> Molecular test (specify): _____  <input type="checkbox"/> Other non-molecular test (specify): _____  <input type="checkbox"/> None  <input type="checkbox"/> Unknown</p>
<p>15d. IF TESTED, what was the test result?</p> <p><input type="checkbox"/> Positive</p>	<p>24c. IF SCREENING/ CONFIRMATORY METHOD WAS USED, WHAT WAS THE RESULT?</p>

<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown	<table border="1"> <tr> <td><input type="checkbox"/> Positive</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Indeterminate</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Positive</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Indeterminate</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Positive</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Indeterminate</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Positive</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Indeterminate</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Positive</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Indeterminate</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Positive</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Indeterminate</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Positive</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Indeterminate</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Positive</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Indeterminate</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown
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<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Unknown																														
<p>19a. Is antimicrobial use (IV or oral) in the 30 days before the date of initial culture collection documented in the H&amp;P or medical administration record?</p> <input type="checkbox"/> Yes (complete 19b) <input type="checkbox"/> No <input type="checkbox"/> Unknown	<p>25a. IS ANTIMICROBIAL USE (IV OR ORAL) IN THE 30 DAYS BEFORE THE DISC DOCUMENTED?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																																
<p>19b . If yes, indicate all antibiotics given in the 30 days before the date of initial culture collection:</p> <ul style="list-style-type: none"> <li>• Amikacin</li> <li>• Amoxicillin</li> <li>• Amoxicillin/Clavulanic Acid</li> <li>• Ampicillin/Sulbactam</li> <li>• Azithromycin</li> <li>• Aztreonam</li> <li>• Cefaclor</li> <li>• Cefazolin</li> <li>• Cefdinir</li> <li>• Cefepime</li> <li>• Cefotaxime</li> <li>• Cefpodoxime</li> <li>• Cefprozil</li> <li>• Ceftazidime</li> <li>• Ceftazidime/Avibactam</li> <li>• Ceftizoxime</li> <li>• Ceftolozane/Tazobactam</li> <li>• Ceftriaxone</li> <li>• Cefuroxime</li> <li>• Cephalexin</li> <li>• Ciprofloxacin</li> <li>• Clarithromycin</li> <li>• Clindamycin</li> <li>• Colistin</li> <li>• Daptomycin</li> <li>• Doripenem</li> <li>• Doxycycline</li> <li>• Ertapenem</li> <li>• Fosfomycin</li> <li>• Gentamicin</li> <li>• Imipenem</li> <li>• Levofloxacin</li> <li>• Linezolid</li> <li>• Meropenem</li> <li>• Metronidazole</li> <li>• Moxifloxacin</li> </ul>	<p>25b. IF YES, CHECK ALL ANTIMICROBIALS USED IN THE 30 DAYS BEFORE THE DISC: (Check all that apply)</p> <input type="checkbox"/> Unknown <input type="checkbox"/> Amikacin <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Amoxicillin/clavulanic acid <input type="checkbox"/> Ampicillin <input type="checkbox"/> Ampicillin/sulbactam <input type="checkbox"/> Azithromycin <input type="checkbox"/> Aztreonam <input type="checkbox"/> Cefazolin <input type="checkbox"/> Cefdinir <input type="checkbox"/> Cefepime <input type="checkbox"/> Cefixime <input type="checkbox"/> Cefotaxime <input type="checkbox"/> Cefoxitin <input type="checkbox"/> Cefpodoxime <input type="checkbox"/> Ceftaroline <input type="checkbox"/> Ceftazidime <input type="checkbox"/> Ceftazidime/avibactam <input type="checkbox"/> Ceftizoxime <input type="checkbox"/> Ceftolozane/tazobactam <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Cefuroxime <input type="checkbox"/> Cephalexin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Clarithromycin <input type="checkbox"/> Clindamycin <input type="checkbox"/> Dalbavancin <input type="checkbox"/> Daptomycin <input type="checkbox"/> Delafloxacin <input type="checkbox"/> Doripenem <input type="checkbox"/> Doxycycline <input type="checkbox"/> Ertapenem <input type="checkbox"/> Fidaxomicin <input type="checkbox"/> Fosfomycin <input type="checkbox"/> Gentamicin <input type="checkbox"/> Imipenem/cilastatin																																

<ul style="list-style-type: none"> <li>• Nitrofurantoin</li> <li>• Ofloxacin</li> <li>• Penicillin</li> <li>• Piperacillin-Tazobactam</li> <li>• Polymyxin B</li> <li>• Rifampin</li> <li>• Tetracycline</li> <li>• Ticarcillin/Clavulanic Acid</li> <li>• Tigecycline</li> <li>• Tobramycin</li> <li>• Trimethoprim-Sulfamethoxazole</li> <li>• Vancomycin, IV</li> <li>• Vancomycin, oral</li> <li>• Unknown</li> <li>• Other (specify): _____</li> <li>• Other (specify): _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Levofloxacin</li> <li><input type="checkbox"/> Linezolid</li> <li><input type="checkbox"/> Meropenem</li> <li><input type="checkbox"/> Meropenem/vaborbactam</li> <li><input type="checkbox"/> Metronidazole</li> <li><input type="checkbox"/> Moxifloxacin</li> <li><input type="checkbox"/> Nitrofurantoin</li> <li><input type="checkbox"/> Oritavancin</li> <li><input type="checkbox"/> Penicillin</li> <li><input type="checkbox"/> Piperacillin/tazobactam</li> <li><input type="checkbox"/> Polymyxin B</li> <li><input type="checkbox"/> Polymyxin E (colistin)</li> <li><input type="checkbox"/> Rifaximin</li> <li><input type="checkbox"/> Tedizolid</li> <li><input type="checkbox"/> Telavancin</li> <li><input type="checkbox"/> Tigecycline</li> <li><input type="checkbox"/> Tobramycin</li> <li><input type="checkbox"/> Trimethoprim</li> <li><input type="checkbox"/> Trimethoprim/sulfamethoxazole</li> <li><input type="checkbox"/> Vancomycin <ul style="list-style-type: none"> <li><input type="checkbox"/> IV</li> <li><input type="checkbox"/> PO</li> </ul> </li> <li><input type="checkbox"/> Other (specify): _____</li> <li><input type="checkbox"/> Other (specify): _____</li> <li><input type="checkbox"/> Other (specify): _____</li> </ul>
<p>15a. Susceptibility Results: Please complete the table below based on the primary antibiotic testing report. Shaded antibiotics are required to have the MIC entered into the ESBL Case Management system, if available.</p>	<p>26. SUSCEPTIBILITY RESULTS: Please complete the table below based on the information found in the indicated data source. Shaded antibiotics are required to have the MIC entered into the MuGSI-CM system, if available.</p> <p>Remove:</p> <p><input type="checkbox"/> Other (Specify): _____</p> <p>Add:</p> <p>Medical record column Meropenem-vaborbactam Minocycline Doxycycline Plazomicin Tetracycline Rifampin Imipenem-relebactam</p> <p>7 new antibiotic were added to this form for consistency with the CRE/CRAB CRF.</p>
	<p>27a. WAS CASE FIRST IDENTIFIED THROUGH AUDIT?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>20. CRF status:</p> <p><input type="checkbox"/> Complete</p> <p><input type="checkbox"/> Pending</p> <p><input type="checkbox"/> Chart unavailable</p>	<p>27b. CRF STATUS:</p> <p><input type="checkbox"/> Complete</p> <p><input type="checkbox"/> Pending</p> <p><input type="checkbox"/> Chart unavailable after 3 requests</p>
<p>22. SO initials: _____</p>	<p>27c. SO INITIALS: _____</p>



23. Comments: _____ _____	27d. COMMENTS: _____ _____
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**8. Multi-site Gram-Negative Surveillance Initiative (MuGSI)- Carbapenem-resistant Pseudomonas aeruginosa (CR-PA) - Form Discontinued**

**9. 2019 Invasive MRSA Infection Case Report Form**

<b>2018 Paper CRF Question</b>	<b>Changes to the 2019 Paper CRF Question</b>
1. State (Residence of patient) ____	1. State ____ (Updated question wording)
2. County (Residence of patient) _____	2. County _____ (Updated question wording)
3. State I.D.: _____	3. State I.D.: _____ (No change)
Patient ID: _____	4. Patient ID: _____ (Updated question number; this was previously at the top of the CRF and not numbered).
4a. Hospital/Lab I.D. where culture identified _____	5. Laboratory ID where incident specimen identified _____ (Updated question number and wording)
4b. Hospital I.D. where patient treated _____	6. Facility ID where patient treated _____ (Updated question number and wording)
5. Sex: • Male • Female	7. Sex at birth: • Male • Female • Unknown • Check if transgender (Updated question number and wording, added two new options—one for unknown sex at birth and a checkbox if the patient is transgender)
6. Date of Birth __/__/____	8. Date of birth __/__/____ (Updated question number)
7. Age ____	9. Age ____ • Days • Mos. • Years (Updated question number and combined with question below [7b on old form])
7b. Is age in day/mo/yr • Days • Mos. • Years	This text (Is age in day/mo/yr) has been removed and the option day/mo/year is now included as a part of question 9
12b. Race • White • Black or African American • American Indian or Alaska Native • Asian • Native Hawaiian or Other Pacific Islander • Unknown	10. Race (Check all that apply) • American Indian or Alaska Native • Asian • Black or African American • Native Hawaiian or Other Pacific Islander • White • Unknown (Updated question number and order of responses; all response options remain the same)
12a. Ethnic Origin • Hispanic or Latino • Not Hispanic or Latino	11. Ethnic origin • Hispanic or Latino • Not Hispanic or Latino

<ul style="list-style-type: none"> <li>• Unknown</li> </ul>	<ul style="list-style-type: none"> <li>• Unknown (Updated question number)</li> </ul>
<p>12c. Weight</p> <ul style="list-style-type: none"> <li>• Unknown</li> </ul> <p>_____ lbs _____ oz OR _____ kg</p>	<p>12. Weight</p> <p>_____ lbs _____ oz OR _____ kg • Unknown</p> <p>(Updated question number and order of responses; all response options remain the same)</p>
<p>12d. Height</p> <ul style="list-style-type: none"> <li>• Unknown</li> </ul> <p>_____ ft. _____ in. OR _____ cm</p>	<p>13. Height</p> <p>_____ ft. _____ in. OR _____ cm • Unknown</p> <p>(Updated question number and order of responses; all response options remain the same)</p>
<p>12e. BMI (do not calculate, only if available in the MR)</p> <ul style="list-style-type: none"> <li>• Unknown</li> </ul> <p>_____</p>	<p>14. BMI (record only if ht. and/or wt. is not available)</p> <ul style="list-style-type: none"> <li>• Unknown</li> </ul> <p>(Updated question number, wording, and order of responses; all response options remain the same)</p>
<p>9. Date of Initial Culture</p> <p>___/___/_____</p>	<p>15. Date of Incident Specimen Collection (DISC)</p> <p>___/___/_____</p> <p>(Updated question number and wording)</p>
<p>10a. Was the patient hospitalized at the time of, or within 30 calendar days after, initial culture?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>If yes, date of admission ___/___/_____</p>	<p>16. Was the patient hospitalized at the time of, or in the 29 calendar days after, the DISC?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>If yes, date of admission ___/___/_____</p> <p>(Updated question number and wording)</p>
<p>11. Was culture collected &gt;3 calendar days after hospital admission?</p> <ul style="list-style-type: none"> <li>• Yes (HO-MRSA case) • No (Complete CRF, CA-MRSA or HACO-MRSA case)</li> </ul> <p>If yes, was case selected for full CRF based on sampling frame 1:10?</p> <ul style="list-style-type: none"> <li>• Yes (Complete CRF) • No (STOP data abstraction)</li> </ul>	<p>17. Was incident specimen collected 3 or more calendar days after hospital admission?</p> <ul style="list-style-type: none"> <li>• Yes (HO-MRSA case) • No (CA-MRSA or HACO-MRSA case)</li> </ul> <p>(Updated question number and wording, dropped second part of question, "If yes, was case selected for full CRF based on sampling frame 1:10?")</p>
<p>8. Sterile site(s) from which MRSA was initially isolated (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• CSF</li> <li>• Pleural fluid</li> <li>• Peritoneal fluid</li> <li>• Pericardial fluid</li> <li>• Joint/Synovial fluid</li> <li>• Bone</li> <li>• Muscle</li> <li>• Internal body site (specify _____)</li> <li>• Other sterile site (specify _____)</li> </ul>	<p>18. Incident specimen collection site (check all that apply)</p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• Bone</li> <li>• CSF</li> <li>• Internal body site (specify _____)</li> <li>• Joint/Synovial fluid</li> <li>• Muscle</li> <li>• Pericardial fluid</li> <li>• Peritoneal fluid</li> <li>• Pleural fluid</li> <li>• Other normally sterile site (specify _____)</li> </ul> <p>(Updated question number, wording, order of responses, and wording of one response options [other sterile site is now other normally sterile site], though all response options remain the same)</p>
<p>16. Location of culture collection (check one)</p> <p><b>Hospital inpatient</b></p> <ul style="list-style-type: none"> <li>• ICU</li> <li>• Surgery/OR</li> <li>• Radiology</li> <li>• Other unit</li> </ul> <p><b>Outpatient</b></p> <ul style="list-style-type: none"> <li>• Clinic/Doctor's office</li> <li>• Surgery</li> <li>• Dialysis/Renal Clinic</li> </ul>	<p>19. Location of specimen collection</p> <ul style="list-style-type: none"> <li>• <b>Outpatient</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Emergency room</li> <li>• Clinic/Doctor's office</li> <li>• Dialysis center</li> <li>• Surgery</li> <li>• Observational/clinical decision unit</li> <li>• Other outpatient</li> </ul> <ul style="list-style-type: none"> <li>• <b>Inpatient</b></li> </ul>

<ul style="list-style-type: none"> <li>• Other outpatient</li> <li>• Emergency Room</li> <li>• Observational Unit/clinical decision unit</li> <li>• LTCF</li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• LTACH</li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Autopsy</li> <li>• Unknown</li> <li>• Other</li> </ul>	<p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• ICU</li> <li>• OR</li> <li>• Radiology</li> <li>• Other inpatient</li> <li>• <b>LTCF</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• <b>LTACH</b></li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• <b>Autopsy</b></li> <li>• <b>Other (specify):</b> _____</li> <li>• <b>Unknown</b></li> </ul> <p>(Updated question number. Added checkboxes for headings “Outpatient” and “Inpatient”. Added a facility ID for “Outpatient” and “Inpatient”. Updated the order of responses. Changed the wording of the response “Dialysis/Renal clinic to “Dialysis” and “Other unit” to “Other inpatient”)</p>
<p>17. Were cultures of the SAME or OTHER sterile sites positive within 30 days after initial culture date?</p> <p>• Yes • No • Unknown</p> <p>If yes, indicate site and date of last positive culture.</p> <ul style="list-style-type: none"> <li>• Blood, Date: _____</li> <li>• CSF, Date: _____</li> <li>• Pleural fluid, Date: _____</li> <li>• Peritoneal fluid, Date: _____</li> <li>• Pericardial fluid, Date: _____</li> <li>• Joint/Synovial fluid, Date: _____</li> <li>• Bone, Date: _____</li> <li>• Muscle, Date: _____</li> <li>• Internal body site (specify _____) Date: _____</li> <li>• Other sterile site (specify _____) Date: _____</li> </ul>	<p>20. Were cultures of the SAME or OTHER sterile site(s) positive within 29 days after DISC?</p> <p>• Yes • No • Unknown</p> <p>If yes, indicate site and date of last positive culture.</p> <ul style="list-style-type: none"> <li>• Blood, Date: _____</li> <li>• Bone, Date: _____</li> <li>• CSF, Date: _____</li> <li>• Internal body site (specify _____), Date: _____</li> <li>• Joint/Synovial fluid, Date: _____</li> <li>• Muscle, Date: _____</li> <li>• Pericardial fluid, Date: _____</li> <li>• Peritoneal fluid, Date: _____</li> <li>• Pleural fluid, Date: _____</li> <li>• Other normally sterile site (specify _____) Date: _____</li> </ul> <p>(Updated question number and wording, order of responses, and wording of one of the response options [other sterile site is now other normally sterile site])</p>
<p>17b. Date of first SA blood culture after which SA not isolated for 14 days</p> <p>___/___/_____</p>	<p>21. Date of first SA blood culture after which SA not isolated for 14 days</p> <p>___/___/_____</p> <p>(Updated question number)</p>
<p>22. Susceptibility Results</p> <p>Cefoxitin • S • R • U</p> <p>Oxacillin • S • R • U</p> <p>Vancomycin • S • I • R • U</p> <p>Clindamycin • S • I • R • U</p> <p>Trimethoprim-sulfamethoxazole • S • I • R • U</p>	<p>22. Susceptibility Results</p> <p>Cefazolin • S • I • R • U</p> <p>Nafcillin • S • I • R • U</p> <p>Cefoxitin • S • R • U</p> <p>Oxacillin • S • R • U</p> <p>Vancomycin • S • I • R • U</p> <p>Clindamycin • S • I • R • U</p> <p>Trimethoprim-sulfamethoxazole • S • I • R • U</p> <p>(Added two antimicrobial agents-Cefazolin and Nafcillin)</p>
<p>15. Where was the patient located on the 4th calendar day prior to the date of initial culture?</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• Long term care facility</li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Long term acute care hospital</li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• Incarcerated</li> </ul>	<p>23. Where was the patient located on the 3<sup>rd</sup> calendar day before the DISC?</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTACH</li> <li>• LTCF</li> <li>• Hospital inpatient</li> <li>• Homeless</li> <li>• Incarcerated</li> <li>• Other: _____</li> <li>• Unknown</li> </ul> <p>Facility ID: _____</p> <p>Facility ID: _____</p> <p>Was patient transferred from this hospital?</p>

<ul style="list-style-type: none"> <li>• Hospital inpatient</li> </ul> Facility ID: <ul style="list-style-type: none"> <li>• Other _____</li> <li>• Unknown</li> </ul>	<ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> (Updated question number and wording, Updated order of the responses, added the response: Was patient transferred from this hospital? • Yes • No • Unknown for patients that were indicated to be a hospital inpatient.)
14. If case is ≤12 months of age, type of birth hospitalization <ul style="list-style-type: none"> <li>• NICU/SCN</li> <li>• Well baby nursery</li> <li>• Unknown</li> </ul>	24. If case is ≤12 months of age, type of birth hospitalization <ul style="list-style-type: none"> <li>• NICU/SCN</li> <li>• Well baby nursery</li> <li>• Unknown</li> </ul> (Updated question number)
20. Underlying conditions: <ul style="list-style-type: none"> <li>• Premature birth</li> </ul> Birth weight _____ lb _____ oz OR _____ g Estimated gestational age _____ weeks	25. If patient <2 years of age were they born premature (<37 weeks gestation)? <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> ---If YES, birth weight: _____ lb _____ oz OR _____ g OR • Unknown birth weight ---If YES, estimated gestational age: _____ weeks OR • Unknown gestational age  (Updated question number and wording. Added “Unknown” checkboxes for birth weight and gestational age)
10b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul>	26. Was the patient in an ICU in the 2 days before the DISC? <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> ---if YES, date of ICU admission: ___-___-____ OR • Date Unknown (Updated question number and wording, broke into two questions, added date of admission)
10b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul>	27. Was the patient in an ICU on the DISC or in the 2 days after the DISC? <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> ---if YES, date of ICU admission: ___-___-____ OR • Date Unknown (Updated question number and wording, broke into two questions, added date of admission)
19. Types of MRSA infection associated with culture(s)  <ul style="list-style-type: none"> <li>• Abscess (not skin)</li> <li>• AV Fistula/Graft infection</li> <li>• Bacteremia</li> <li>• Bursitis</li> <li>• Catheter Site Infection</li> <li>• Cellulitis</li> <li>• Chronic Ulcer/Wound</li> <li>• Decubitus/Pressure Ulcer</li> <li>• Empyema</li> <li>• Endocarditis</li> <li>• Epidural abscess</li> <li>• Meningitis</li> <li>• Peritonitis</li> <li>• Pneumonia</li> <li>• Osteomyelitis</li> <li>• Septic Arthritis</li> <li>• Septic Emboli</li> <li>• Septic Shock</li> <li>• Skin Abscess</li> <li>• Surgical Incision</li> <li>• Surgical Site (internal)</li> <li>• Urinary Tract</li> <li>• Other (Specify): _____</li> </ul>	28. Types of MRSA infection associated with culture(s)  <ul style="list-style-type: none"> <li>• Abscess (not skin)</li> <li>• AV Fistula/Graft infection</li> <li>• Bacteremia</li> <li>• Bursitis</li> <li>• Catheter Site Infection</li> <li>• Cellulitis</li> <li>• Chronic Ulcer/Wound</li> <li>• Decubitus/Pressure Ulcer</li> <li>• Empyema</li> <li>• Endocarditis</li> <li>• Epidural abscess</li> <li>• Meningitis</li> <li>• Peritonitis</li> <li>• Pneumonia</li> <li>• Osteomyelitis</li> <li>• Septic Arthritis</li> <li>• Septic Emboli</li> <li>• Septic Shock</li> <li>• Skin Abscess</li> <li>• Surgical Incision</li> <li>• Surgical Site (internal)</li> <li>• Urinary Tract</li> <li>• Other (Specify): _____</li> </ul> (Updated question number, no change to the responses)
20. Underlying Conditions <ul style="list-style-type: none"> <li>• Abscess/Boil (Recurrent)</li> <li>• AIDS</li> <li>• Chronic Cognitive Deficit</li> <li>• Chronic Liver Disease</li> <li>• Chronic Pulmonary Disease</li> <li>• IVDU</li> <li>• Metastatic solid tumor</li> <li>• Myocardial Infarct</li> <li>• Obesity</li> <li>• Other drug use</li> </ul>	29. Underlying Conditions <b>CHRONIC LUNG DISEASE</b> <ul style="list-style-type: none"> <li>• Cystic fibrosis</li> <li>• Chronic pulmonary disease</li> </ul> <b>CHRONIC METABOLIC</b> <b>NEUROLOGIC CONDITION</b> <ul style="list-style-type: none"> <li>• Cerebral palsy</li> <li>• Chronic cognitive deficit</li> </ul>

<ul style="list-style-type: none"> <li>• Chronic Kidney Disease</li> <li>• Chronic Skin Breakdown</li> <li>• Congestive Heart Failure</li> <li>• Connective Tissue Disease</li> <li>• Current Smoker</li> <li>• CVA/Stroke</li> <li>• Cystic fibrosis</li> <li>• Decubitus/Pressure Ulcer</li> <li>• Dementia</li> <li>• Diabetes</li> <li>• Hematologic Malignancy</li> <li>• Hemiplegia/Paraplegia</li> <li>• HIV</li> <li>• Influenza (within 10 days of initial culture)</li> </ul>	<ul style="list-style-type: none"> <li>• Peptic ulcer disease</li> <li>• Peripheral vascular disease</li> <li>• Premature birth</li> </ul> <p>Birth weight _____ lb  _____oz OR _____ g</p> <p>Estimated gestational age  _____ weeks</p> <ul style="list-style-type: none"> <li>• Solid tumor (non metastatic)</li> <li>• Other (Specify for cases ≤12 months of age):</li> </ul>	<p><b>DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diabetes mellitus <ul style="list-style-type: none"> <li>• with chronic complications</li> </ul> </li> </ul> <p><b>CARDIOVASCULAR DISEASE</b></p> <ul style="list-style-type: none"> <li>• CVA/Stroke/TIA</li> <li>• Congenital heart disease</li> <li>• Congestive heart failure</li> <li>• Myocardial infarction</li> <li>• Peripheral vascular disease (PVD)</li> </ul> <p><b>GASTROINTESTINAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diverticular disease</li> <li>• Inflammatory Bowel disease</li> <li>• Peptic ulcer disease</li> <li>• Short gut syndrome</li> </ul> <p><b>IMMUNOCOMPROMISED CONDITION</b></p> <ul style="list-style-type: none"> <li>• HIV infection <ul style="list-style-type: none"> <li>• AIDS/CD4 count &lt;200</li> </ul> </li> <li>• Primary immunodeficiency</li> <li>• Transplant, hematopoietic stem cell</li> <li>• Transplant, solid organ</li> </ul> <p><b>LIVER DISEASE</b></p> <ul style="list-style-type: none"> <li>• Chronic liver disease <ul style="list-style-type: none"> <li>• Ascites</li> <li>• Cirrhosis</li> <li>• Hepatic encephalopathy</li> <li>• Variceal bleeding</li> </ul> </li> <li>• Hepatitis C <ul style="list-style-type: none"> <li>• Treated, in SVC</li> <li>• Current, chronic</li> </ul> </li> </ul> <p><b>MALIGNANCY</b></p> <ul style="list-style-type: none"> <li>• Malignancy, hematologic</li> <li>• Malignancy, solid organ (non-metastatic)</li> <li>• Malignancy, solid organ (metastatic)</li> </ul>	<ul style="list-style-type: none"> <li>• Dementia</li> <li>• Epilepsy/seizure/ seizure disorder</li> <li>• Multiple sclerosis</li> <li>• Neuropathy</li> <li>• Parkinson’s Disease</li> <li>• Other specify: _____</li> </ul> <p><b>PLEGIAS/PARALYSIS</b></p> <ul style="list-style-type: none"> <li>• Hemiplegia</li> <li>• Paraplegia</li> <li>• Quadriplegia</li> </ul> <p><b>RENAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Chronic kidney disease <ul style="list-style-type: none"> <li>Lowest serum creatinine: _____mg/Dl</li> </ul> </li> </ul> <p><b>SKIN CONDITION</b></p> <ul style="list-style-type: none"> <li>• Burn</li> <li>• Decubitus/pressure ulcer</li> <li>• Surgical wound</li> <li>• Other chronic ulcer or chronic wound</li> </ul> <p><b>OTHER</b></p> <ul style="list-style-type: none"> <li>• Connective tissue disease</li> <li>• Obesity or morbid obesity</li> <li>• Pregnant</li> <li>• Other (specify only for cases ≤12 months of age): _____</li> </ul>
<p>(Updated question number, re-ordered options based on system and alphabet, moved 6 conditions to another location on the CRF [IVDU, Other drug use, Current smoker, Premature birth, birth weight, estimated gestational age], removed 2 conditions [abscess/boil (recurrent), influenza (within 10 days of initial culture)], and added 22 conditions [an option under diabetes for “with chronic complications”; congenital heart disease; diverticular disease; inflammatory bowel disease; cerebral palsy; epilepsy/seizure/seizure disorder; multiple sclerosis; neuropathy; Parkinson’s disease; other neurologic condition; quadriplegia; lowest serum creatinine for those with chronic kidney disease; surgical wound; other chronic ulcer or wound; primary immunodeficiency; transplant, hematopoietic stem cell; transplant, solid organ; ascites; hepatitis C; 2 options under hepatitis C: treated, in SVR and current, chronic, cirrhosis;</p>			

hepatic encephalopathy; variceal bleeding]. There were minor wording changes for eight conditions [CVA/stroke to CVA/Stroke/TIA; Diabetes to Diabetes mellitus; Hematologic malignancy to Malignancy, hematologic; metastatic solid tumor to Malignancy, solid organ (metastatic); myocardial infarct to myocardial infarction; obesity to obesity or morbid obesity; peripheral vascular disease to peripheral vascular disease (PVD); solid tumor (non metastatic) to Malignancy, solid organ (non-metastatic)], one question was broken into two [Hemiplegia and paraplegia are now their own checkboxes rather than hemiplegia/paraplegia). One condition (pregnancy) was added to this question, but had previously stood as a stand-alone question (Q13).

**20. Underlying Conditions**

- Abscess/Boil (Recurrent)
- AIDS
- Chronic Cognitive Deficit
- Chronic Liver Disease
- Chronic Pulmonary Disease
- Chronic Kidney Disease
- Chronic Skin Breakdown
- Congestive Heart Failure
- Connective Tissue Disease
- Current Smoker
- CVA/Stroke
- Cystic fibrosis
- Decubitus/Pressure Ulcer
- Dementia
- Diabetes
- Hematologic Malignancy
- Hemiplegia/Paraplegia
- HIV
- Influenza (within 10 days of initial culture)
- IVDU
- Metastatic solid tumor
- Myocardial Infarct
- Obesity
- Other drug use
- Peptic ulcer disease
- Peripheral vascular disease
- Premature birth
- Birth weight \_\_\_\_\_ lb  
\_\_\_\_\_oz OR \_\_\_\_\_ g
- Estimated gestational age  
\_\_\_\_\_ weeks
- Solid tumor (non metastatic)
- Other (Specify for cases ≤12 months of age): \_\_\_\_\_

**30. Substance Use, current**

**Smoking: (Check all that apply)**

- None
- Tobacco
- E-nicotine delivery system
- Unknown
- Marijuana

**Alcohol Abuse:**

- Yes
- No
- Unknown

**Other Substances (Check all that apply):**

• None	• Unknown	
	Documented use disorder (DUD)/abuse:	Mode of delivery (Check all that apply):
• Marijuana/cannabinoid (other than smoking)	• DUD or abuse	• IDU • Skin popping • Non-IDU • Unknown
• Opioid, DEA schedule I (e.g., heroin)	• DUD or abuse	• IDU • Skin popping • Non-IDU • Unknown
• Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	• DUD or abuse	• IDU • Skin popping • Non-IDU • Unknown
• Cocaine or methamphetamine	• DUD or abuse	• IDU • Skin popping • Non-IDU • Unknown
• Other (Specify):	• DUD or abuse	• IDU • Skin popping • Non-IDU • Unknown
• Unknown substance	• DUD or abuse	• IDU • Skin popping • Non-IDU • Unknown

The data in this section was formerly collected in the underlying conditions section (IVDU [changed to injection drug user], Current smoker [changed to smoking], and other drug use). See the highlighted conditions in the prior column.

	<p>There are six new check boxes that allow “other drug” use to be captured in more detail. These questions focus on type of drug and mode of delivery.</p>																				
<p>13. At the time of first positive culture, patient was:</p> <ul style="list-style-type: none"> <li>• Pregnant</li> <li>• Post-partum</li> <li>• Neither</li> <li>• Unknown</li> </ul>	<p>This question has been deleted. A pregnancy checkbox is now included in Q20, underlying conditions</p>																				
<p>21. Prior healthcare exposure</p> <ul style="list-style-type: none"> <li>• None • Unknown</li> <li>• Previous document MRSA infection or colonization If yes, Month ____ Year _____ or previous state id: _____</li> <li>• Hospitalized within year before initial culture date If yes, Month ____ Day ____ Year _____ • Unknown If known, Facility ID: _____</li> <li>• Admitted to a LTACH within year before initial culture date If known, Facility ID: _____</li> <li>• Residence in a long-term care facility within year before initial culture date If known, Facility ID: _____</li> <li>• Surgery within year before initial culture date</li> </ul> <p>If yes, list the surgeries and dates of surgery that occurred within <u>90 days</u> prior to the initial culture:</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">Surgery</th> <th style="text-align: left;">Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>• Central vascular catheter in place at or any time in the 2 calendar days prior to initial culture</li> <li>• Dialysis within year before initial culture date (hemodialysis or peritoneal dialysis)</li> <li>• Current chronic dialysis Type • Peritoneal • Unknown • Hemodialysis Type of vascular access • AV fistula/graft • Hemodialysis CVC • Unknown</li> </ul>	Surgery	Date	_____	__-__-____	_____	__-__-____	_____	__-__-____	_____	__-__-____	<p>31. Prior healthcare exposure(s)</p> <p>Previous documented MRSA infection or colonization</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> <li>If yes, Month ____ Year ____ or previous state id: _____</li> </ul> <p>Previous hospitalization in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> <li>If yes, date of discharge closed to DISC: __/__/____ Facility ID: _____</li> </ul> <p>Overnight stay in LTACH in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> <li>Facility ID: _____</li> </ul> <p>Overnight stay in LTCF in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> <li>Facility ID: _____</li> </ul> <p>Surgery in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>If yes, list the surgeries and dates of surgery that occurred within <u>90 days</u> prior to the DISC:</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">Surgery</th> <th style="text-align: left;">Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> </tbody> </table> <p>Central line in place on the DISC (up to the time of collection), or at any time in the 2 calendar days before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>Dialysis in the year before DISC (hemodialysis or peritoneal dialysis)</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>Current chronic dialysis • Yes • No • Unknown Type: • Hemodialysis • Peritoneal • Unknown If hemodialysis, type of vascular access: • AV fistula/graft • Hemodialysis central line • Unknown</p> <p>(Updated question number and wording. Checkboxes were updated to yes/no/unknown responses, removing the need for</p>	Surgery	Date	_____	__-__-____	_____	__-__-____	_____	__-__-____	_____	__-__-____
Surgery	Date																				
_____	__-__-____																				
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_____	__-__-____																				

	None/Unknown checkboxes on prior CRF. Order of sub-questions has changed [not shown].)
<p>18. Patient outcome</p> <ul style="list-style-type: none"> <li>Survived Date of discharge: ___/___/___ If survived, was the patient transferred to a LTCF? • Yes • No • Unknown If yes, facility ID: _____</li> <li>Survived, was the patient transferred to a LTACH? • Yes • No • Unknown If yes, facility ID: _____</li> <li>Died Date of death: ___/___/___ Was MRSA cultured from a normally sterile site &lt; calendar day 7 before death? • Yes • No • Unknown</li> <li>Unknown</li> </ul>	<p>32. Patient outcome</p> <ul style="list-style-type: none"> <li>Survived Date of discharge: ___/___/___ • Left against medical advice (AMA) If survived, discharged to: • Private residence • Other • LTCF Facility ID: _____ Specify: _____ • LTACH Facility ID: _____ • Unknown</li> <li>Died Date of death: ___/___/___ On the day of or in the 6 calendar days before death, was the pathogen of interest isolate from a site that meets the case definition? • Yes • No • Unknown</li> <li>Unknown</li> </ul> <p>(Updated question number and wording. Collapsed two questions (If patient survived, was the patient transferred to a LTCF and If patient survived was the patient transferred to a LTACH) into a single question (If survived, discharged to) and added a checkbox for “left against medical advice” and for “date unknown” (for both date of discharge [if survived] and date of death [if died])</p>
<p>23. Was case first identified through audit?</p> <ul style="list-style-type: none"> <li>Yes • No • Unknown</li> </ul>	<p>33. Was case first identified through audit?</p> <ul style="list-style-type: none"> <li>Yes • No • Unknown</li> </ul> <p>(Updated question number)</p>
<p>24. CRF status</p> <ul style="list-style-type: none"> <li>Complete</li> <li>Incomplete</li> <li>Edited &amp; Correct</li> <li>Chart unavailable after 3 requests</li> </ul>	<p>34. CRF Status</p> <ul style="list-style-type: none"> <li>Complete</li> <li>Incomplete</li> <li>Edited &amp; Correct</li> <li>Chart unavailable after 3 requests</li> </ul> <p>(Updated question number)</p>
<p>25. Does this case have recurrent MRSA disease?</p> <ul style="list-style-type: none"> <li>Yes • No • Unknown</li> </ul> <p>If yes, previous (1<sup>st</sup>) state ID _____</p>	<p>35. Does this case have recurrent MRSA disease?</p> <ul style="list-style-type: none"> <li>Yes • No • Unknown</li> </ul> <p>If yes, previous (1<sup>st</sup>) state ID _____</p> <p>(Updated question number)</p>
<p>26. Date reported to EIP site</p> <p>___/___/___</p>	<p>36. Date reported to EIP site</p> <p>___/___/___</p> <p>(Updated question number)</p>
<p>27. Initials of S.O.</p> <p>_____</p>	<p>37. S.O. Initials</p> <p>_____</p> <p>(Updated question number and wording)</p>

**10. 2019 Invasive MSSA Infections Case Report Form**

2018 Paper CRF Question	Changes to the 2019 Paper CRF Question
<p>1. State (Residence of patient)</p> <p>_____</p>	<p>1. State</p> <p>_____</p> <p>(Updated question wording)</p>
<p>2. County (Residence of patient)</p> <p>_____</p>	<p>2. County</p> <p>_____</p> <p>(Updated question wording)</p>
<p>3. State I.D.: _____</p>	<p>3. State I.D.: _____</p>



	(No change)
Patient ID: _____	4. Patient ID: _____ (Updated question number; this was previously at the top of the CRF and not numbered).
4a. Hospital/Lab I.D. where culture identified _____	5. Laboratory ID where incident specimen identified _____ (Updated question number and wording)
4b. Hospital I.D. where patient treated _____	6. Facility ID where patient treated _____ (Updated question number and wording)
5. Sex: • Male • Female	7. Sex at birth: • Male • Female • Unknown • Check if transgender (Updated question number and wording, added two new options—one for unknown sex at birth and a checkbox if the patient is transgender)
6. Date of Birth _/_/____	8. Date of birth _/_/____ (Updated question number)
7. Age ____	9. Age ____ • Days • Mos. • Years (Updated question number and combined with question below [7b on old form])
7b. Is age in day/mo/yr • Days • Mos. • Years	This text (Is age in day/mo/yr) has been removed and the option day/mo/year is now included as a part of question 9
12b. Race • White • Black or African American • American Indian or Alaska Native • Asian • Native Hawaiian or Other Pacific Islander • Unknown	10. Race (Check all that apply) • American Indian or Alaska Native • Asian • Black or African American • Native Hawaiian or Other Pacific Islander • White • Unknown (Updated question number and order of responses; all response options remain the same)
12a. Ethnic Origin • Hispanic or Latino • Not Hispanic or Latino • Unknown	11. Ethnic origin • Hispanic or Latino • Not Hispanic or Latino • Unknown (Updated question number)
12c. Weight • Unknown ____ lbs ____ oz OR ____ kg	12. Weight ____ lbs ____ oz OR ____ kg • Unknown (Updated question number and order of responses; all response options remain the same)
12d. Height • Unknown ____ ft. ____ in. OR ____ cm	13. Height ____ ft. ____ in. OR ____ cm • Unknown (Updated question number and order of responses; all response options remain the same)
12e. BMI (do not calculate, only if available in the MR) • Unknown _____	14. BMI (record only if ht. and/or wt. is not available) ____ • Unknown (Updated question number, wording, and order of responses; all response options remain the same)
9. Date of Initial Culture	15. Date of Incident Specimen Collection (DISC)

___/___/_____	___/___/_____
	(Updated question number and wording)
10a. Was the patient hospitalized at the time of, or within 30 calendar days after, initial culture? • Yes • No • Unknown If yes, date of admission ___/___/_____	16. Was the patient hospitalized at the time of, or in the 29 calendar days after, the DISC? • Yes • No • Unknown If yes, date of admission ___/___/_____
	(Updated question number and wording)
11. Was culture collected >3 calendar days after hospital admission? • Yes (HO case) • No	17. Was incident specimen collected 3 or more calendar days after hospital admission? • Yes (HO-MSSA case) • No (CA-MSSA or HACO-MSSA case)
8. Sterile site(s) from which MSSA was initially isolated (check all that apply) • Blood • CSF • Pleural fluid • Peritoneal fluid • Pericardial fluid • Joint/Synovial fluid • Bone • Muscle • Internal body site (specify _____) • Other sterile site (specify _____)	18. Incident specimen collection site (check all that apply) • Blood • Bone • CSF • Internal body site (specify _____) • Joint/Synovial fluid • Muscle • Pericardial fluid • Peritoneal fluid • Pleural fluid • Other normally sterile site (specify _____) (Updated question number, wording, order of responses, and wording of one response options [other sterile site is now other normally sterile site], though all response options remain the same)
16. Location of culture collection (check one) <b>Hospital inpatient</b> • ICU • Surgery/OR • Radiology • Other unit <b>Outpatient</b> • Clinic/Doctor's office • Surgery • Dialysis/Renal Clinic • Other outpatient  • Emergency Room • Observational Unit/clinical decision unit • LTCF Facility ID: _____ • LTACH Facility ID: _____ • Autopsy • Unknown • Other	19. Location of specimen collection • <b>Outpatient</b> Facility ID: _____ • Emergency room • Clinic/Doctor's office • Dialysis center • Surgery • Observational/clinical decision unit • Other outpatient • <b>Inpatient</b> Facility ID: _____ • ICU • OR • Radiology • Other inpatient • <b>LTCF</b> Facility ID: _____ • <b>LTACH</b> Facility ID: _____ • <b>Autopsy</b> • <b>Other (specify):</b> _____ • <b>Unknown</b>  (Updated question number. Added checkboxes for headings "Outpatient" and "Inpatient". Added a facility ID for "Outpatient" and "Inpatient". Updated the order of responses. Changed the wording of the response "Dialysis/Renal clinic to "Dialysis" and "Other unit" to "Other inpatient")
17. Were cultures of the SAME or OTHER sterile sites positive within 30 days after initial culture date? • Yes • No • Unknown	20. Were cultures of the SAME or OTHER sterile site(s) positive within 29 days after DISC? • Yes • No • Unknown

<p>If yes, indicate site and date of last positive culture.</p> <ul style="list-style-type: none"> <li>• Blood, Date: _____</li> <li>• CSF, Date: _____</li> <li>• Pleural fluid, Date: _____</li> <li>• Peritoneal fluid, Date: _____</li> <li>• Pericardial fluid, Date: _____</li> <li>• Joint/Synovial fluid, Date: _____</li> <li>• Bone, Date: _____</li> <li>• Muscle, Date: _____</li> <li>• Internal body site (specify _____) Date: _____</li> <li>• Other sterile site (specify _____) Date: _____</li> </ul>	<p>If yes, indicate site and date of last positive culture.</p> <ul style="list-style-type: none"> <li>• Blood, Date: _____</li> <li>• Bone, Date: _____</li> <li>• CSF, Date: _____</li> <li>• Internal body site (specify _____), Date: _____</li> <li>• Joint/Synovial fluid, Date: _____</li> <li>• Muscle, Date: _____</li> <li>• Pericardial fluid, Date: _____</li> <li>• Peritoneal fluid, Date: _____</li> <li>• Pleural fluid, Date: _____</li> <li>• Other normally sterile site (specify _____) Date: _____</li> </ul> <p>(Updated question number and wording, order of responses, and wording of one of the response options [other sterile site is now other normally sterile site])</p>
<p>17b. Date of first SA blood culture after which SA not isolated for 14 days ____/____/_____</p>	<p>21. Date of first SA blood culture after which SA not isolated for 14 days ____/____/_____</p> <p>(Updated question number)</p>
<p>22. Susceptibility Results</p> <p>Cefoxitin • S • R • U</p> <p>Oxacillin • S • R • U</p> <p>Vancomycin • S • I • R • U</p> <p>Clindamycin • S • I • R • U</p> <p>Trimethoprim-sulfamethoxazole • S • I • R • U</p>	<p>22. Susceptibility Results</p> <p>Cefazolin • S • I • R • U</p> <p>Nafcillin • S • I • R • U</p> <p>Cefoxitin • S • R • U</p> <p>Oxacillin • S • R • U</p> <p>Vancomycin • S • I • R • U</p> <p>Clindamycin • S • I • R • U</p> <p>Trimethoprim-sulfamethoxazole • S • I • R • U</p> <p>(Added two antimicrobial agents-Cefazolin and Nafcillin)</p>
<p>15. Where was the patient located on the 4th calendar day prior to the date of initial culture?</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• Long term care facility</li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Long term acute care hospital</li> <li>• Homeless</li> <li>• Incarcerated</li> <li>• Hospital inpatient</li> </ul> <p>Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Other _____</li> <li>• Unknown</li> </ul>	<p>23. Where was the patient located on the 3<sup>rd</sup> calendar day before the DISC?</p> <ul style="list-style-type: none"> <li>• Private residence</li> <li>• LTACH</li> <li>• LTCHF</li> <li>• Facility ID: _____</li> <li>• Homeless</li> <li>• Hospital inpatient</li> <li>• Incarcerated</li> <li>• Facility ID: _____</li> <li>• Other: _____</li> <li>• Was patient transferred from this hospital?</li> <li>• Unknown</li> </ul> <p>• Yes • No • Unknown</p> <p>(Updated question number and wording, Updated order of the responses, added the response: Was patient transferred from this hospital? • Yes • No • Unknown for patients that were indicated to be a hospital inpatient.)</p>
<p>14. If case is ≤12 months of age, type of birth hospitalization</p> <ul style="list-style-type: none"> <li>• NICU/SCN</li> <li>• Well baby nursery</li> <li>• Unknown</li> </ul>	<p>24. If case is ≤12 months of age, type of birth hospitalization</p> <ul style="list-style-type: none"> <li>• NICU/SCN</li> <li>• Well baby nursery</li> <li>• Unknown</li> </ul> <p>(Updated question number)</p>
<p>20. Underlying conditions:</p> <ul style="list-style-type: none"> <li>• Premature birth</li> </ul> <p>Birth weight _____ lb _____ oz OR _____ g</p> <p>Estimated gestational age _____ weeks</p>	<p>25. If patient &lt;2 years of age were they born premature (&lt;37 weeks gestation)?</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>---If YES, birth weight: _____ lb _____ oz OR _____ g OR • Unknown birth weight</p> <p>---If YES, estimated gestational age: _____ weeks OR • Unknown gestational age</p> <p>(Updated question number and wording. Added “Unknown”)</p>

<p>10b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? • Yes • No • Unknown</p>	<p>checkboxes for birth weight and gestational age)</p> <p>26. Was the patient in an ICU in the 2 days before the DISC? • Yes • No • Unknown ---if YES, date of ICU admission: ___-___-____ OR • Date Unknown (Updated question number and wording, broke into two questions, added date of admission)</p>		
<p>10b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? • Yes • No • Unknown</p>	<p>27. Was the patient in an ICU on the DISC or in the 2 days after the DISC? • Yes • No • Unknown ---if YES, date of ICU admission: ___-___-____ OR • Date Unknown (Updated question number and wording, broke into two questions, added date of admission)</p>		
<p>19. Types of MSSA infection associated with culture(s)</p> <ul style="list-style-type: none"> <li>• Abscess (not skin)</li> <li>• AV Fistula/Graft infection</li> <li>• Bacteremia</li> <li>• Bursitis</li> <li>• Catheter Site Infection</li> <li>• Cellulitis</li> <li>• Chronic Ulcer/Wound</li> <li>• Decubitus/Pressure Ulcer</li> <li>• Empyema</li> <li>• Endocarditis</li> <li>• Epidural abscess</li> <li>• Meningitis</li> <li>• Peritonitis</li> <li>• Pneumonia</li> <li>• Osteomyelitis</li> <li>• Septic Arthritis</li> <li>• Septic Emboli</li> <li>• Septic Shock</li> <li>• Skin Abscess</li> <li>• Surgical Incision</li> <li>• Surgical Site (internal)</li> <li>• Urinary Tract</li> <li>• Other (Specify):_____</li> </ul>	<p>28. Types of MSSA infection associated with culture(s)</p> <ul style="list-style-type: none"> <li>• Abscess (not skin)</li> <li>• AV Fistula/Graft infection</li> <li>• Bacteremia</li> <li>• Bursitis</li> <li>• Catheter Site Infection</li> <li>• Cellulitis</li> <li>• Chronic Ulcer/Wound</li> <li>• Decubitus/Pressure Ulcer</li> <li>• Empyema</li> <li>• Endocarditis</li> <li>• Epidural abscess</li> <li>• Meningitis</li> <li>• Peritonitis</li> <li>• Pneumonia</li> <li>• Osteomyelitis</li> <li>• Septic Arthritis</li> <li>• Septic Emboli</li> <li>• Septic Shock</li> <li>• Skin Abscess</li> <li>• Surgical Incision</li> <li>• Surgical Site (internal)</li> <li>• Urinary Tract</li> <li>• Other (Specify):_____</li> </ul> <p>(Updated question number, no change to the responses)</p>		
<p>20. Underlying Conditions</p> <ul style="list-style-type: none"> <li>• Abscess/Boil (Recurrent)</li> <li>• AIDS</li> <li>• Chronic Cognitive Deficit</li> <li>• Chronic Liver Disease</li> <li>• Chronic Pulmonary Disease</li> <li>• Chronic Kidney Disease</li> <li>• Chronic Skin Breakdown</li> <li>• Congestive Heart Failure</li> <li>• Connective Tissue Disease</li> <li>• Current Smoker</li> <li>• CVA/Stroke</li> <li>• Cystic fibrosis</li> <li>• Decubitus/Pressure Ulcer</li> <li>• Dementia</li> <li>• Diabetes</li> <li>• Hematologic Malignancy</li> <li>• Hemiplegia/Paraplegia</li> <li>• HIV</li> <li>• Influenza (within 10 days of initial culture)</li> <li>• IVDU</li> <li>• Metastatic solid tumor</li> <li>• Myocardial Infarct</li> <li>• Obesity</li> <li>• Other drug use</li> <li>• Peptic ulcer disease</li> <li>• Peripheral vascular disease</li> <li>• Premature birth</li> <li>• Birth weight _____ lb _____oz OR _____ g</li> <li>• Estimated gestational age _____ weeks</li> <li>• Solid tumor (non metastatic)</li> <li>• Other (Specify for cases ≤12 months of age):</li> </ul>	<p>29. Underlying Conditions</p> <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 50%;"> <p><b>CHRONIC LUNG DISEASE</b></p> <ul style="list-style-type: none"> <li>• Cystic fibrosis</li> <li>• Chronic pulmonary disease</li> </ul> <p><b>CHRONIC METABOLIC DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diabetes mellitus <ul style="list-style-type: none"> <li>• with chronic complications</li> </ul> </li> </ul> <p><b>CARDIOVASCULAR DISEASE</b></p> <ul style="list-style-type: none"> <li>• CVA/Stroke/TIA</li> <li>• Congenital heart disease</li> <li>• Congestive heart failure</li> <li>• Myocardial infarction</li> <li>• Peripheral vascular disease (PVD)</li> </ul> <p><b>GASTROINTESTINAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diverticular disease</li> <li>• Inflammatory Bowel disease</li> <li>• Peptic ulcer disease</li> <li>• Short gut syndrome</li> </ul> <p><b>IMMUNOCOMPROMISED CONDITION</b></p> <ul style="list-style-type: none"> <li>• HIV infection <ul style="list-style-type: none"> <li>• AIDS/CD4 count &lt;200</li> </ul> </li> </ul> </td> <td style="vertical-align: top; width: 50%;"> <p><b>NEUROLOGIC CONDITION</b></p> <ul style="list-style-type: none"> <li>• Cerebral palsy</li> <li>• Chronic cognitive deficit</li> <li>• Dementia</li> <li>• Epilepsy/seizure/seizure disorder</li> <li>• Multiple sclerosis</li> <li>• Neuropathy</li> <li>• Parkinson's Disease</li> <li>• Other specify:_____</li> </ul> <p><b>PLEGIAS/PARALYSIS</b></p> <ul style="list-style-type: none"> <li>• Hemiplegia</li> <li>• Paraplegia</li> <li>• Quadriplegia</li> </ul> <p><b>RENAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Chronic kidney disease <ul style="list-style-type: none"> <li>• Lowest serum creatinine:_____mg/Dl</li> </ul> </li> </ul> <p><b>SKIN CONDITION</b></p> <ul style="list-style-type: none"> <li>• Burn</li> <li>• Decubitus/pressure ulcer</li> <li>• Surgical wound</li> <li>• Other chronic ulcer or</li> </ul> </td> </tr> </table>	<p><b>CHRONIC LUNG DISEASE</b></p> <ul style="list-style-type: none"> <li>• Cystic fibrosis</li> <li>• Chronic pulmonary disease</li> </ul> <p><b>CHRONIC METABOLIC DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diabetes mellitus <ul style="list-style-type: none"> <li>• with chronic complications</li> </ul> </li> </ul> <p><b>CARDIOVASCULAR DISEASE</b></p> <ul style="list-style-type: none"> <li>• CVA/Stroke/TIA</li> <li>• Congenital heart disease</li> <li>• Congestive heart failure</li> <li>• Myocardial infarction</li> <li>• Peripheral vascular disease (PVD)</li> </ul> <p><b>GASTROINTESTINAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Diverticular disease</li> <li>• Inflammatory Bowel disease</li> <li>• Peptic ulcer disease</li> <li>• Short gut syndrome</li> </ul> <p><b>IMMUNOCOMPROMISED CONDITION</b></p> <ul style="list-style-type: none"> <li>• HIV infection <ul style="list-style-type: none"> <li>• AIDS/CD4 count &lt;200</li> </ul> </li> </ul>	<p><b>NEUROLOGIC CONDITION</b></p> <ul style="list-style-type: none"> <li>• Cerebral palsy</li> <li>• Chronic cognitive deficit</li> <li>• Dementia</li> <li>• Epilepsy/seizure/seizure disorder</li> <li>• Multiple sclerosis</li> <li>• Neuropathy</li> <li>• Parkinson's Disease</li> <li>• Other specify:_____</li> </ul> <p><b>PLEGIAS/PARALYSIS</b></p> <ul style="list-style-type: none"> <li>• Hemiplegia</li> <li>• Paraplegia</li> <li>• Quadriplegia</li> </ul> <p><b>RENAL DISEASE</b></p> <ul style="list-style-type: none"> <li>• Chronic kidney disease <ul style="list-style-type: none"> <li>• Lowest serum creatinine:_____mg/Dl</li> </ul> </li> </ul> <p><b>SKIN CONDITION</b></p> <ul style="list-style-type: none"> <li>• Burn</li> <li>• Decubitus/pressure ulcer</li> <li>• Surgical wound</li> <li>• Other chronic ulcer or</li> </ul>
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	<ul style="list-style-type: none"> <li>• Primary immunodeficiency</li> <li>• Transplant, hematopoietic stem cell</li> <li>• Transplant, solid organ</li> </ul> <p><b>LIVER DISEASE</b></p> <ul style="list-style-type: none"> <li>• Chronic liver disease <ul style="list-style-type: none"> <li>• Ascites</li> <li>• Cirrhosis</li> <li>• Hepatic encephalopathy</li> <li>• Variceal bleeding</li> </ul> </li> <li>• Hepatitis C <ul style="list-style-type: none"> <li>• Treated, in SVC</li> <li>• Current, chronic</li> </ul> </li> </ul> <p><b>MALIGNANCY</b></p> <ul style="list-style-type: none"> <li>• Malignancy, hematologic</li> <li>• Malignancy, solid organ (non-metastatic)</li> <li>• Malignancy, solid organ (metastatic)</li> </ul> <p>(Updated question number, re-ordered options based on system and alphabet, moved 6 conditions to another location on the CRF [IVDU, Other drug use, Current smoker, Premature birth, birth weight, estimated gestational age], removed 2 conditions [abscess/boil (recurrent), influenza (within 10 days of initial culture)], and added 22 conditions [an option under diabetes for “with chronic complications”; congenital heart disease; diverticular disease; inflammatory bowel disease; cerebral palsy; epilepsy/seizure/seizure disorder; multiple sclerosis; neuropathy; Parkinson’s disease; other neurologic condition; quadriplegia; lowest serum creatinine for those with chronic kidney disease; surgical wound; other chronic ulcer or wound; primary immunodeficiency; transplant, hematopoietic stem cell; transplant, solid organ; ascites; hepatitis C; 2 options under hepatitis C: treated, in SVR and current, chronic, cirrhosis; hepatic encephalopathy; variceal bleeding]. There were minor wording changes for eight conditions [CVA/stroke to CVA/Stroke/TIA; Diabetes to Diabetes mellitus; Hematologic malignancy to Malignancy, hematologic; metastatic solid tumor to Malignancy, solid organ (metastatic); myocardial infarct to myocardial infarction; obesity to obesity or morbid obesity; peripheral vascular disease to peripheral vascular disease (PVD); solid tumor (non metastatic) to Malignancy, solid organ (non-metastatic)], one question was broken into two [Hemiplegia and paraplegia are now their own checkboxes rather than hemiplegia/paraplegia). One condition (pregnancy) was added to this question, but had previously stood as a stand-alone question (Q13).</p>
<p><b>20. Underlying Conditions</b></p> <ul style="list-style-type: none"> <li>• Abscess/Boil (Recurrent)</li> <li>• AIDS</li> <li>• Chronic Cognitive Deficit</li> <li>• Chronic Liver Disease</li> <li>• Chronic Pulmonary Disease</li> <li>• Chronic Kidney Disease</li> <li>• Chronic Skin Breakdown</li> <li>• IVDU</li> <li>• Metastatic solid tumor</li> <li>• Myocardial Infarct</li> <li>• Obesity</li> <li>• Other drug use</li> <li>• Peptic ulcer disease</li> <li>• Peripheral vascular disease</li> </ul>	<p><b>30. Substance Use</b></p> <p><b>Smoking:</b></p> <ul style="list-style-type: none"> <li>• None</li> <li>• Tobacco</li> <li>• E-nicotine delivery system</li> <li>• Unknown</li> <li>• Marijuana</li> </ul> <p><b>Alcohol Abuse:</b></p> <ul style="list-style-type: none"> <li>• No</li> <li>• Unknown</li> </ul>

<ul style="list-style-type: none"> <li>• Congestive Heart Failure</li> <li>• Connective Tissue Disease</li> <li>• Current Smoker</li> <li>• CVA/Stroke</li> <li>• Cystic fibrosis</li> <li>• Decubitus/Pressure Ulcer</li> <li>• Dementia</li> <li>• Diabetes</li> <li>• Hematologic Malignancy</li> <li>• Hemiplegia/Paraplegia</li> <li>• HIV</li> <li>• Influenza (within 10 days of initial culture)</li> </ul> <ul style="list-style-type: none"> <li>• Premature birth</li> <li>Birth weight _____ lb _____ oz OR _____ g</li> <li>Estimated gestational age _____ weeks</li> <li>• Solid tumor (non metastatic)</li> <li>• Other (Specify for cases ≤12 months of age): _____</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> </ul> <p>Other Substances (Check all that apply):</p> <table border="1"> <tr> <td>• None</td> <td>• Unknown</td> <td></td> </tr> <tr> <td>• Marijuana (other than smoking)</td> <td>• Documented use disorder</td> <td>• IDU • Skin popping • Non-IDU • Unknown</td> </tr> <tr> <td>• Opioid, DEA schedule I (e.g., heroin)</td> <td>• Documented use disorder</td> <td>• IDU • Skin popping • Non-IDU • Unknown</td> </tr> <tr> <td>• Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)</td> <td>• Documented use disorder</td> <td>• IDU • Skin popping • Non-IDU • Unknown</td> </tr> <tr> <td>• Cocaine or methamphetamine</td> <td>• Documented use disorder</td> <td>• IDU • Skin popping • Non-IDU • Unknown</td> </tr> <tr> <td>• Other (Specify):</td> <td>• Documented use disorder</td> <td>• IDU • Skin popping • Non-IDU • Unknown</td> </tr> <tr> <td>• Unknown substance</td> <td>• Documented use disorder</td> <td>• IDU • Skin popping • Non-IDU • Unknown</td> </tr> </table> <p>The data in this section was formerly collected in the underlying conditions section (IVDU [changed to injection drug user], Current smoker [changed to smoking], and other drug use). See the highlighted conditions in the prior column.</p> <p>There are six new check boxes that allow “other drug” use to be captured in more detail. These questions focus on type of drug and mode of delivery.</p>	• None	• Unknown		• Marijuana (other than smoking)	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown	• Opioid, DEA schedule I (e.g., heroin)	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown	• Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown	• Cocaine or methamphetamine	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown	• Other (Specify):	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown	• Unknown substance	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown
• None	• Unknown																					
• Marijuana (other than smoking)	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown																				
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• Other (Specify):	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown																				
• Unknown substance	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown																				
<p>13. At the time of first positive culture, patient was:</p> <ul style="list-style-type: none"> <li>• Pregnant</li> <li>• Post-partum</li> <li>• Neither</li> <li>• Unknown</li> </ul>	<p>This question has been deleted. A pregnancy checkbox is now included in Q20, underlying conditions</p>																					
<p>21. Prior healthcare exposure</p> <ul style="list-style-type: none"> <li>• None • Unknown</li> <li>• Previous document MSSA infection or colonization If yes, Month _____ Year _____ or previous state id: _____</li> <li>• Hospitalized within year before initial culture date If yes, Month _____ Day _____ Year _____ • Unknown If known, Facility ID: _____</li> <li>• Admitted to a LTACH within year before initial culture date If known, Facility ID: _____</li> <li>• Residence in a long-term care facility within year before initial culture date If known, Facility ID: _____</li> </ul>	<p>31. Prior healthcare exposure(s)</p> <p>Previous documented MSSA infection or colonization</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> <li>If yes, Month _____ Year _____ or previous state id: _____</li> </ul> <p>Previous hospitalization in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> <li>If yes, date of discharge closed to DISC: ___/___/___ Facility ID: _____</li> </ul> <p>Overnight stay in LTACH in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> <li>Facility ID: _____</li> </ul> <p>Overnight stay in LTCF in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> <li>Facility ID: _____</li> </ul>																					

<ul style="list-style-type: none"> <li>• Surgery within year before initial culture date</li> </ul> <p>If yes, list the surgeries and dates of surgery that occurred within <u>90 days</u> prior to the initial culture:</p> <table border="0"> <thead> <tr> <th>Surgery</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>• Central vascular catheter in place at or any time in the 2 calendar days prior to initial culture</li> <li>• Dialysis within year before initial culture date (hemodialysis or peritoneal dialysis)</li> <li>• Current chronic dialysis <ul style="list-style-type: none"> <li>Type • Peritoneal • Unknown</li> <li>• Hemodialysis</li> <li>Type of vascular access</li> <li>• AV fistula/graft</li> <li>• Hemodialysis CVC</li> <li>• Unknown</li> </ul> </li> </ul>	Surgery	Date	_____	__-__-____	_____	__-__-____	_____	__-__-____	_____	__-__-____	<p>Surgery in the year before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>If yes, list the surgeries and dates of surgery that occurred within <u>90 days</u> prior to the DISC:</p> <table border="0"> <thead> <tr> <th>Surgery</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> <tr> <td>_____</td> <td>__-__-____</td> </tr> </tbody> </table> <p>Central line in place on the DISC (up to the time of collection), or at any time in the 2 calendar days before DISC</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>Dialysis in the year before DISC (hemodialysis or peritoneal dialysis)</p> <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> <p>Current chronic dialysis • Yes • No • Unknown</p> <p>Type: • Hemodialysis • Peritoneal • Unknown</p> <p>If hemodialysis, type of vascular access:</p> <ul style="list-style-type: none"> <li>• AV fistula/graft • Hemodialysis central line</li> <li>• Unknown</li> </ul> <p>(Updated question number and wording. Checkboxes were updated to yes/no/unknown responses, removing the need for None/Unknown checkboxes on prior CRF. Order of sub-questions has changed [not shown].)</p>	Surgery	Date	_____	__-__-____	_____	__-__-____	_____	__-__-____	_____	__-__-____
Surgery	Date																				
_____	__-__-____																				
_____	__-__-____																				
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_____	__-__-____																				
_____	__-__-____																				
_____	__-__-____																				
_____	__-__-____																				
<p>18. Patient outcome</p> <ul style="list-style-type: none"> <li>• Survived</li> <li>Date of discharge: __/__/____</li> <li>If survived, was the patient transferred to a LTCF? <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> </li> <li>If yes, facility ID: _____</li> <li>If survived, was the patient transferred to a LTACH? <ul style="list-style-type: none"> <li>• Yes • No • Unknown</li> </ul> </li> <li>If yes, facility ID: _____</li> <li>• Died</li> <li>Date of death: __/__/____</li> <li>Was MSSA cultured from a normally sterile site &lt; calendar day 7 before death? • Yes • No • Unknown</li> <li>• Unknown</li> </ul>	<p>32. Patient outcome</p> <ul style="list-style-type: none"> <li>• Survived</li> <li>Date of discharge: __/__/____</li> <li>• Left against medical advice (AMA)</li> <li>If survived, discharged to: <ul style="list-style-type: none"> <li>• Private residence • Other</li> <li>• LTCF Facility ID:_____ Specify:_____</li> <li>• LTACH Facility ID:_____ • Unknown</li> </ul> </li> <li>• Died</li> <li>Date of death: __/__/____</li> <li>On the day of or in the 6 calendar days before death, was the pathogen of interest isolate from a site that meets the case definition? • Yes • No • Unknown</li> <li>• Unknown</li> </ul> <p>(Updated question number and wording. Collapsed two questions (If patient survived, was the patient transferred to a LTCF and If patient survived was the patient transferred to a LTACH) into a single question (If survived, discharged to) and added a checkbox for “left against medical advice” and for “date unknown” (for both date of discharge [if survived] and date of death [if died])</p>																				

23. Was case first identified through audit? • Yes • No • Unknown	33. Was case first identified through audit? • Yes • No • Unknown (Updated question number)
24. CRF status • Complete • Incomplete • Edited & Correct • Chart unavailable after 3 requests	34. CRF Status • Complete • Incomplete • Edited & Correct • Chart unavailable after 3 requests (Updated question number)
25. Does this case have recurrent MSSA disease? • Yes • No • Unknown If yes, previous (1 <sup>st</sup> ) state ID _____	35. Does this case have recurrent MSSA disease? • Yes • No • Unknown If yes, previous (1 <sup>st</sup> ) state ID _____ (Updated question number)
26. Date reported to EIP site ___/___/_____	36. Date reported to EIP site ___/___/_____ (Updated question number)
27. Initials of S.O. _____	37. S.O. Initials _____ (Updated question number and wording)

**11. 2018 CDI Case Report and Treatment Form**

<u>Question on 2018 Form</u>	<u>Question on 2019 Form</u>
<b>28.</b> <b>Identified through audit</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Removed</u>
<b>5.</b> <b>DATE OF BIRTH</b> ____-____-_____	<b>10.</b> <b>DATE OF BIRTH</b> ____-____-_____ <input type="checkbox"/> Unknown
<b>6. Age</b>	<b>12.</b> <b>Age (years)</b>
<b>7a.</b> <b>SEX:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>12.</b> <b>Sex at birth</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender
<b>9.</b> <b>Was patient hospitalized on the date of or in the 6 calendar days after incident C. diff+ stool collection?</b> ... If YES, Date of Admission: ____-____-_____	<b>15.</b> <b>Was patient hospitalized on the date of or in the 6 calendar days after incident C. diff+ stool collection?</b> ... If YES, Date of Admission: ____-____-_____ <input type="checkbox"/> Unknown
<b>10.</b> <b>Where was the patient located on the 3rd calendar day before the date of incident C. diff+ stool collection?</b> <input type="checkbox"/> Private Residence	<b>16.</b> <b>Where was the patient located on the 3rd calendar day before the date of incident C. diff+ stool collection?</b>



<b>Question on 2018 Form</b>	<b>Question on 2019 Form</b>
<input type="checkbox"/> LTCF Facility ID _____ <input type="checkbox"/> Hospital Inpatient Facility ID _____ <input type="checkbox"/> LTACH Facility ID _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Private Residence <input type="checkbox"/> LTCF Facility ID _____ <input type="checkbox"/> Hospital Inpatient Facility ID _____ Was the patient transferred from this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> LTACH Facility ID _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown
<b>8c.</b> <b>Location of incident C. diff+ stool collection:</b> <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Observation Unit/CDU <input type="checkbox"/> Hospital Inpatient Facility ID _____ <input type="checkbox"/> LTCF Facility ID _____ <input type="checkbox"/> LTACH Facility ID _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	<b>17.</b> <b>Location of incident C. diff+ stool collection:</b> <input type="checkbox"/> Outpatient Facility ID _____ <input type="checkbox"/> Emergency room <input type="checkbox"/> Clinic/doctor's office <input type="checkbox"/> Dialysis center <input type="checkbox"/> Surgery <input type="checkbox"/> Observation/Clinical decision unit <input type="checkbox"/> Other outpatient <input type="checkbox"/> Hospital Inpatient Facility ID _____ <input type="checkbox"/> ICU <input type="checkbox"/> OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other inpatient <input type="checkbox"/> LTCF Facility ID _____ <input type="checkbox"/> LTACH Facility ID _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown
<b>11a. Was incident C. diff+ stool collected at least 3 calendar days after the date of hospital admission?</b> <input type="checkbox"/> Yes (HCFO – go to 11d) <input type="checkbox"/> No	<b>18a. Was incident C. diff+ stool collected at least 3 calendar days after the date of hospital admission?</b> <input type="checkbox"/> Yes (HCFO – go to 18d) <input type="checkbox"/> No
<b>11b. Was incident C. diff+ stool collected at an outpatient setting for a LTCF resident, or in a LTCF or LTACH?</b> <input type="checkbox"/> Yes (HCFO – go to 11d) <input type="checkbox"/> No	<b>18b. Was incident C. diff+ stool collected at an outpatient setting for a LTCF resident, or in a LTCF or LTACH?</b> <input type="checkbox"/> Yes (HCFO – go to 18d) <input type="checkbox"/> No
<b>11c. Was the patient admitted from a LTCF or a LTACH?</b> <input type="checkbox"/> Yes (HCFO – go to 11d) <input type="checkbox"/> No (CO - stop data abstraction here) <b>Facility ID:</b> _____	<b>18c. Was the patient admitted from a LTCF or a LTACH?</b> <input type="checkbox"/> Yes (HCFO – go to 18d) <input type="checkbox"/> No (CO - stop data abstraction here) <b>Facility ID:</b> _____

<b>Question on 2018 Form</b>	<b>Question on 2019 Form</b>
<p><b>14.</b>  <b>Exclusion criteria for CA-CDI:</b>  <input type="checkbox"/> None  <input type="checkbox"/> Unknown  <input type="checkbox"/> Hospitalized (overnight) in the 12 weeks before the date of incident C. diff+ stool collection  Date of most recent discharge  ____ - ____ - _____  <input type="checkbox"/> Unknown  Facility ID _____  <input type="checkbox"/> Overnight stay in LTACH in the 12 weeks before the date of incident C.diff + stool collection  Facility ID _____  <input type="checkbox"/> Residence in LTCF in the 12 weeks before the date of incident C.diff + stool collection  Facility ID _____</p>	<p><b>20a-20c.</b>  <b>Exposures to healthcare in the 12 weeks before the date of incident C. diff+ stool collection</b>  <b>Previous hospitalization</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown  If yes, date of discharge closest to date of incident C. diff+ stool collection:  ____ - ____ - _____  <input type="checkbox"/> Unknown  Facility ID _____  <b>Overnight stay in LTACH</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown  Facility ID _____  <b>Overnight stay in LTCF</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown    Facility ID _____</p>
<p><b>15a.</b>  <b>Chronic Hemodialysis</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown</p>	<p><b>20d.</b>  <b>Chronic dialysis</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown  Type:  <input type="checkbox"/> Hemodialysis  <input type="checkbox"/> Peritoneal  <input type="checkbox"/> Unknown</p>
<p><b>15b.</b>  Surgical procedure  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown</p>	<p><b>20e.</b>  Surgery  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown</p>
<p><b>21.</b>  <b>UNDERLYING CONDITIONS:</b> (Check all that apply)  <input type="checkbox"/> AIDS  <input type="checkbox"/> Chronic Kidney Disease  <input type="checkbox"/> CVA/Stroke  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Hematologic Malignancy  <input type="checkbox"/> Hemiplegia/Paraplegia  <input type="checkbox"/> Metastatic Solid Tumor  <input type="checkbox"/> Myocardial infarct  <input type="checkbox"/> Peripheral Vascular Disease  <input type="checkbox"/> Solid Organ Transplant  <input type="checkbox"/> Solid Tumor (non metastatic)  <input type="checkbox"/> Stem Cell Transplant</p>	<p><b>21.</b>  <b>UNDERLYING CONDITIONS:</b> (Check all that apply)  <input type="checkbox"/> AIDS/CD4 count &lt;200  <input type="checkbox"/> Chronic Kidney Disease  Lowest serum creatinine: _____ mg/dL  <input type="checkbox"/> CVA/Stroke/TIA  <input type="checkbox"/> Diabetes mellitus  <input type="checkbox"/> [Diabetes mellitus ]with chronic complications  <input type="checkbox"/> Malignancy, hematologic  <input type="checkbox"/> Hemiplegia  <input type="checkbox"/> Paraplegia  <input type="checkbox"/> Quadriplegia  <input type="checkbox"/> Malignancy, solid organ (metastatic)  <input type="checkbox"/> Myocardial infarction</p>

Question on 2018 Form	Question on 2019 Form
	<input type="checkbox"/> Peripheral Vascular Disease (PVD) <input type="checkbox"/> Transplant, solid organ <input type="checkbox"/> Malignancy, solid organ (non-metastatic) <input type="checkbox"/> Transplant, hematopoietic stem cell <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Ascites <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatic encephalopathy <input type="checkbox"/> Variceal bleeding Hepatitis C [Hepatitis C] treated, in SVR [Hepatitis C] current, chronic <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Epilepsy/seizure/seizure disorder <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other [neurological condition] (specify): _____ <input type="checkbox"/> Burn <input type="checkbox"/> Decubitus/pressure ulcer <input type="checkbox"/> Surgical wound <input type="checkbox"/> Other chronic ulcer or chronic wound <input type="checkbox"/> Other[skin condition] (specify): _____ <input type="checkbox"/> Obesity or morbid obesity
<p><b>17b.</b>  <b>ICU Admission</b> (in the 2 calendar days before, the day of, or the 6 calendar days after the date of incident C. diff+ stool collection)  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown            If YES, Date of ICU Admission _____  <input type="checkbox"/> Unknown</p>	<p><b>26, 27</b>  <b>Was the patient in an ICU on the day of or in the 6 days after the date of incident C. diff+ stool collection?</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown            If Yes, date of ICU admission:            ____ - ____ - _____  <input type="checkbox"/> Unknown</p>
<p><b>18, 20.2e</b>  <b>RADIOGRAPHIC FINDINGS</b> (in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident C. diff+ stool collection)  <input type="checkbox"/> Toxic megacolon  <input type="checkbox"/> Ileus  <input type="checkbox"/> Neither toxic megacolon nor ileus  <input type="checkbox"/> Both toxic megacolon and ileus  <input type="checkbox"/> Not Done  <input type="checkbox"/> Information not available</p> <p><b>Other findings</b> (in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident C. diff+ stool collection)  <input type="checkbox"/> Toxic megacolon  <input type="checkbox"/> Ileus  <input type="checkbox"/> Neither toxic megacolon nor ileus</p>	<p><b>28.</b>            Toxic megacolon and ileus (in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident C. diff+ stool collection)  <b>RADIOGRAPHIC FINDINGS</b>  <input type="checkbox"/> Toxic megacolon  <input type="checkbox"/> Ileus  <input type="checkbox"/> Neither toxic megacolon nor ileus  <input type="checkbox"/> Both toxic megacolon and ileus  <input type="checkbox"/> Not Done  <input type="checkbox"/> Information not available</p> <p>Clinical findings  <input type="checkbox"/> Toxic megacolon  <input type="checkbox"/> Ileus  <input type="checkbox"/> Neither toxic megacolon nor ileus  <input type="checkbox"/> Both toxic megacolon and ileus</p>

<b>Question on 2018 Form</b>	<b>Question on 2019 Form</b>
<input type="checkbox"/> Both toxic megacolon and ileus <input type="checkbox"/> Information not available	<input type="checkbox"/> Information not available
<b>17a.</b> <b>Colectomy</b> (related to CDI): ... If YES, Date of Procedure: ____ - ____ - ____	<b>30.</b> <b>Colectomy</b> (related to CDI): ... If YES, Date of Procedure: ____ - ____ - ____ <input type="checkbox"/> Unknown
<b>23d.</b> <b>Antimicrobial therapy</b> ( Check all that apply)  <input type="checkbox"/> Amp/sulb <input type="checkbox"/> Imipenem <input type="checkbox"/> Rifampin <input type="checkbox"/> Tetracycline	<b>33d.</b> <b>Antimicrobial therapy</b> ( Check all that apply)  <input type="checkbox"/> Ampicillin/sulbactam <input type="checkbox"/> Cefixime <input type="checkbox"/> Ceftaroline <input type="checkbox"/> Ceftazidime/avibactam <input type="checkbox"/> Ceftizoxime <input type="checkbox"/> Ceftolozane/tazobactam <input type="checkbox"/> Dalbavancin <input type="checkbox"/> Delafloxacin <input type="checkbox"/> Doripenem <input type="checkbox"/> Fosfomycin <input type="checkbox"/> Imipenem/cilastatin <input type="checkbox"/> Meropenem/vaborbactam <input type="checkbox"/> Oritavancin <input type="checkbox"/> Polymyxin B <input type="checkbox"/> Polymyxin E (colistin) <input type="checkbox"/> Tedizolid <input type="checkbox"/> Telavancin <input type="checkbox"/> Trimethoprim
<b>17c.</b> <b>Any additional positive stool test for C. diff <math>\geq 2</math> and <math>\leq 8</math> weeks after the date of incident C. diff+ stool collection?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Date of first recurrent specimen: ____ - ____ - ____	<b>36.</b> <b>Any recurrent C. diff episodes following this incident C. diff episode?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Date of first recurrent specimen: ____ - ____ - ____
<b>24.</b> Treatment ... <input type="checkbox"/> Probiotics (specify) _____ <input type="checkbox"/> Stool transplant ... Course 1... Course 2... Course 3...	<b>34.</b> Treatment ... Course 1... Course 2... Course 3... <input type="checkbox"/> Probiotics (specify) _____ <input type="checkbox"/> Stool transplant ...

## 12. 2019 HAIC Candidemia Case Report

2018 CRF Question	2019 CRF Question
15. Sex:	15. Sex at birth:

<ul style="list-style-type: none"> <li>• Female</li> <li>• Male</li> <li><input type="checkbox"/> Check if transgender</li> </ul>	<ul style="list-style-type: none"> <li>• Male</li> <li>• Female</li> <li>• Unknown</li> <li>• Check if transgender</li> </ul> <p>(Updated order of responses)</p>																								
<p>19. Race</p> <ul style="list-style-type: none"> <li>• White</li> <li>• Black or African American</li> <li>• American Indian or Alaska Native</li> <li>• Asian</li> <li>• Native Hawaiian or Other Pacific Islander</li> <li>• Unknown</li> </ul>	<p>19. Race (Check all that apply)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native</li> <li>• Asian</li> <li>• Black or African American</li> <li>• Native Hawaiian or Other Pacific Islander</li> <li>• White</li> <li>• Unknown</li> </ul> <p>(Updated question number and order of responses; all response options remain the same)</p>																								
<p>22. Location of specimen collection (check one)</p> <p><b>Hospital inpatient</b> Hospital Inpatient</p> <p>Facility ID: _____</p> <p><input type="checkbox"/> ICU</p> <p><input type="checkbox"/> Surgery/OR</p> <p><input type="checkbox"/> Radiology</p> <p><input type="checkbox"/> Other Unit</p> <p><input type="checkbox"/> Outpatient</p> <p><input type="checkbox"/> Clinic/Doctor's office</p> <p><input type="checkbox"/> Surgery</p> <p><input type="checkbox"/> Dialysis center</p> <p><input type="checkbox"/> Other outpatient</p> <p><input type="checkbox"/> Emergency Room</p> <p><input type="checkbox"/> Observational/clinical decision unit</p> <p><input type="checkbox"/> LTCF Facility ID: _____</p> <p><input type="checkbox"/> LTACH Facility ID: _____</p> <p><input type="checkbox"/> Autopsy</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>22. Location of specimen collection</p> <p>• <b>Outpatient</b> Facility ID: _____</p> <ul style="list-style-type: none"> <li>• Emergency room</li> <li>• Clinic/Doctor's office</li> <li>• Dialysis center</li> <li>• Surgery</li> <li>• Observational/clinical decision unit</li> <li>• Other outpatient</li> </ul> <p>• <b>Inpatient</b> Facility ID: _____</p> <ul style="list-style-type: none"> <li>• ICU</li> <li>• OR</li> <li>• Radiology</li> <li>• Other inpatient</li> </ul> <p>• <b>LTCF</b> Facility ID: _____</p> <p>• <b>LTACH</b> Facility ID: _____</p> <p>• <b>Autopsy</b></p> <p>• <b>Other (specify):</b> _____</p> <p>• <b>Unknown</b></p> <p>(Added checkboxes for headings "Outpatient" and "Inpatient". Added a facility ID for "Outpatient" and "Inpatient". Updated the order of responses).</p>																								
<p>25. Antifungal susceptibility testing (check here <input type="checkbox"/> if no testing done/no test reports available):</p> <table border="1" data-bbox="147 1444 781 1520"> <tr> <td>Amphotericin B</td> <td><input type="checkbox"/> S</td> <td><input type="checkbox"/> SDD</td> <td><input type="checkbox"/> I</td> <td><input type="checkbox"/> R</td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td colspan="5" style="text-align: center;">NS</td> </tr> </table>	Amphotericin B	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/>		NS					<p>25. Antifungal susceptibility testing (check here <input type="checkbox"/> if no testing done/no test reports available):</p> <table border="1" data-bbox="883 1507 1500 1583"> <tr> <td>Amphotericin B</td> <td><input type="checkbox"/> S</td> <td><input type="checkbox"/> SDD</td> <td><input type="checkbox"/> I</td> <td><input type="checkbox"/> R</td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td colspan="2" style="text-align: center;">NS</td> <td><input type="checkbox"/> NI</td> <td><input type="checkbox"/> ND</td> <td><input type="checkbox"/></td> </tr> </table> <p>(added options "NI" and "ND" for each drug –see above for example)</p>	Amphotericin B	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/>		NS		<input type="checkbox"/> NI	<input type="checkbox"/> ND	<input type="checkbox"/>
Amphotericin B	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/>																				
	NS																								
Amphotericin B	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/>																				
	NS		<input type="checkbox"/> NI	<input type="checkbox"/> ND	<input type="checkbox"/>																				
<p>26. Additional non-<i>Candida</i> organisms isolated from blood cultures on the same day as DISC: 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>26a. If yes, additional organisms (Enter up to 3 pathogens): _____, _____, _____</p>	<p>26. Additional non-<i>Candida</i> organisms isolated from blood cultures on the day of or in the 7 days before DISC: 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>26a. If yes, additional organisms (Enter up to 3 pathogens): _____, _____, _____</p>																								
	<p>27. At the time of DISC, was the patient known to be colonized with or being managed as if they were colonized</p>																								

	<p><b>with multi-drug resistant organism (MDRO) infection control (e.g.: on contact precautions)? MDROs include CRE, CRPA, CRAB, MRSA, and VRE.</b></p> <p>1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>27a. If yes, specify organisms (<i>Enter up to 3 pathogens</i>):</p> <p>_____, _____,</p> <p>_____</p> <p>(added new question)</p>
<p><b>29. Other known sites of <i>Candida</i>/yeast infection or colonization in the 7 days before or 3 days after the DISC?</b> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Peritoneal fluid or abdominal cavity</p> <p><input type="checkbox"/> Urine</p> <p><input type="checkbox"/> Respiratory specimen</p> <p><input type="checkbox"/> Pleural fluid</p> <p><input type="checkbox"/> CSF</p> <p><input type="checkbox"/> Bone</p> <p><input type="checkbox"/> Skin</p> <p><input type="checkbox"/> Catheter tip</p> <p><input type="checkbox"/> Other site (specify): _____</p>	<p><b>30. Did the patient have any of the following types of infection/colonization related to their <i>Candida</i> infection?</b> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Abscess</p> <p><input type="checkbox"/> Splenic</p> <p><input type="checkbox"/> Liver</p> <p><input type="checkbox"/> Pulmonary</p> <p><input type="checkbox"/> Candiduria</p> <p><input type="checkbox"/> CNS involvement (meningitis, brain abscess)</p> <p><input type="checkbox"/> Eyes (endophthalmitis or chorioretinitis)</p> <p><input type="checkbox"/> Endocarditis</p> <p><input type="checkbox"/> Peritonitis</p> <p><input type="checkbox"/> Respiratory specimen with <i>Candida</i></p> <p><input type="checkbox"/> Septic emboli</p> <p><input type="checkbox"/> Lungs</p> <p><input type="checkbox"/> Brain</p> <p><input type="checkbox"/> Osteomyelitis</p> <p><input type="checkbox"/> Skin lesions</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>(changed question number, wording slightly and changed more options)</p>
<p>32. Patient outcome: 1 <input type="checkbox"/> Survived 9 <input type="checkbox"/> Unknown</p> <p>Date of discharge:</p> <p>____ - ____ - _____ <input type="checkbox"/> Unknown</p>	<p>33. Patient outcome</p> <p>Date of discharge: 1 <input type="checkbox"/> Survived 9 <input type="checkbox"/> Unknown</p> <p>____ - ____ - _____ <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Left against medical advice (AMA)</p> <p>(updated number and added option for left AMA)</p>
	<p><b>34. Did the patient have any of the following classes or specific ICD-10 codes, including any sub-codes for this hospitalization?</b> (Check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> B37 (candidiasis)</p> <p>Specify sub-code: _____</p> <p>Specify sub-code: _____</p> <p><input type="checkbox"/> P37.5 (neonatal candidiasis)</p> <p><input type="checkbox"/> B48 (other mycoses, not classified elsewhere)</p> <p><input type="checkbox"/> B49 (unspecified mycoses)</p> <p><input type="checkbox"/> T80.211 (BSI due to central venous catheter)</p> <p><input type="checkbox"/> A41.9 (sepsis, unspecified organism)</p> <p><input type="checkbox"/> R65.2 (severe sepsis)</p> <p><b>(new question)</b></p>
<p><b>36. Underlying conditions</b> (Check all that apply): <input type="checkbox"/> <input type="checkbox"/> Malignancy</p> <p><input type="checkbox"/> Malignancy, Hematologic</p>	<p><b>38. Underlying Conditions</b></p> <p><input type="checkbox"/> Chronic Lung Disease <input type="checkbox"/> Liver Disease</p>

<p><b>None</b>    <input type="checkbox"/> <b>Unknown</b></p> <p><input type="checkbox"/> <b>Chronic Lung Disease</b></p> <p><input type="checkbox"/> Cystic Fibrosis</p> <p><input type="checkbox"/> Chronic Pulmonary disease</p> <p><input type="checkbox"/> <b>Chronic Metabolic Disease</b></p> <p><input type="checkbox"/> Diabetes Mellitus</p> <p><input type="checkbox"/> With Chronic Complications</p> <p><input type="checkbox"/> <b>Cardiovascular Disease</b></p> <p><input type="checkbox"/> CVA/Stroke/TIA</p> <p><input type="checkbox"/> Congenital Heart disease</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> Myocardial infarction</p> <p><input type="checkbox"/> Peripheral Vascular Disease (PVD)</p> <p><input type="checkbox"/> <b>Gastrointestinal Disease</b></p> <p><input type="checkbox"/> Diverticular disease</p> <p><input type="checkbox"/> Inflammatory Bowel Disease</p> <p><input type="checkbox"/> Peptic Ulcer Disease</p> <p><input type="checkbox"/> Short gut syndrome</p> <p><input type="checkbox"/> <b>Immunocompromised Condition</b></p> <p><input type="checkbox"/> HIV infection</p> <p><input type="checkbox"/> AIDS/CD4 count &lt;200</p> <p><input type="checkbox"/> Primary Immunodeficiency</p> <p><input type="checkbox"/> Transplant, Hematopoietic Stem Cell</p> <p><input type="checkbox"/> Transplant, Solid Organ</p> <p><input type="checkbox"/> <b>Chronic Liver Disease</b></p> <p><input type="checkbox"/> Ascites</p> <p><input type="checkbox"/> Chronic hepatitis C</p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> Hepatic Encephalopathy</p> <p><input type="checkbox"/> Variceal Bleeding</p>	<p><input type="checkbox"/> Malignancy, Solid Organ (non-metastatic)</p> <p><input type="checkbox"/> Malignancy, Solid Organ (metastatic)</p> <p><input type="checkbox"/> <b>Neurologic Condition</b></p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Chronic Cognitive Deficit</p> <p><input type="checkbox"/> Dementia</p> <p><input type="checkbox"/> Epilepsy/seizure/seizure disorder</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> <b>Plegia s/Paralysis</b></p> <p><input type="checkbox"/> Hemiplegia</p> <p><input type="checkbox"/> Paraplegia</p> <p><input type="checkbox"/> Quadriplegia</p> <p><input type="checkbox"/> <b>Renal Disease</b></p> <p><input type="checkbox"/> Chronic Kidney Disease</p> <p>Lowest serum creatinine: - _____ mg/DL</p> <p><input type="checkbox"/> <b>Skin Condition</b></p> <p><input type="checkbox"/> Burn</p> <p><input type="checkbox"/> Decubitus/Pressure Ulcer</p> <p><input type="checkbox"/> Surgical Wound</p> <p><input type="checkbox"/> Other chronic ulcer or chronic wound</p> <p><input type="checkbox"/> Other skin condition (specify): _____</p> <p><input type="checkbox"/> <b>Other</b></p> <p><input type="checkbox"/> Connective tissue disease</p> <p><input type="checkbox"/> Obesity or morbid obesity</p> <p><input type="checkbox"/> Pregnant</p>	<p><input type="checkbox"/> Cystic Fibrosis</p> <p><input type="checkbox"/> Chronic Pulmonary disease</p> <p><input type="checkbox"/> <b>Chronic Metabolic Disease</b></p> <p><input type="checkbox"/> Diabetes Mellitus</p> <p><input type="checkbox"/> With Chronic Complications</p> <p><input type="checkbox"/> <b>Cardiovascular Disease</b></p> <p><input type="checkbox"/> CVA/Stroke/TIA</p> <p><input type="checkbox"/> Congenital Heart Failure</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> Myocardial infarction</p> <p><input type="checkbox"/> Peripheral Vascular Disease (PVD)</p> <p><input type="checkbox"/> <b>Gastrointestinal Disease</b></p> <p><input type="checkbox"/> Diverticular disease</p> <p><input type="checkbox"/> Inflammatory Bowel Disease</p> <p><input type="checkbox"/> Peptic Ulcer Disease</p> <p><input type="checkbox"/> Short gut syndrome</p> <p><input type="checkbox"/> <b>Immunocompromised Condition</b></p> <p><input type="checkbox"/> HIV infection</p> <p><input type="checkbox"/> AIDS/CD4 count &lt;200</p> <p><input type="checkbox"/> Primary Immunodeficiency</p> <p><input type="checkbox"/> Transplant, Hematopoietic Stem Cell</p> <p><input type="checkbox"/> Transplant, Solid Organ</p> <p><input type="checkbox"/> Chronic Liver Disease</p> <p><input type="checkbox"/> Ascites</p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> Hepatic Encephalopathy</p> <p><input type="checkbox"/> Variceal Bleeding</p> <p><input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> Treated, in SVR</p> <p><input type="checkbox"/> Current, chronic</p> <p><input type="checkbox"/> <b>Malignancy</b></p> <p><input type="checkbox"/> Malignancy, Hematologic</p> <p><input type="checkbox"/> Malignancy, Solid Organ (non-metastatic)</p> <p><input type="checkbox"/> Malignancy, Solid Organ (metastatic)</p> <p><input type="checkbox"/> <b>Neurologic Condition</b></p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Chronic Cognitive Deficit</p> <p><input type="checkbox"/> Dementia</p> <p><input type="checkbox"/> Epilepsy/seizure/seizure disorder</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Other (specify): _____</p>
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(Updated question number, changed wording of Hepatitis C question and added 2 options under hepatitis C: treated, in SVR and current, chronic, cirrhosis; removed "skin conditions" after "other")

<p><b>37. Social History (check all that apply):</b>    <input type="checkbox"/> <b>None</b>    <input type="checkbox"/> <b>Unknown</b></p> <p><input type="checkbox"/> Smoker</p> <p><input type="checkbox"/> E-Cigarette Use</p> <p><input type="checkbox"/> Alcohol Abuse</p> <p><input type="checkbox"/> Injection Drug Use</p> <p><input type="checkbox"/> Skin Popping</p> <p><input type="checkbox"/> Other drug use</p>	<p><b>39. Substance Use</b></p> <p><b>Smoking:</b></p> <ul style="list-style-type: none"> <li>• None</li> <li>• Tobacco</li> <li>• E-nicotine delivery system</li> <li>• Unknown</li> <li>• Marijuana</li> </ul> <p><b>Alcohol Abuse:</b></p> <ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> <li>• Unknown</li> </ul> <p><b>Other Substances (Check all that apply):</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 2px;">• None</td> <td style="width: 33%; padding: 2px;">• Unknown</td> <td style="width: 33%;"></td> </tr> <tr> <td style="padding: 2px;">• Marijuana (other than smoking)</td> <td style="padding: 2px;">• Documented use disorder</td> <td style="padding: 2px;">• IDU • Skin popping • Non-IDU • Unknown</td> </tr> <tr> <td style="padding: 2px;">• Opioid, DEA</td> <td style="padding: 2px;">• Documented</td> <td style="padding: 2px;">• IDU • Skin</td> </tr> </table>	• None	• Unknown		• Marijuana (other than smoking)	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown	• Opioid, DEA	• Documented	• IDU • Skin
• None	• Unknown									
• Marijuana (other than smoking)	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown								
• Opioid, DEA	• Documented	• IDU • Skin								

	schedule I (e.g., heroin)	use disorder	popping • Non-IDU • Unknown
	• Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown
	• Cocaine or methamphetamine	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown
	• Other (Specify):	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown
	• Unknown substance	• Documented use disorder	• IDU • Skin popping • Non-IDU • Unknown
44a. If yes, date of neutropenia ( <i>mm-dd-yyyy</i> ): <input type="text"/> - <input type="text"/> - <input type="text"/> <b>*Neutropenia: ANC ≤ 500 OR calculated as:</b> <b>WBC count * (% polys + % bands) ≤ 500</b> Laboratory-calculated ANC: _____ _____ * (% _____ + % _____) = _____	Removed in the new version		
<b>47. Did the patient have a CVC on the day of incident specimen collection or at any time in the 2 calendar days before DISC?</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Had CVC but can't find dates    9 <input type="checkbox"/> Unknown	<b>51. Did the patient have a CVC in the 2 calendar days before DISC?</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Had CVC but can't find dates 9 <input type="checkbox"/> Unknown (update number and changed wording of question slightly)		
<b>48. Did the patient have a midline catheter on the day of incident specimen collection or at any time in the 2 calendar days before DISC?</b> 1 <input type="checkbox"/> Yes    0 <input type="checkbox"/> No    9 <input type="checkbox"/> Unknown	<b>52. Did the patient have a midline catheter in the 2 calendar days before DISC?</b> 1 <input type="checkbox"/> Yes    0 <input type="checkbox"/> No    9 <input type="checkbox"/> Unknown (updated number and changed working of question slightly)		
NEW QUESTION	<b>53. Did the patient have any of the following indwelling devices present in the 3 calendar days before DISC?</b> <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Indwelling urethral <input type="checkbox"/> Suprapubic <input type="checkbox"/> Respiratory <input type="checkbox"/> ET/NT <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Gastrostomy  (Added new question)		

**Estimated Annualized Burden Hours**

As a result of proposed changes to forms highlighted in yellow, the estimated annualized burden is expected to decrease by 360 hours, from 40,349 to 39,989 and the estimated number of annual responses



is shown to decrease by 8,850 from 115,600 to 106,750 responses. The changes to the amended forms have minimal to no impact on burden estimates.

The following table is updated for the entire 0920-0978 burden table. The forms included in this change request are highlighted:

Type of Respondent	Form Name	No. of respondents	No. of responses per respondent	Avg. burden per response (in hours)	Current Total Burden	After Proposed Changes
State Health Department	ABCs Case Report Form (Att. 1)	10	809	20/60	2697	<b>2697</b>
	ABCs Invasive Pneumococcal Disease in Children Case Report Form	10	22	10/60	37	<b>37</b>
	ABCs <i>H. influenzae</i> Neonatal Sepsis Expanded Surveillance Form (Att. 2)	10	6	10/60	10	<b>10</b>
	ABCs Severe GAS Infection Supplemental Form	10	136	20/60	453	<b>453</b>
	ABCs Neonatal Infection Expanded Tracking Form (Att. 3)	10	37	20/60	123	<b>123</b>
	<del>Surveillance for Non-Invasive Pneumococcal Pneumonia (SNIIPP) FORM DISCONTINUED</del>	<del>10</del>	<del>125</del>	<del>10/60</del>	<del>208</del>	<del>0</del>
	FoodNet Campylobacter	10	850	21/60	2975	<b>2975</b>
	FoodNet Cryptosporidium	10	130	10/60	217	<b>217</b>
	FoodNet Cyclospora	10	3	10/60	5	<b>5</b>
	FoodNet Listeria monocytogenes	10	13	20/60	43	<b>43</b>
	FoodNet Salmonella	10	827	21/60	2895	<b>2895</b>
	FoodNet Shiga toxin producing E. coli	10	190	20/60	633	<b>633</b>
	FoodNet Shigella	10	290	10/60	483	<b>483</b>
	FoodNet Vibrio	10	25	10/60	42	<b>42</b>
	FoodNet Yersinia	10	30	10/60	50	<b>50</b>
	FoodNet Hemolytic Uremic Syndrome	10	10	1	100	<b>100</b>
	Influenza Hospitalization Surveillance Network Case Report Form (Att 4)	10	1000	25/60	4167	<b>4167</b>
	Influenza Hospitalization Surveillance Project Vaccination Phone Script Consent Form (English)	10	333	5/60	278	<b>278</b>
	Influenza Hospitalization Surveillance Project Vaccination Phone Script Consent Form (Spanish)	10	333	5/60	278	<b>278</b>
	Influenza Hospitalization Surveillance Project Provider	10	333	5/60	278	<b>278</b>

	Vaccination History Fax Form (Children/Adults)					
	MuGSI Case Report Form for Carbapenem-resistant Enterobacteriaceae (CRE) and <i>Acinetobacter baumannii</i> (CRAB) (Att 5)	10	500	<del>20/60</del> 25/60	1667	<b>2083</b>
	MuGSI Extended-Spectrum Beta-Lactamase-Producing Enterobacteriaceae (ESBL) (Att 6)	10	1200	<del>20/60</del> 25/60	4000	<b>5000</b>
	MuGSI–Carbapenem-resistant <i>Pseudomonas aeruginosa</i> (CR-PA) FORM DISCONTINUED	<del>10</del>	<del>344</del>	<del>45/60</del>	2580	<b>0</b>
	Invasive Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Infection Case Report Form (Att 7)	10	<del>609</del> 474	<del>20/60</del> 25/60	2030	<b>1975</b>
	Invasive Methicillin-sensitive <i>Staphylococcus aureus</i> (MSSA) Infection Case Report Form (Att 8)	10	<del>1,035</del> 754	<del>20/60</del> 25/60	3450	<b>3142</b>
	CDI Case Report and Treatment Form (Att 9)	10	1650	<del>30/60</del> 35/60	8250	<b>9625</b>
	HAIC Candidemia Case Report (Att 10)	9	800	20/60	2400	<b>2400</b>
TOTAL					40,349	<b>39,985</b>