



Invasive Methicillin-Sensitive Staphylococcus aureus
Healthcare-Associated Infections Community Interface (HAIC) Case Report - 2021

Form Approved
OMB No. 0920-0978
Expires xx/xx/xxxx

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

- PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC -

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

7. SEX AT BIRTH: 8. DATE OF BIRTH: 9. AGE: 10. RACE: (Check all that apply) 13. ETHNIC ORIGIN:

12. WEIGHT: 13. HEIGHT: 14. BMI (record only if ht. and/or wt. is not available) 15. DATE OF INCIDENT SPECIMEN COLLECTION (DISC):

16. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER, THE DISC? 17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?

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

19. LOCATION OF SPECIMEN COLLECTION: 20. WERE CULTURES OS THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?
IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:

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

22. SUSCEPTIBILITY RESULTS [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)]
Cefazolin 1 S 2 I 3 R 9 U Cefoxitin 1 S 3 R 9 U Clindamycin 1 S 2 I 3 R 9 U
Nafcillin 1 S 2 I 3 R 9 U Oxacillin 1 S 3 R 9 U Trimethoprim-Sulfamethoxazole 1 S 2 I 3 R 9 U
Vancomycin 1 S 2 I 3 R 9 U

23. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC? 24. IF CASE IS <12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION:
25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)?

Public reporting burden of this collection of information is estimated to average 28 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

<b>26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>IF YES, date of ICU admission:</b> ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown	<b>27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>IF YES, date of ICU admission:</b> ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown
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**28. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S):** (Check all that apply) 1  None 1  Unknown

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

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

<b>CHRONIC LUNG DISEASE</b> 1 <input type="checkbox"/> Cystic fibrosis 1 <input type="checkbox"/> Chronic pulmonary disease  <b>CHRONIC METABOLIC DISEASE</b> 1 <input type="checkbox"/> Diabetes mellitus 1 <input type="checkbox"/> With chronic complications  <b>CARDIOVASCULAR DISEASE</b> 1 <input type="checkbox"/> CVA/Stroke/TIA 1 <input type="checkbox"/> Congenital heart disease 1 <input type="checkbox"/> Congestive heart failure 1 <input type="checkbox"/> Myocardial infarction 1 <input type="checkbox"/> Peripheral vascular disease (PVD)  <b>GASTROINTESTINAL DISEASE</b> 1 <input type="checkbox"/> Diverticular disease 1 <input type="checkbox"/> Inflammatory bowel disease 1 <input type="checkbox"/> Peptic ulcer disease 1 <input type="checkbox"/> Short gut syndrome	<b>IMMUNOCOMPROMISED CONDITION</b> 1 <input type="checkbox"/> HIV infection 1 <input type="checkbox"/> AIDS/CD4 count <200 1 <input type="checkbox"/> Primary immunodeficiency 1 <input type="checkbox"/> Transplant, hematopoietic stem cell 1 <input type="checkbox"/> Transplant, solid organ  <b>LIVER DISEASE</b> 1 <input type="checkbox"/> Chronic liver disease 1 <input type="checkbox"/> Ascites 1 <input type="checkbox"/> Cirrhosis 1 <input type="checkbox"/> Hepatic encephalopathy 1 <input type="checkbox"/> Variceal bleeding 1 <input type="checkbox"/> Hepatitis C 1 <input type="checkbox"/> Treated, in SVR 1 <input type="checkbox"/> Current, chronic	<b>MALIGNANCY</b> 1 <input type="checkbox"/> Malignancy, hematologic 1 <input type="checkbox"/> Malignancy, solid organ (non-metastatic) 1 <input type="checkbox"/> Malignancy, solid organ (metastatic)  <b>NEUROLOGIC CONDITION</b> 1 <input type="checkbox"/> Cerebral palsy 1 <input type="checkbox"/> Chronic cognitive deficit 1 <input type="checkbox"/> Dementia 1 <input type="checkbox"/> Epilepsy/seizure/seizure disorder 1 <input type="checkbox"/> Multiple sclerosis 1 <input type="checkbox"/> Neuropathy 1 <input type="checkbox"/> Parkinson's Disease 1 <input type="checkbox"/> Other (specify): _____ _____  <b>PLEGIAS/PARALYSIS</b> 1 <input type="checkbox"/> Hemiplegia 1 <input type="checkbox"/> Paraplegia 1 <input type="checkbox"/> Quadriplegia	<b>RENAL DISEASE</b> 1 <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____mg/DL 1 <input type="checkbox"/> Unknown or not done  <b>SKIN CONDITION</b> 1 <input type="checkbox"/> Burn 1 <input type="checkbox"/> Decubitus/pressure ulcer 1 <input type="checkbox"/> Surgical wound 1 <input type="checkbox"/> Other chronic ulcer or chronic wound 1 <input type="checkbox"/> Other skin condition (specify): _____ _____  <b>OTHER</b> 1 <input type="checkbox"/> Connective tissue disease 1 <input type="checkbox"/> Obesity or morbid obesity 1 <input type="checkbox"/> Pregnant 1 <input type="checkbox"/> Other (specify only for cases ≤12 months of age): _____ _____
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**30. WAS THE PATIENT HOMELESS IN THE YEAR BEFORE DISC?** 1  Yes 2  No 9  Unknown

**31. SUBSTANCE USE:**

<b>SMOKING:</b> 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Tobacco 1 <input type="checkbox"/> E-nicotine delivery system 1 <input type="checkbox"/> Marijuana	<b>ALCOHOL ABUSE:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
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**OTHER SUBSTANCES (CHECK ALL THAT APPLY):** 1  None 1  Unknown

1 <input type="checkbox"/> Marijuana, cannabinoid (other than smoking) 1 <input type="checkbox"/> Opioid, DEA schedule I (e.g., Heroin) 1 <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone) 1 <input type="checkbox"/> Opioid, NOS 1 <input type="checkbox"/> Cocaine 1 <input type="checkbox"/> Methamphetamine 1 <input type="checkbox"/> Other (specify): _____ _____ 1 <input type="checkbox"/> Unknown substance	<b>DOCUMENTED USE DISORDER (DUD/ABUSE):</b> 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse	<b>MODE OF DELIVERY (Check all that apply):</b> 1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
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**DURING THE CURRENT HOSPITALIZATION DID THE PATIENT RECEIVE MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER?** 1  Yes 2  No 9  N/A (patient not hospitalized or did not have DUD)

**32. PRIOR HEALTHCARE EXPOSURE(S):**

**PREVIOUS DOCUMENTED MSSA INFECTION OR COLONIZATION**

1  Yes 2  No 9  Unknown

If YES: \_\_\_\_\_ OR previous STATE I.D.: \_\_\_\_\_  
Month Year

**OVERNIGHT STAY IN LTACH IN THE YEAR BEFORE DISC**

1  Yes 2  No 9  Unknown

Facility ID: \_\_\_\_\_

**PREVIOUS HOSPITALIZATION IN THE YEAR BEFORE DISC**

1  Yes 2  No 9  Unknown

If YES, DATE OF DISCHARGE CLOSEST TO DISC: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

OR, 1  Date unknown

Facility ID: \_\_\_\_\_

**OVERNIGHT STAY IN LTCF IN THE YEAR BEFORE DISC**

1  Yes 2  No 9  Unknown

Facility ID: \_\_\_\_\_

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

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

Surgery Date

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

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

1  Yes 2  No 9  Unknown

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

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

1  Yes 2  No 9  Unknown

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

TYPE: 1  Hemodialysis 1  Peritoneal 1  Unknown

**IF HEMODIALYSIS**, type of vascular access:

1  AV fistula/graft 2  Hemodialysis central line 9  Unknown

**33. PATIENT OUTCOME** 1  Survived

2  Died

2  Unknown

DATE OF DISCHARGE: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ OR 1  Date Unknown

DATE OF DEATH: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ OR 1  Date Unknown

1  Left against medical advice (AMA)

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?

IF SURVIVED, DISCHARGED TO:

- 1  Private Residence 4  Other (specify): \_\_\_\_\_
- 2  LTCF Facility ID: \_\_\_\_\_
- 3  LTACH Facility ID: \_\_\_\_\_ 9  Unknown

**34a. DID THE PATIENT HAVE A POSITIVE TEST FOR SARS-CoV-2 (MOLECULAR ASSAY, SEROLOGY OR OTHER CONFIRMATORY TEST) ON OR BEFORE THE DISC?** 1  Yes 2  No 9  Unknown

COVID-NET CASE ID \_\_\_\_\_

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

CDC 2019 NCOV ID: \_\_\_\_\_

Local case ID: \_\_\_\_\_ Local record ID: \_\_\_\_\_ State case identifier: \_\_\_\_\_ Legacy case identifier: \_\_\_\_\_

IF YES, COMPLETE TABLE BELOW

IF YES, COMPLETE TABLE BELOW	Specimen collection date	Test Type
FIRST positive test for SARS-CoV-2 on or before the DISC:	____ - ____ - ____ 1 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Molecular assay 1 <input type="checkbox"/> Serology 1 <input type="checkbox"/> Method unknown 1 <input type="checkbox"/> Other (specify): _____
MOST RECENT positive test for SARS-CoV-2 on or before the DISC:	____ - ____ - ____ 1 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Molecular assay 1 <input type="checkbox"/> Serology 1 <input type="checkbox"/> Method unknown 1 <input type="checkbox"/> Other (specify): _____

**34. WAS CASE FIRST IDENTIFIED THROUGH AUDIT?**

1  Yes 2  No  
9  Unknown

**35. CRF STATUS:**

- 1  Complete  
 2  Incomplete  
 3  Edited & Correct  
 4  Chart unavailable after 3 requests

**36. DOES THIS CASE HAVE RECURRENT MRSA DISEASE?**

1  Yes 2  No  
9  Unknown

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

\_\_\_\_\_

**37. DATE REPORTED TO EIP SITE:**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

**38. DATE ABSTRACTION:**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

**39. S.O. INITIALS:**

\_\_\_\_\_

**40. COMMENTS:**