



Respiratory Tract Infection Event

Page 1 of 4

*Required for saving

*Facility ID:		Event #:	
*Resident ID:		Secondary ID:	Medicare #:
Resident Name, Last:		First:	Middle:
*Gender: M F Other		*Date of Birth:	
Ethnicity (Specify):		Race (Specify):	
*Date of First Admission to Facility		*Date of Current Admission to Facility	
Event Details			
*Event Type: RTI		*Date of Event:	
*Resident Care Location			
*Primary Resident Service Type (check one)			
<input type="checkbox"/> Long-term general nursing <input type="checkbox"/> Long-term dementia <input type="checkbox"/> Skilled nursing/Short-term rehab <input type="checkbox"/> Ventilator <input type="checkbox"/> Long-term psychiatric <input type="checkbox"/> Bariatric <input type="checkbox"/> Hospice/Palliative			
*Ventilator: YES NO		Date of Device Insertion:	Location of Device Insertion:
*Imaging: Was a Chest X-Ray Performed: <input type="checkbox"/> YES <input type="checkbox"/> NO			
Findings: <input type="checkbox"/> New infiltrate <input type="checkbox"/> New Consolidation <input type="checkbox"/> Other findings consistent with pneumonia <input type="checkbox"/> Negative			
*Specify Criteria Used (check all that apply)			
<u>Constitutional Signs and Symptoms:</u>			
Fever: which of the following were documented		Any acute change in mental status from baseline	
<input type="checkbox"/> Single temperature > 37.8° C (>100° F) <input type="checkbox"/> Repeated temperatures >37.2° C (99° F) <input type="checkbox"/> Single temperature >1.1° C (2° F) over baseline <input type="checkbox"/> Term "fever" documented without value		<input type="checkbox"/> Fluctuating: behavior fluctuating <input type="checkbox"/> Inattention: difficulty focusing attention <input type="checkbox"/> Confusion/disorganized thinking <input type="checkbox"/> Altered consciousness	
Acute functional decline: increase in assistance with activities of daily living (ADL) from baseline:			
<input type="checkbox"/> Bed mobility <input type="checkbox"/> Dressing <input type="checkbox"/> Eating <input type="checkbox"/> Toilet Use <input type="checkbox"/> Transfer <input type="checkbox"/> Personal hygiene <input type="checkbox"/> Locomotion within the facility			
Leukocytosis: <i>documentation of at least one of the following</i>			
<input type="checkbox"/> Neutrophilia >10,000 leukocytes per/ml ³ (enter value) _____ <input type="checkbox"/> Left shift (6% bands or ≥ 1,500 bands/mm ³)			
<u>Respiratory Signs and Symptoms:</u>			
Decreased oxygenation: <i>documentation of at least one of the following</i>			
<input type="checkbox"/> Pulse oximetry with single O ₂ saturation < 94% <input type="checkbox"/> Pulse oximetry with single O ₂ saturation with reduction of >3% <input type="checkbox"/> Resident newly placed on oxygen			
<input type="checkbox"/> Respiratory rate >24 breaths per minute <input type="checkbox"/> New onset hypotension <input type="checkbox"/> Pulse >100 <input type="checkbox"/> Rigors or chills <input type="checkbox"/> Malaise <input type="checkbox"/> New onset hypothermia <input type="checkbox"/> Myalgia or body aches <input type="checkbox"/> Loss of appetite or decreased oral intake			
<input type="checkbox"/> New or increased cough <input type="checkbox"/> New or increase sputum production <input type="checkbox"/> Pleuritic chest pain <input type="checkbox"/> Runny nose or sneezing <input type="checkbox"/> Abnormal lung exam (new or changed) <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Sore throat, difficulty swallowing, hoarseness <input type="checkbox"/> Headache or eye pain <input type="checkbox"/> Swollen or tender glands in the neck <input type="checkbox"/> No documented respiratory signs or symptoms			
<u>Laboratory/Diagnostic</u>			
<input type="checkbox"/> Positive flu PCR <input type="checkbox"/> Positive legionella urinary antigen testing <input type="checkbox"/> Positive S. pneumonia urinary antigen <input type="checkbox"/> Positive sputum culture			
*Specific Event Type (check one): <input type="checkbox"/> PNA 1 <input type="checkbox"/> PNA 2 <input type="checkbox"/> PNA 3 <input type="checkbox"/> LRI 1 <input type="checkbox"/> LRI 2			
*Secondary Bloodstream Infection: Yes No			
Died: Yes No		Event contributed to death? Yes No	
*Transferred to acute care facility within 7 days: Yes No		*Pathogens Identified: Yes No *If yes, specify on Page 2	
<small>Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).</small>			
<small>Public reporting burden of this collection of information is estimated to average 35 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, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).</small>			
<small>CDC 57.115 (Front) Rev 6 V. 8.6</small>			

Respiratory Tract Infection Event

Page 2 of 4

Pathogen #	Gram-positive Organisms								
_____	<i>Staphylococcus</i> coagulase-negative (specify species if available):		VANC SIRN						
_____	_____ <i>Enterococcus faecium</i>	DAPTO SNSN	GENTHL^s SRN	LNZ SIRN	VANC SIRN				
_____	_____ <i>Enterococcus faecalis</i>								
_____	_____ <i>Enterococcus</i> spp. (Only those not identified to the species level)								
_____	<i>Staphylococcus aureus</i>	CIPRO/LEVO/MOXI SIRN	CLIND SIRN	DAPTO SNSN	DOXY/MINO SIRN	ERYTH SIRN	GENT SIRN	LNZ SRN	
		OX/CEFOX/METH SIRN	RIF SIRN	TETRA SIRN	TIG SNSN	TMZ SIRN	VANC SIRN		
Pathogen #	Gram-negative Organisms								
_____	<i>Acinetobacter</i> (specify species)	AMK SIRN	AMPSUL SIRN	AZT SIRN	CEFEP SIRN	CEFTAZ SIRN	CIPRO/LEVO SIRN	COL/PB SIRN	
_____		GENT SIRN	IMI SIRN	MERO/DORI SIRN		PIP/PIPTAZ SIRN	TETRA/DOXY/MINO SIRN		
_____		TMZ SIRN	TOBRA SIRN						
_____	<i>Escherichia coli</i>	AMK SIRN	AMP SIRN	AMPSUL/AMXCLV SIRN		AZT SIRN	CEFAZ SIRN	CEFEP S I/S-DDRN	CEFOT/CEFTRX SIRN
_____		CEFTAZ SIRN	CEFUR SIRN	CEFOX/CETET SIRN		CIPRO/LEVO/MOXI SIRN	COL/PB[†] SRN		
_____		ERTA SIRN	GENT SIRN	IMI SIRN	MERO/DORI SIRN	PIPTAZ SIRN	TETRA/DOXY/MINO SIRN		
_____		TIG SIRN	TMZ SIRN	TOBRA SIRN					
_____	<i>Enterobacter</i> (specify species)	AMK SIRN	AMP SIRN	AMPSUL/AMXCLV SIRN		AZT SIRN	CEFAZ SIRN	CEFEP S I/S-DDRN	CEFOT/CEFTRX SIRN
_____		CEFTAZ SIRN	CEFUR SIRN	CEFOX/CETET SIRN		CIPRO/LEVO/MOXI SIRN	COL/PB[†] SRN		
_____		ERTA SIRN	GENT SIRN	IMI SIRN	MERO/DORI SIRN	PIPTAZ SIRN	TETRA/DOXY/MINO SIRN		
_____		TIG SIRN	TMZ SIRN	TOBRA SIRN					
_____	_____ <i>Klebsiella pneumoniae</i>	AMK SIRN	AMP SIRN	AMPSUL/AMXCLV SIRN		AZT SIRN	CEFAZ SIRN	CEFEP S I/S-DDRN	CEFOT/CEFTRX SIRN
_____	_____ <i>Klebsiella oxytoca</i>	CEFTAZ SIRN	CEFUR SIRN	CEFOX/CETET SIRN		CIPRO/LEVO/MOXI SIRN	COL/PB[†] SRN		
_____		ERTA SIRN	GENT SIRN	IMI SIRN	MERO/DORI SIRN	PIPTAZ SIRN	TETRA/DOXY/MINO SIRN		
_____		TIG SIRN	TMZ SIRN	TOBRA SIRN					

Respiratory Tract Infection Event

Page 3 of 4

Pathogen #	Gram-negative Organisms (<i>continued</i>)									
_____	<i>Pseudomonas aeruginosa</i>	AMK SIR N	AZT SIR N	CEFEP SIR N	CEFTAZ SIR N	CIPRO/LEVO SIR N	COL/PB SIR N	GENT SIR N		
		IMI SIR N	MERO/DORI SIR N	PIP/PIPTAZ SIR N	TOBRA SIR N					
Pathogen #	Fungal Organisms									
_____	<i>Candida</i> (specify species if available) _____	ANID SIR N	CASPO S NS N	FLUCO S S-DD R N	FLUCY SIR N	ITRA S S-DD R N	MICA S NS N	VORI S S-DD R N		
Pathogen #	Other Organisms									
_____	Organism 1 (specify) _____	Drug 1 SIR N	Drug 2 SIR N	Drug 3 SIR N	Drug 4 SIR N	Drug 5 SIR N	Drug 6 SIR N	Drug 7 SIR N	Drug 8 SIR N	Drug 9 SIR N
_____	Organism 1 (specify) _____	Drug 1 SIR N	Drug 2 SIR N	Drug 3 SIR N	Drug 4 SIR N	Drug 5 SIR N	Drug 6 SIR N	Drug 7 SIR N	Drug 8 SIR N	Drug 9 SIR N
_____	Organism 1 (specify) _____	Drug 1 SIR N	Drug 2 SIR N	Drug 3 SIR N	Drug 4 SIR N	Drug 5 SIR N	Drug 6 SIR N	Drug 7 SIR N	Drug 8 SIR N	Drug 9 SIR N

Result Codes

S = Susceptible I = Intermediate R = Resistant NS = Non-susceptible S-DD = Susceptible-dose dependent N = Not tested

[§] **GENTHL results: S = Susceptible/Synergistic and R = Resistant/Not Synergistic**

[†] **Clinical breakpoints have not been set by FDA or CLSI, Sensitive and Resistant designations should be based upon epidemiological cutoffs of Sensitive MIC ≤ 2 and Resistant MIC ≥ 4**

Drug Codes:

AMK = amikacin	CEFTRX = ceftriaxone	FLUCY = flucytosine	OX = oxacillin
AMP = ampicillin	CEFUR= cefuroxime	GENT = gentamicin	PB = polymyxin B
AMPSUL = ampicillin/sulbactam	CETET= cefotetan	GENTHL = gentamicin –high level test	PIP = piperacillin
AMXCLV = amoxicillin/clavulanic acid	CIPRO = ciprofloxacin	IMI = imipenem	PIPTAZ = piperacillin/tazobactam
ANID = anidulafungin	CLIND = clindamycin	ITRA = itraconazole	RIF = rifampin
AZT = aztreonam	COL = colistin	LEVO = levofloxacin	TETRA = tetracycline
CASPO = caspofungin	DAPTO = daptomycin	LNZ = linezolid	TIG = tigecycline
CEFAZ= ceftazidime	DORI = doripenem	MERO = meropenem	TMZ = trimethoprim/sulfamethoxazole
CEFEP = cefepime	DOXY = doxycycline	METH = methicillin	TOBRA = tobramycin
CEFOT = cefotaxime	ERTA = ertapenem	MICA = micafungin	VANC = vancomycin
CEFOX= ceftoxitin	ERYTH = erythromycin	MINO = minocycline	VORI = voriconazole
CEFTAZ = ceftazidime	FLUCO = fluconazole	MOXI = moxifloxacin	



Respiratory Tract Infection Event

Page 4 of 4

Custom Fields

Label		Label	
_____	___/___/___	_____	___/___/___
-		-	
_____	_____	_____	_____
-		-	
_____	_____	_____	_____
-		-	
_____	_____	_____	_____
-		-	
_____	_____	_____	_____
-		-	
_____	_____	_____	_____
-		-	
_____	_____	_____	_____
-		-	

Comments



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

Custom Fields

--