

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA) FORM  
3b: FLUOROQUINOLONE**

CDC ID: -

Date: //

Data collector initials: \_\_\_\_\_

Drugs given (check all that apply):  Ciprofloxacin  Levofloxacin  Moxifloxacin  Delafloxacin

**Infections and other antimicrobial drugs**

**1. Which infections present during the hospitalization, as reported on the GPA form (question 6), were being treated with a fluoroquinolone?**  None

- Infection no. 1 (site \_\_\_\_\_)  Infection no. 2 (site \_\_\_\_\_)  Infection no. 3 (site \_\_\_\_\_)  
 Infection no. 4 (site \_\_\_\_\_)  Infection not listed in table due to >4 infections (site \_\_\_\_\_)  
 Unknown

**2. Did the patient receive other antimicrobial drugs in the hospital during the period defined by the date that was 5 days before the first date of fluoroquinolone and the date that was 5 days after the last date of fluoroquinolone?**

- Yes—complete table below  
 No  
 Unknown

**2a. Other antimicrobial drugs given in the hospital:**

5 days before fluoroquinolone first date\*: \_\_\_/\_\_\_/\_\_\_\_

5 days after fluoroquinolone last date\*\*: \_\_\_/\_\_\_/\_\_\_\_

No.	Drug name***	First date (mm/dd/yy)	First Route	Last date (mm/dd/yy)	Last Route
1		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
2		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
3		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
4		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
5		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
6		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
7		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
8		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
9		___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___/___/___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH

10		___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
11		___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
12		___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
13		___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
14		___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH
15		___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH	___ / ___ / ___ <input type="checkbox"/> Unk	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH

\*or admission date if fluoroquinolone first date ≤5 days after admission

\*\*or discharge date if fluoroquinolone last date ≤5 days before discharge

\*\*\*Enter separate records for vancomycin IV and vancomycin PO

More drugs than fit in the table:

Laboratory testing CDC ID: -

3. Complete the table for POSITIVE cultures collected from the date 5 days before fluoroquinolone first date (5 days before: \_\_\_/\_\_\_/\_\_\_) through the fluoroquinolone last date (\_\_\_/\_\_\_/\_\_\_): No positive cultures:  Culture data unknown:

No.	Specimen	Collect date (mm/dd/yy)	Test result final date (mm/dd/yy)	Pathogens identified (insert code)	Pathogen susceptible to ciprofloxacin?	Pathogen susceptible to levofloxacin?	Pathogen susceptible to moxifloxacin?	Pathogen susceptible to delafloxacin?	Antimicrobial drugs given on the DAY AFTER the test result was final	Were pathogens susceptible (S) to ≥1 antimicrobial the patient was getting the DAY AFTER the test result was final?
1	<input type="checkbox"/> Blood <input type="checkbox"/> <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>
2	<input type="checkbox"/> Blood <input type="checkbox"/> <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>
3	<input type="checkbox"/> Blood <input type="checkbox"/> <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>
4	<input type="checkbox"/> Blood <input type="checkbox"/> <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>
5	<input type="checkbox"/> Blood <input type="checkbox"/> <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>
6	<input type="checkbox"/> Blood <input type="checkbox"/> <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>

7	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>
8	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>
9	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>
10	<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Lower resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>

More positive cultures than fit in the table:

CDC ID: -

**4. Complete the table for NEGATIVE cultures collected from 5 days before fluoroquinolone first date through the fluoroquinolone last date:**

No negative cultures:  Culture data unknown:

No.	Collect date (mm/dd/yy)	Specimen	Culture result final date (mm/dd/yy)	No.	Collect date (mm/dd/yy)	Specimen	Culture result final date (mm/dd/yy)
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___	6	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___	7	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___	8	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___
4	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___	9	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___
5	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___	10	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	___/___/___

More negative cultures than fit in the table:

**5. Complete the table for non-culture microbiology tests (positive and negative) collected from 5 days before fluoroquinolone first date through the fluoroquinolone last date:**

No non-culture tests done:  Non-culture test data unknown:

No.	Collect date (mm/dd/yy)	Specimen	Test	What pathogen(s) were tested for?	Result
1	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafllu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____ Path3_____
2	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafllu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____ Path3_____
3	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafllu	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1_____Path2_____ Path3_____

		<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	
4	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafllu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
5	___ / ___ / ___	<input type="checkbox"/> Blood <input type="checkbox"/> Lower resp <input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno <input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Parafllu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____

More tests than fit in the table:

**IV to PO conversion**

**6. Between the fluoroquinolone first date and the fluoroquinolone last date, was there a conversion from IV to PO fluoroquinolone administration? Check one:**

- Yes → Date of conversion from IV to PO administration: \_\_\_ / \_\_\_ / \_\_\_ or  Date unknown
- No → For example, patient received only IV fluoroquinolones, or was switched from PO to IV fluoroquinolones, or was switched from IV to PO to IV.
- Not applicable → Patient received only PO fluoroquinolones.
- Unknown

CDC ID: -

**Post-discharge antimicrobial treatment**

**7. Was a fluoroquinolone prescribed at discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge)?**

- Yes  No  Unknown

**7a. If yes to question 7, what drug(s) were prescribed? Check all that apply:**

Drug	Route (check all that apply)
<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> IV <input type="checkbox"/> PO <input type="checkbox"/> Unknown
<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> IV <input type="checkbox"/> PO <input type="checkbox"/> Unknown
<input type="checkbox"/> Moxifloxacin	<input type="checkbox"/> IV <input type="checkbox"/> PO <input type="checkbox"/> Unknown
<input type="checkbox"/> Delafloxacin	<input type="checkbox"/> IV <input type="checkbox"/> PO <input type="checkbox"/> Unknown

**7b. If yes to question 7, what is the total duration of the post-discharge fluoroquinolone prescription?**  
 \_\_\_ days, OR the prescription end date is \_\_\_ / \_\_\_ / \_\_\_, OR  Duration is unknown

**7c. Were any other antimicrobial drugs prescribed at discharge?**

- Yes  No  Unknown

**7d. If yes to question 7c, what drugs were prescribed?**

No.	Drug name	Route (check all that apply)
1		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unknown
2		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unknown
3		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unknown
4		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unknown
5		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unknown

**\*\*\*FORM IS COMPLETE\*\*\***