

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA)  
FORM 3d: UTI**

CDC ID: -

Date: //

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

**Clinical information**

**1. Check any of the following ICD-10 codes that were present on admission for this patient:**  None

N10     N11.0     N11.1     N11.8     N11.9     N12     N15.1     N15.9     N16     N28.84  
 N28.85     N28.86     N30.00     N30.01     N30.10     N30.11     N30.20     N30.21     N30.30     N30.31  
 N30.40     N30.41     N30.80     N30.81     N30.90     N30.91     N34.0     N34.1     N34.2     N39.0  
 R82.71     R82.90     N41.0     N41.1     N41.2     B37.49     O23.00     Other (specify): \_\_\_\_\_

**2. UTI onset date (mm/dd/yy):** \_\_\_ / \_\_\_ / \_\_\_ or

Prior to survey hospitalization but specific date unknown     Unable to determine

**3. UTI signs and symptoms in first 2 hospital days; check all that apply:**  None

Fever                                     Frequency                                     Costovertebral angle (CVA) pain or tenderness  
 Nausea or vomiting                     Visible blood in urine                     Suprapubic pain, swelling or tenderness  
 Urgency                                     Abdominal pain                             Mental status changes or functional decline  
 Rigors                                       Urinary incontinence                     Pain or burning with urination

**4. Did the patient have an indwelling urinary catheter in place for ≥2 days on the day of UTI onset or on the day prior to UTI onset (or if onset date unknown, on the day of survey hospital admission)?**

Yes     No     Unknown

**4a. If yes, were any of the following done within 5 days after UTI onset date (or if onset date unknown, within 5 days after survey hospital admission)?**

Catheter changed     Catheter removed     Catheter neither changed nor removed     Unknown

**Antimicrobial treatment**

**5. Was the patient receiving antimicrobial treatment for this UTI before the survey hospitalization?**

Yes     No     Unknown

**6. Present-on-admission (POA) UTI treatment during the survey hospitalization:**

First date (mm/dd/yy): \_\_\_ / \_\_\_ / \_\_\_ or  Unknown    Last date (mm/dd/yy): \_\_\_ / \_\_\_ / \_\_\_ or  Unknown

**7. Complete the table for all antimicrobial drugs given to treat POA UTI during the survey hospitalization:**

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

	INH	INH
More than 5 antimicrobial drugs were given to treat POA UTI: <input type="checkbox"/>		

CDC ID: -

**Antimicrobial treatment**

**7a. Did the patient receive other antimicrobial drugs in the hospital during the POA UTI treatment period?**

Yes—complete table below in 7b.     No     Unknown

**7b. Other antimicrobial drugs given in the hospital (during the UTI treatment period defined by the dates in #6):**

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

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

More drugs than fit in the table:

**8. Were antimicrobial drugs prescribed at hospital discharge (i.e., prescribed to be administered to the patient for additional days after hospital discharge) to treat POA UTI or for other reasons?**

Yes     No     Unknown

**8a. Antimicrobial drugs prescribed at discharge for POA UTI or other reasons (enter POA UTI drugs first):**

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

More drugs than fit in the table:

**8b. If antimicrobial drugs were prescribed at discharge for POA-UTI, what was the total duration of the post-discharge POA UTI treatment?**

\_\_\_\_\_ days, OR the prescription end date is \_\_\_/\_\_\_/\_\_\_\_\_, OR  Duration is unknown



**Laboratory testing**

9. Complete table below for POSITIVE cultures collected in the first 5 hospital days ( \_\_\_ / \_\_\_ / \_\_\_ through \_\_\_ / \_\_\_ / \_\_\_):

No positive cultures:

Culture data unknown:

No	Specimen	Collect date (mm/dd/yy)	Culture result final date (mm/dd/yy)	Pathogens identified (insert codes)	Culture growth quantity* for urine cultures only	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"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	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
2	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	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
3	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	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
4	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	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
5	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	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
6	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp <input type="checkbox"/> Urine cath <input type="checkbox"/> Stool <input type="checkbox"/> Urine other <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	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

7	<input type="checkbox"/> Urine CC <input type="checkbox"/> Lower resp	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
	<input type="checkbox"/> Urine cath <input type="checkbox"/> Stool				Path2: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk		Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
8	<input type="checkbox"/> Urine other <input type="checkbox"/> Blood	___/___/___	___/___/___	Path1 _____ Path2 _____ Path3 _____	Path3: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk	Drug1 _____ Drug2 _____ Drug3 _____ Drug4 _____	Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
	<input type="checkbox"/> Other _____				Path1: <input type="checkbox"/> ≥10 <sup>5</sup> CFU/ml or similar <input type="checkbox"/> <10 <sup>5</sup> or similar <input type="checkbox"/> Unk		Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

More positive cultures than fit in the table:

Urine CC=urine clean catch. Urine cath=urine collected from an indwelling urinary catheter. Urine other=urine collected via other or unspecified means.

\*Check "≥10<sup>5</sup> CFU/ml or similar" if quantity of growth in the culture is reported to be as follows: moderate, many, heavy, abundant, etc.; Check "<10<sup>5</sup> or similar" if quantity of growth in the culture is reported to be <10<sup>5</sup> CFU/ml or as follows: few, scarce, scant, rare, etc. Check "unknown" if no organism quantity is noted in the culture report.

CDC ID: -



No.	Urinalysis date (mm/dd/yy)	Pyuria (>5 WBCs / hpf)	Nitrites	Leukocyte esterase	Bacteria	Yeast	
<b>10. Complete the table for NEGATIVE cultures collected in the first 5 hospital days:</b>							
No negative cultures: <input type="checkbox"/> Culture data unknown: <input type="checkbox"/>							
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"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____		6	___/___/___	<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:

**11. Complete the table for urinalyses collected in the first 5 hospital days:**

No urinalyses done:  Unknown whether urinalyses were done:

**12. Complete the table for non-culture tests (positive and negative) collected in the first 5 hospital days:**

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"/> Paraflu <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"/> PCR <input type="checkbox"/> DFA	<input type="checkbox"/> Legionella <input type="checkbox"/> Cdiff <input type="checkbox"/> RSV <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Adeno	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code):

		<input type="checkbox"/> Upper resp <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Other _____	<input type="checkbox"/> Antigen test <input type="checkbox"/> Other _____	<input type="checkbox"/> Influenza <input type="checkbox"/> hMPV <input type="checkbox"/> Paraflu <input type="checkbox"/> Other _____	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"/> 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"/> Paraflu <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____
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"/> Paraflu <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"/> Paraflu <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:

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