

HAI & ANTIMICROBIAL USE PREVALENCE SURVEY: ANTIMICROBIAL QUALITY ASSESSMENT (AQUA)

FORM 3c: CAP

Form Approved
OMB No. 0920-0852
Exp. Date 03/31/2025

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 Unknown

- J09.X1 J09.X2 J09.X3 J10.00 J10.01 J10.08 J10.1 J10.2 J10.81 J10.82
J10.83 J10.89 J11.00 J11.08 J11.1 J11.2 J11.81 J11.82 J11.83 J11.89
J12.0 J12.1 J12.2 J12.3 J12.81 J12.89 J12.9 J13 J14 J15.0
J15.1 J15.3 J15.4 J15.20 J15.211 J15.212 J15.29 J15.5 J15.6 J15.7
J15.8 J15.9 J16.0 J16.8 J18.0 J18.1 J18.9 A48.1 Other (specify): _____

2. CAP onset date (mm/dd/yy): ___ / ___ / ___ or
Prior to survey hospitalization but specific date unknown Unable to determine

3. CAP signs and symptoms in first 2 hospital days; check all that apply: None
- | | | |
|--|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Increased secretions/sputum production | <input type="checkbox"/> Grunting |
| <input type="checkbox"/> Chills or rigors | <input type="checkbox"/> Hemoptysis | <input type="checkbox"/> Nasal flaring |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Head bobbing |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Mental status changes or functional decline | <input type="checkbox"/> Chest wall retractions |
| <input type="checkbox"/> O ₂ saturation < 90% | <input type="checkbox"/> Apnea | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Rhinorrhea | <input type="checkbox"/> Muscle aches |

4. Did the patient require mechanical ventilation at any time during the hospitalization?

- Yes
No
Unknown

4a. If yes, was the patient removed from mechanical ventilation before hospital discharge?

- Yes, clinical status improved
Yes, removed from mechanical ventilation for end-of-life care (or for reasons other than improvement)
No
Unknown

5. Complete the chest imaging table, recording studies done in the first 5 hospital days (___ / ___ / ___ through ___ / ___ / ___):

No imaging studies done: Unknown whether imaging studies were done:

	Date (mm/dd/yy)	Findings on chest imaging studies		
1	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
2	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
3	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates <input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia <input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these
4	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> New or worsening infiltrates	<input type="checkbox"/> Air space density/opacity <input type="checkbox"/> No evidence of pneumonia	<input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitation <input type="checkbox"/> Pleural <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> None of these

		<input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> effusion	
5	___ / ___ / ___	<input type="checkbox"/> Bronchopneumonia/pneumonia	<input type="checkbox"/> Air space density/opacity	<input type="checkbox"/> Consolidation	<input type="checkbox"/> Cannot rule out pneumonia
		<input type="checkbox"/> New or worsening infiltrates	<input type="checkbox"/> No evidence of pneumonia	<input type="checkbox"/> Cavitation	<input type="checkbox"/> None of these
		<input type="checkbox"/> Infiltrate, single lobe	<input type="checkbox"/> Infiltrate, multiple lobes	<input type="checkbox"/> Pleural effusion	

CDC ID: -

Antimicrobial drug treatment

6. Was the patient receiving antimicrobial treatment for this episode of CAP before the survey hospitalization?

Yes No Unknown

7. CAP treatment during the survey hospitalization:

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

8. Complete the table for all antimicrobial drugs given to treat CAP 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"/> <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"/> <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"/> <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"/> <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"/> <input type="checkbox"/> PO <input type="checkbox"/> INH

More than 5 antimicrobial drugs were given to treat CAP:

8a. Did the patient receive other antimicrobial drugs in the hospital during the CAP treatment period?

Yes—complete table below in 8b. No Unknown

8b. Other antimicrobial drugs given in the hospital (during the CAP treatment period defined by the dates in #7):

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:

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

Yes No Unknown

9a. Antimicrobial drugs prescribed at discharge for CAP or other reasons (enter CAP 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"/> CAP <input type="checkbox"/> Other <input type="checkbox"/> Unknown
2		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unk	<input type="checkbox"/> CAP <input type="checkbox"/> Other <input type="checkbox"/> Unknown
3		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unk	<input type="checkbox"/> CAP <input type="checkbox"/> Other <input type="checkbox"/> Unknown
4		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unk	<input type="checkbox"/> CAP <input type="checkbox"/> Other <input type="checkbox"/> Unknown
5		<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> PO <input type="checkbox"/> INH <input type="checkbox"/> Unk	<input type="checkbox"/> CAP <input type="checkbox"/> Other <input type="checkbox"/> Unknown

More drugs than fit in the table:

9b. If antimicrobials were prescribed at discharge for CAP, what was the total duration of the post-discharge CAP treatment?

___ days, OR the prescription end date is ___ / ___ / ___, OR Duration is unknown

Laboratory testing

10. Complete table below for POSITIVE cultures collected in the first 5 hospital days:

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 lower respiratory 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"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	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"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	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"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	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"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	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"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	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"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Stool <input type="checkbox"/> Upper resp <input type="checkbox"/> Other _____	___ / ___ / ___	___ / ___ / ___	Path1 _____ Path2 _____ Path3 _____	Path1: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path2: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk Path3: <input type="checkbox"/> ≥10 ⁴ CFU/ml or similar <input type="checkbox"/> <10 ⁴ or similar <input type="checkbox"/> Unk	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"/> Sputum	<input type="checkbox"/> Blood	___ / ___ / ___	___ / ___ / ___	Path1 _____	Path1: <input type="checkbox"/> $\geq 10^4$ CFU/ml or similar <input type="checkbox"/> $< 10^4$ or similar <input type="checkbox"/> Unk	Drug1 _____	Path1: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>									
	<input type="checkbox"/> ETA	<input type="checkbox"/> Urine							Path2 _____	Path2: <input type="checkbox"/> $\geq 10^4$ CFU/ml or similar <input type="checkbox"/> $< 10^4$ or similar <input type="checkbox"/> Unk	Drug2 _____	Path2: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>					
	<input type="checkbox"/> BAL	<input type="checkbox"/> Stool											Path3 _____	Path3: <input type="checkbox"/> $\geq 10^4$ CFU/ml or similar <input type="checkbox"/> $< 10^4$ or similar <input type="checkbox"/> Unk	Drug3 _____	Path3: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	
	<input type="checkbox"/> Upper resp																Drug4 _____
	<input type="checkbox"/> Other _____																

More positive cultures than fit in the table:

ETA=endotracheal aspirate (or tracheal aspirate). BAL=bronchoalveolar lavage (includes bronchial lavage, mini-BAL).
 *Check " $\geq 10^4$ CFU/ml or similar" if quantity of growth in the culture is reported to be as follows: moderate, many, heavy, abundant, etc. Check " $< 10^4$ or similar" if quantity of growth in the culture is reported to be $< 10^4$ CFU/ml or as follows: few, scarce, scant, rare, etc. Check "unknown" if no organism quantity is noted in the culture report.

CDC ID: -

CDC ID: -

11. During the first 5 hospital days, did the patient have a Gram stain of lower respiratory secretions (sputum, BAL, ETA, etc.)? Yes No Unknown

11a. If yes, did the Gram stain report indicate the following:

- Heavy, 4+, or ≥25 neutrophils (or white blood cells) per low power field [x100]
 Rare, occasional, few, 1+ or 2+, or ≤10 squamous epithelial cells per low power field [x100]
 Neither of the above
 Unknown

12. Complete the table for NEGATIVE cultures collected during the first 5 hospital days:

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:

13. Complete the table for non-culture microbiology tests (positive and negative) collected during 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"/> Parafllu <input type="checkbox"/> Other _____ <input type="checkbox"/> SARS-CoV-2	<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"/> SARS-CoV-2	<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"/> 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"/> SARS-CoV-2	<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"/> SARS-CoV-2	<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"/> SARS-CoV-2	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Positive (insert code): Path1 _____ Path2 _____ Path3 _____

More tests than fit in the table:

14. Did the patient have any of the following blood test results during the first 2 hospital days?

Check all that apply, or None.

- | | | |
|---|---|--|
| <input type="checkbox"/> Arterial pH < 7.35 | <input type="checkbox"/> BUN > 30 mg/dL (11 mmol/L) | <input type="checkbox"/> Glucose > 250 mg/dL |
| <input type="checkbox"/> PaO ₂ < 60 mmHg | <input type="checkbox"/> Sodium < 130 mmol/L | <input type="checkbox"/> Hematocrit < 30% |

FORM IS COMPLETE