**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY**

Form Approved

OMB No. 0920-0852

Exp. Date 03/31/2025

**PATIENT INFORMATION FORM**

**CDC ID:** \_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Survey date:** \_\_\_ /\_\_\_ /\_\_\_\_\_\_\_ **Data collector** **initials:** \_\_\_\_\_\_\_\_\_\_\_\_

**If data collected on survey date, enter data collection time:** \_\_\_ : \_\_\_\_ [ ] am [ ] pm **OR** [ ] Data collection done retrospectively

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| **I. Identifiers** (NOT transmitted to CDC) |
| **Patient name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | **Date of birth (mm/dd/yyyy):** \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ |
| **Patient address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **City:** \_\_\_\_\_\_\_\_\_\_**State:** \_\_\_\_\_\_\_\_\_\_**ZIP:** \_\_\_\_\_\_\_\_\_\_ |
| **Address type: (check one)**[ ] Residential [ ] Other [ ] Post office box [ ] Insufficient [ ] Long-term care facility [ ] Missing[ ] Corrections [ ] Military [ ] Homeless  |
| **Hospital name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Hospital unit name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Room number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Medical record no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **II. Demographic information** |  |
| **Admission date (mm/dd/yyyy):** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ | **CDC location code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Age:** \_\_\_\_\_ [ ]  yrs [ ]  mos [ ]  dys [ ]  Unknown | **Primary Payer:**[ ] Medicare[ ] Medicaid[ ] Private insurance[ ] Self-pay | [ ] No charge[ ] Other[ ] Unknown |
| **Ethnicity**: (check one)[ ] Hispanic or Latino[ ] Not Hispanic or Latino[ ] Not Documented | **Race:** (check all that apply)[ ] American Indian or Alaska Native [ ] Other [ ] Asian [ ] Not Documented [ ] Black or African American[ ] Native Hawaiian/other Pacific Islander[ ] White |
| **Sex at birth:** [ ] Male [ ] Female [ ] Unknown |

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| **III. Weight and height** |
| **Weight:**\_\_\_\_\_\_lbs. \_\_\_\_\_\_ oz. OR \_\_\_\_\_kg [ ] Unknown | **Height:**\_\_\_\_\_\_ft. \_\_\_\_\_ in. OR \_\_\_\_\_cm[ ] Unknown  | **BMI:** (record only if height or weight unavailable)\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Unknown [ ] NA |

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| **IV. Devices and pressure injuries/ulcers present on the survey date**  |
| **Urinary catheter:** [ ] Yes [ ] No [ ] Unknown  | **Ventilator:** [ ] Yes [ ] No [ ] Unknown |
| **Central line:** [ ] Yes [ ] No [ ] Unknown **If “Yes,” indicate how many lines**: [ ] 1 line [ ] >1 line [ ]  Unknown |
| **Pressure injury or ulcer:** [ ] Yes [ ] No [ ] Unknown **If “Yes” did any pressure injuries or ulcers develop after admission?** [ ] Yes [ ] No [ ] Unknown **Indicate the highest stage of the pressure injuries** [ ] Stage 1  [ ] Stage 2 [ ] Stage 3 [ ] Stage 4   **or ulcers on the survey date:**    [ ] Unstageable   [ ] Unknown |

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| **V. COVID-19 status** |
| **SARS-CoV-2 viral test(s) performed during the 14 days before hospital admission or the first 2 days of hospital admission (check all that apply):**  [ ]  Positive test; Enter positive test collection date closest to admission date (mm/dd/yyyy): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ [ ] Unknown [ ]  Negative test; Enter negative test collection date closest to admission date (mm/dd/yyyy): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ [ ] Unknown[ ]  No test performed[ ]  Unknown**SARS-CoV-2 viral test(s) performed on or after hospital day 3 (day 1= admission date) through the survey date (check all that apply):**  [ ]  Positive test; Enter positive test collection date closest to survey date (mm/dd/yyyy): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ [ ] Unknown [ ]  Negative test; Enter negative test collection date closest to survey date (mm/dd/yyyy): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ [ ] Unknown[ ]  No test performed[ ]  Unknown**Has the patient received any COVID-19 vaccine prior to survey date?**  [ ]  Yes [ ]  No[ ]  Unknown **If yes, enter the number of COVID-19 vaccine doses the patient has received:** \_\_\_\_\_\_\_\_\_ [ ]  Unknown |

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| **VI. Antimicrobials administered or scheduled to be administered:** |
|  **On the survey date:** [ ] Yes [ ] No [ ] Unknown **On the day before the survey date:** [ ] Yes [ ] No [ ] Unknown |

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| **VI. Follow-up information**  |
| **Enter date of follow-up data collection:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_  |
| **Hospital discharge date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_ **OR** check one: **[ ]** Unknown **[ ]** Still in hospital |
| **Patient outcome at time of hospital discharge: [ ]** Survived **[ ]** Died **[ ]** Unknown [ ] Still in hospital |

Public reporting burden of this collection of information is estimated to average 17 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0852).

**FORM IS COMPLETE**