

HAI & ANTIMICROBIAL USE PREVALENCE SURVEY  
PATIENT INFORMATION FORM

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

CDC ID: \_\_\_\_ - \_\_\_\_\_

Survey date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

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

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

|  |   |
|--|---|
| <b>I. Identifiers (NOT transmitted to CDC)</b>   |   |
| Patient name: _____                              | Date of birth (mm/dd/yyyy): ____ / ____ / _____ |
| Patient address: _____                           | City: _____ State: _____ ZIP: _____             |
| <b>Address type: (check one)</b>                 |   |
| <input type="checkbox"/> Residential             | <input type="checkbox"/> Other                  |
| <input type="checkbox"/> Post office box         | <input type="checkbox"/> Insufficient           |
| <input type="checkbox"/> Long-term care facility | <input type="checkbox"/> Missing                |
| <input type="checkbox"/> Corrections             |   |
| <input type="checkbox"/> Military                |   |
| <input type="checkbox"/> Homeless                |   |
| Hospital name: _____                             | Hospital unit name: _____                       |
| Room number: _____                               | Medical record no.: _____                       |

|  |  |
|--|--|
| <b>II. Demographic information</b>   |  |
| Admission date (mm/dd/yyyy): ____ / ____ / _____   | CDC location code: _____   |
| Age: ____ <input type="checkbox"/> yrs <input type="checkbox"/> mos <input type="checkbox"/> dys <input type="checkbox"/> Unknown  | <b>Primary Payer:</b><br><input type="checkbox"/> Medicare <input type="checkbox"/> No charge<br><input type="checkbox"/> Medicaid <input type="checkbox"/> Other<br><input type="checkbox"/> Private insurance <input type="checkbox"/> Unknown<br><input type="checkbox"/> Self-pay  |
| <b>Ethnicity:</b> (check one)<br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Not Hispanic or Latino<br><input type="checkbox"/> Not Documented | <b>Race:</b> (check all that apply)<br><input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other<br><input type="checkbox"/> Asian <input type="checkbox"/> Not Documented<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Native Hawaiian/other Pacific Islander<br><input type="checkbox"/> White |
| <b>Sex at birth:</b><br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown   |  |

|   |  |   |
|---|--|---|
| <b>III. Weight and height</b>   |  |   |
| Weight: ____ lbs. ____ oz.<br>OR ____ kg <input type="checkbox"/> Unknown | Height: ____ ft. ____ in.<br>OR ____ cm <input type="checkbox"/> Unknown | BMI: (record only if height or weight unavailable)<br>____ <input type="checkbox"/> Unknown <input type="checkbox"/> NA |

|   |   |
|---|---|
| <b>IV. Devices and pressure injuries/ulcers present on the survey date</b>  |   |
| Urinary catheter: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   | Ventilator: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Central line: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "Yes," indicate how many lines: <input type="checkbox"/> 1 line <input type="checkbox"/> >1 line <input type="checkbox"/> Unknown  |   |
| Pressure injury or ulcer: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |   |
| If "Yes" did any pressure injuries or ulcers develop after admission?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |   |
| Indicate the highest stage of the pressure injuries or ulcers on the survey date:<br><input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4<br><input type="checkbox"/> Unstageable <input type="checkbox"/> Unknown |   |

**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

**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

**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**