**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 \_\_\_\_\_cmUnknown | **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: UnknownStill 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**