

**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

I. Identifiers (NOT transmitted to CDC)	
Patient name: _____	Date of birth (mm/dd/yyyy): ____ / ____ / _____
Patient address: _____	City: _____ State: _____ ZIP: _____
Address type: (check one)	
<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.: _____

II. Demographic information	
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	Primary Payer: <input type="checkbox"/> Medicare <input type="checkbox"/> No charge <input type="checkbox"/> Medicaid <input type="checkbox"/> Other <input type="checkbox"/> Private insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Self-pay
Ethnicity: (check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Not Documented	Race: (check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other <input type="checkbox"/> Asian <input type="checkbox"/> Not Documented <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> White
Sex at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	

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

IV. Devices and pressure injuries/ulcers present on the survey date	
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? <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: <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 <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).

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