Form Approved
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HAI & ANTIMICROBIAL USE PREVALENCE SURVEY
PATIENT INFORMATION FORM

CDC ID: ____ - _____ **Survey date:** ___ /___ /_____ **Data collector initials:** _____

If data collected <u>on survey date</u>, 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)
☐Residential
☐Post office box
☐Long-term care facility
☐Corrections
☐Military
☐Homeless
☐Other
☐Insufficient
☐Missing

Hospital name: _____ **Hospital unit name:** _____

Room number: _____ **Medical record no.:** _____

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
☐Asian
☐Black or African American
☐Native Hawaiian/other Pacific Islander
☐White
☐Other
☐Not Documented

Sex at birth:
☐Male ☐Female ☐Unknown

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

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 or ulcers on the survey date:
☐Stage 1 ☐Stage 2 ☐Stage 3 ☐Stage 4
☐Unstageable ☐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

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