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

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: _____**ZIP:** _____**State:** _____ **City:**_____

Address type: (check one)
FORMCHECKBOX
FORMCHECKBOX
FORMCHECKBOX
FORMCHECKBOX
FORMCHECKBOX Military
FORMCHECKBOX
Other
Insufficient
Missing FORMCHECKBOX
FORMCHECKBOX
FORMCHECKBOX

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
FORMCHECKBOX

Race: (check all that apply)
American Indian or Alaska Native
Asian
FORMCHECKBOX
FORMCHECKBOX
Not Documented

FORMCHECKBOX
FORMCHECKBOX

FORMCHECKBOX FORMCHECKBOX
FORMCHECKBOX FORMCHECKBOX
FORMCHECKBOX
FORMCHECKBOX

FORMCHECKBOX
FORMCHECKBOX

FORMCHECKBOX

FORMCHECKBOX