

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: _____	ZIP: _____ State: _____ City: _____
Address type: (check one)	
FORMCHECKBOX	Other FORMCHECKBOX
FORMCHECKBOX	Insufficient FORMCHECKBOX
FORMCHECKBOX	Missing FORMCHECKBOX
FORMCHECKBOX	
FORMCHECKBOX Military	
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 No charge Medicaid Other Private insurance Unknown Self-pay
Ethnicity: (check one) Hispanic or Latino Not Hispanic or Latino FORMCHECKBOX	Race: (check all that apply) American Indian or Alaska Native FORMCHECKBOX Asian FORMCHECKBOX Not Documented

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