**VIM-Carbapenem Resistant *Pseudomonas aeruginosa* (VIM-CRPA)**

**Outbreak Investigation**

**Abstraction Form**

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| Patient Name: |  |
| Medical Record Number: |  |
| Outbreak ID Number: |  |
| Jurisdiction: |  |
| ARLN ID: |  |

**DO NOT SEND THIS FIRST PAGE TO CDC**

**PLEASE KEEP FOR YOUR RECORDS**

Please complete the tables below, either on paper or directly into REDCap. If information is unknown, please write “NA.” Thank you!

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| **Today’s Date** (mm-dd-yyyy): | **Abstractor’s Initials:** |
| **Patient Demographics** | |
| Patient sex: □ Female □Male | Patient Age (yrs): |
| Patient ethnicity (please select only one):   * Hispanic * Not Hispanic * Unknown | Patient race (please select all that apply):   * American Indian or Alaska Native * Asian * Black or African American * Native Hawaiian or other Pacific Islander * White * Unknown |

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| **Isolate information** | |
| Date of collection of first positive VIM-CRPA culture or screening test (mm-dd-yyyy): | Specimen source: |
| Type of facility where specimen collected:   * Emergency Department ACH * Inpatient ACH * LTACH * Skilled nursing facility (SNF) * Inpatient rehabilitation center * Assisted Living Facility * Outpatient clinic, type\_\_\_\_\_\_\_\_ * Other, please specify:\_\_\_\_\_\_\_\_ | Facility name: |
| Facility State (2-letter abbreviation): |

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| **Inpatient Admission Information** | | | | | | | | | | |
| Is the patient currently admitted or has been admitted to a facility in the 3 months prior to date of first VIM-CRPA(+)? □ Yes □ No | | | | | | | | | | |
| *If yes, please list* ***all*** *inpatient admissions in the 3 months prior to date of first VIM-CRPA(+)* | | | | | | | | | | |
| Name of facility | | Type of facility (LTACH, ACH, Nursing home, Inpatient rehab, other) | Facility state (2-letter abbrev) | | Admit date | | Admit diagnosis | | Admitted from (Home, LTACH, Nursing Home, Rehab, Other) | Discharge Date |
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| Status of admission: | | | | | | | | | | |
| □ Still Inpatient  □ Discharged Home  □ Deceased: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cause of Death\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
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| All discharge diagnoses: | | | | | | | | | | |
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| **Outpatient Information:** | | | | | | | | | | |
| Has the patient visited an outpatient clinic in the 3 months prior to date of first VIM-CRPA(+)? □ Yes □ No | | | | | | | | | | |
| *If yes, please list all outpatient healthcare visits in the 3 months prior to first VIM-CRPA(+)* | | | | | | | | | | |
| Date | Clinic Name | | | Type of clinic/specialty (e.g., ophthalmology) | | Reason for visit | | Care received (incl. procedures) | | |
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**Past Medical** **History** (*check all that apply*):

□ Myocardial infarction

□ Congestive heart failure (EF\_\_\_\_\_)

□ Peripheral vascular disease

□ Cerebrovascular disease

□ Dementia

□ Chronic lung disease

□ Connective tissue disease

□ Ulcer disease

□ Diabetes Mellitus

□ Hemiplegia

□ Paraplegia

□ Moderate or severe renal disease

□ Solid tumor (non-metastatic)

□ Lymphoma, Multiple Myeloma

□ Mild liver disease

□ Moderate or severe liver disease

□ Dialysis Dependent

□ HIV (CD4\_\_\_\_)

□ AIDS

□ Major Trauma (30d prior to admission)

□ Previous Surgery (30d prior to admission)

□ Obesity

□ Metastatic solid tumor

□ Other Malignancy (type\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ Hypertension

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other Immunosuppression

(please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ Leukemia

□ Ocular disease

□ Glaucoma

□ Cataracts

□ Diabetic retinopathy

□ Macular degeneration

□ Other\_\_\_\_\_\_\_\_\_\_\_

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| **Clinical History:** |

**History of Present Illness** *(Give a brief summary of patient’s illness, MDRO screening*):

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| **Healthcare outside of state of VIM-CRPA(+)** | | | | | | | | | | | |
| Has the patient received any healthcare outside of the state (but within the United States) where the VIM-CRPA(+) culture was identified (inpatient or outpatient), anytime during the year prior to their first VIM-CRPA(+)? □ Yes □No | | | | | | | | | | | |
| *If yes, please list all patient healthcare that has not already been listed above.* | | | | | | | | | | | |
| Date | Facility name | | | Facility type | State | | Reason for visit | | Inpatient/Outpatient | | Procedures performed |
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| Did the patient receive any medical care outside of the US anytime during the year prior to their first VIM-CRPA(+)? □ Yes □No | | | | | | | | | | | |
| *If yes, please list medical care outside of the US* | | | | | | | | | | | |
| Dates of care | | Country | Facility type | | | Facility name | | Inpatient/Outpatient | | Type of care received (including any procedures) | |
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| **Microbiology: Did patient have any other cultures (screening or clinical) collected in the 6 months prior to first VIM-CRPA culture?** □ Yes □ No  *If yes, please list below -- Please be sure to* ***include any CRPA negative cultures****.* | | | | | | |
| Date | Specimen Source  (e.g., blood, urine) | Positive for *P. aeruginosa*?  (Yes/No) | Carbapenem resistant?  (Yes/No/  Unknown) | Carbapenemase mechanism testing performed (Yes/No; if Yes indicate results (e.g., VIM, IMP, KPC, etc) | ARLN ID  (if pos) | Indication (Screening or clinical) |
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| **Microbiology: Did patient have any other screening swabs collected (non-culture-based) in the 6 months prior to first VIM-CRPA (+)?** □ Yes □ No  *If yes, please list below -- Please be sure to* ***include any negative results****.* | | | | | |
| Date | Type (admit, PPS, discharge) | Specimen Source (e.g., rectal swab) | VIM +  (Yes/No/  unknown) | Organism genus, species  (if unknown, put NA) | ARLN ID  (if VIM+) |
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| **Medications Received** | | | |
| Was the patient on medication or antibiotics at any time 3 months prior to first VIM-CRPA (+) culture? □ Yes □ No | | | |
| *If yes, please list all medications the patient has taken 3 months prior to their first VIM-CRPA(+) culture* | | | |
| Name (generic) | Route (IV, PO, etc.) | Dates | Manufacturer |
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| **Non-invasive radiology (e.g., X rays, CTs, Ultrasound, Swallow study, etc.): Did patient have any non-invasive radiologic studies, inpatient or outpatient, 3 months prior to first VIM-CRPA(+) culture?** □ Yes □ No*If yes, please list below.* | | | | | |
| Date | Type of Study | Inpatient or Outpatient | Location  (e.g., bedside, radiology) | Facility name | Notes (e.g., brand of U/S gel) |
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| **Invasive Procedures: Please list all procedures, inpatient or outpatient, 3 months prior to the positive culture (e.g., scopes, OR procedures, interventional radiology)** | | | | |
| Date | Procedure | Inpatient or Outpatient | Location (e.g., bedside, OR)   Include OR #, scope ID, if known | Facility name |
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| **Devices: Please list 3 months prior to the identification of first VIM-CRPA(+)** | | | |
| Device | Site | Date Inserted | Date Removed (if still present, please write NA) |
| □ Central Venous Catheter (e.g., CVC, PICC) |  |  |  |
| □ Non-invasive urinary catheter (e.g., Condom Catheter) |  |  |  |
| □ Invasive urinary catheter (e.g., Foley) |  |  |  |
| □ Suprapubic urinary catheter |  |  |  |
| Feeding Tube:  □Nasogastric/Nasoduodenal  □ PEG/PEJ (stomach) |  |  |  |
| □ Endotracheal tube |  |  |  |
| □ Tracheostomy tube |  |  |  |
| □ Noninvasive ventilation |  |  |  |
| □ Mechanical ventilation |  |  |  |
| □ Surgical drain |  |  |  |
| □ Other: describe\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| □ Other: describe\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| □ Other: describe\_\_\_\_\_\_\_\_\_\_ |  |  |  |

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| **Respiratory Therapy** | | |
| *Did the patient receive mechanical ventilation anytime in the 3 months prior to their first VIM-CRPA(+):* □ Yes □No  *If yes:* | | |
| Dates of ventilation: | Ventilator brand: | |
| Did the patient receive a tracheostomy?   * Yes * No | | |
| **CPAP/BIPAP** | | |
| Does the patient currently use a CPAP or BIPAP, or has used one anytime 3 months prior to first VIM-CRPA(+)?   * CPAP * BIPAP * None required | | |
| **Nebulizers and Humidifiers** | | |
| Did the patient receive any nebulizer treatments in the 3 months prior to first VIM-CRPA (+)?   * Yes * No   *If yes please fill in the below* | | |
| Diluent for Nebulizer | | Dates diluent used |
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| Did the patient use a humidifier in the 3 months prior to first VIM-CRPA (+)?   * Yes * No | | |

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| **Eye care** | | |
| Did the patient use contact lenses or bandage lenses within the 3 months prior to first VIM-CRPA(+)?   * Contact lenses * Bandage lenses * No | | |
| Does the patient receive routine eye care?   * Yes * No | | |
| If yes, type of eye care?   * Medicated eye drops * Artificial tears * Eye irrigation * Topical ointments | | |
| **Please list all products used for patient eye care within the 3 months prior to first VIM-CRPA(+), including contact lens solution, not including medications listed above** | | |
| Product name | Date(s) | Brand |
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| **Oral care** |
| What type of oral care does the patient receive in the 3 months prior to the first VIM-CRPA (+) culture?  *Please select all types of care the patient has received:*   * Toothbrush/paste * CHG * Mouthwash * Other, specify\_\_\_\_\_\_\_\_\_\_\_ |

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| **Skin & wound care** |
| How is the patient bathed in the 3 months prior to first VIM-CRPA(+)?   * Shower * Bed Bath * CHG bath, please specify brand & manufacturer\_\_\_\_\_\_\_ * Pre-moistened towelette/wipe, please specify brand & manufacturer\_\_\_\_\_\_\_\_ * Perineal care wipe, please specify brand & manufacturer\_\_\_\_\_\_\_\_\_\_ * Other: |
| Does the patient receive any wound care currently or in the 3 months prior to first VIM-CRPA(+)?   * Yes * No |
| If yes, please select all that apply:   * Dressing changes * Irrigation * Sharp debridement * Wound vac management * Other, specify:\_\_\_\_\_\_\_\_ |

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| **Please list all topical products (lotions, ointments, antiseptics, etc) used on the patient in the 3 months prior to the first VIM-CRPA(+) unless it’s listed in the medication section.** | | |
| Product | Manufacturer | Lot #s (if available) |
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| **Diet (List all 3 months prior to the first positive culture, including NPO):** | | | |
| Diet ordered | Route | Dates | If enteral or parenteral feeding, brand name |
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| **Consult Services (List all 3 months prior to first positive culture): □ Yes □ No** *If yes, please list below.* | | |
| Service | Start Date | End Date |
| □ Occupational Therapy |  |  |
| □ Physical Therapy |  |  |
| □ Respiratory Therapy |  |  |
| □ Wound Care Team |  |  |
| □ Dialysis |  |  |
| □ Other: Specify\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Other Notes:**