**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: |  |

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**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
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| Does the patient receive routine eye care?* Yes
* No
 |
| If yes, type of eye care?* Medicated eye drops
* Artificial tears
* Eye irrigation
* Topical ointments
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| **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:**