Form Approved
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VIM-Carbapenem Resistant *Pseudomonas aeruginosa* (VIM-CRPA) Outbreak Investigation Abstraction Form

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!

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

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):

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

Outbreak ID Number: _____ARLN ID:_____

*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
Status of admission:						
□ Still Inpatient □ Discharged Home □ Deceased: Date_____ Cause of Death_____						
All discharge diagnoses:						

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)

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_____

Clinical History:

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

_____
_____
_____
_____
_____

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

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)

Outbreak ID Number: _____ARLN ID:_____

Microbiology: Did patient have any other <u>cultures</u> (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)

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+)

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

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	Location	Facility name	Notes (e.g., brand of U/S gel)

		Outpatient	(e.g., bedside, radiology)		

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

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_____			

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
Did the patient use a humidifier in the 3 months prior to first VIM-CRPA (+)? ☐ Yes ☐ No	

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

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_____

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:_____

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)

Diet (List all 3 months prior to the first positive culture, including NPO):			
Diet ordered	Route	Dates	If enteral or parenteral feeding, brand name

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: