



Custom Event

Facility ID:	Event #:																																																																																																
*Patient ID:	Social Security #:																																																																																																
Secondary ID:	Medicare #:																																																																																																
Patient Name, Last:	First: Middle:																																																																																																
*Gender: M F Other	*Date of Birth:																																																																																																
Ethnicity (Specify):	Race (Specify):																																																																																																
Event Details																																																																																																	
*Event Type:	*Date of Event:																																																																																																
Post Procedure Event: Yes No	Date of Procedure:																																																																																																
NHSN Procedure Code:	ICD-10-PCS or CPT Procedure Code:																																																																																																
MDRO/CDI Infection Surveillance: No	Date Admitted to Facility:																																																																																																
Location:																																																																																																	
Specific Event Type (used only for CDC defined events):																																																																																																	
Specify Criteria Used (check all that apply)																																																																																																	
<table border="0"> <tr> <td colspan="3" style="text-align: center;"><u>Signs and Symptoms</u></td> <td colspan="3" style="text-align: center;"><u>Laboratory or Diagnostic Testing</u></td> </tr> <tr> <td><input type="checkbox"/> Abscess</td> <td><input type="checkbox"/> Heat</td> <td><input type="checkbox"/> Dysuria</td> <td><input type="checkbox"/> Organism(s) identified</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Apnea</td> <td><input type="checkbox"/> Hypotension</td> <td><input type="checkbox"/> Fever</td> <td><input type="checkbox"/> Culture or non-culture based testing not performed</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Bradycardia</td> <td><input type="checkbox"/> Hypothermia</td> <td><input type="checkbox"/> Bilious aspirate</td> <td><input type="checkbox"/> Organism(s) identified from blood specimen⁺</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Cough</td> <td><input type="checkbox"/> Lethargy</td> <td><input type="checkbox"/> Erythema or redness</td> <td><input type="checkbox"/> Other positive laboratory tests⁺</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Vomiting</td> <td><input type="checkbox"/> Nausea</td> <td><input type="checkbox"/> Abdominal distension</td> <td><input type="checkbox"/> > 15 colonies cultured from IV cannula tip using semiquantitative culture method</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Pain or tenderness</td> <td colspan="2"></td> <td><input type="checkbox"/> Pneumatosis intestinalis by radiograph</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Drainage or material⁺</td> <td colspan="2"></td> <td><input type="checkbox"/> Portal venous gas (Hepatobiliary gas) by radiograph</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Wheezing, rales or rhonchi</td> <td colspan="2"></td> <td><input type="checkbox"/> Pneumoperitoneum by radiograph</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Diarrhea⁺</td> <td colspan="2"></td> <td><input type="checkbox"/> Imaging test evidence of infection⁺</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Swelling or inflammation</td> <td colspan="2"></td> <td colspan="3" style="text-align: center;"><u>Clinical Diagnosis</u></td> </tr> <tr> <td><input type="checkbox"/> Occult or gross blood in stools (with no rectal fissure)</td> <td colspan="2"></td> <td><input type="checkbox"/> Physician diagnosis of this event type⁺</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Surgical evidence of extensive bowel necrosis (>2 cm of bowel affected)</td> <td colspan="2"></td> <td><input type="checkbox"/> Physician institutes appropriate antimicrobial therapy⁺</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Surgical evidence of pneumatosis intestinalis with or without intestinal perforation</td> <td colspan="2"></td> <td colspan="3"></td> </tr> <tr> <td colspan="6"><input type="checkbox"/> Other evidence of infection found on invasive procedure, gross anatomic exam, or histopathologic exam⁺</td> </tr> <tr> <td colspan="6"><input type="checkbox"/> Other signs and symptoms⁺</td> </tr> </table>		<u>Signs and Symptoms</u>			<u>Laboratory or Diagnostic Testing</u>			<input type="checkbox"/> Abscess	<input type="checkbox"/> Heat	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Organism(s) identified			<input type="checkbox"/> Apnea	<input type="checkbox"/> Hypotension	<input type="checkbox"/> Fever	<input type="checkbox"/> Culture or non-culture based testing not performed			<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Bilious aspirate	<input type="checkbox"/> Organism(s) identified from blood specimen ⁺			<input type="checkbox"/> Cough	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Erythema or redness	<input type="checkbox"/> Other positive laboratory tests ⁺			<input type="checkbox"/> Vomiting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Abdominal distension	<input type="checkbox"/> > 15 colonies cultured from IV cannula tip using semiquantitative culture method			<input type="checkbox"/> Pain or tenderness			<input type="checkbox"/> Pneumatosis intestinalis by radiograph			<input type="checkbox"/> Drainage or material ⁺			<input type="checkbox"/> Portal venous gas (Hepatobiliary gas) by radiograph			<input type="checkbox"/> Wheezing, rales or rhonchi			<input type="checkbox"/> Pneumoperitoneum by radiograph			<input type="checkbox"/> Diarrhea ⁺			<input type="checkbox"/> Imaging test evidence of infection ⁺			<input type="checkbox"/> Swelling or inflammation			<u>Clinical Diagnosis</u>			<input type="checkbox"/> Occult or gross blood in stools (with no rectal fissure)			<input type="checkbox"/> Physician diagnosis of this event type ⁺			<input type="checkbox"/> Surgical evidence of extensive bowel necrosis (>2 cm of bowel affected)			<input type="checkbox"/> Physician institutes appropriate antimicrobial therapy ⁺			<input type="checkbox"/> Surgical evidence of pneumatosis intestinalis with or without intestinal perforation						<input type="checkbox"/> Other evidence of infection found on invasive procedure, gross anatomic exam, or histopathologic exam ⁺						<input type="checkbox"/> Other signs and symptoms ⁺					
<u>Signs and Symptoms</u>			<u>Laboratory or Diagnostic Testing</u>																																																																																														
<input type="checkbox"/> Abscess	<input type="checkbox"/> Heat	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Organism(s) identified																																																																																														
<input type="checkbox"/> Apnea	<input type="checkbox"/> Hypotension	<input type="checkbox"/> Fever	<input type="checkbox"/> Culture or non-culture based testing not performed																																																																																														
<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Bilious aspirate	<input type="checkbox"/> Organism(s) identified from blood specimen ⁺																																																																																														
<input type="checkbox"/> Cough	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Erythema or redness	<input type="checkbox"/> Other positive laboratory tests ⁺																																																																																														
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Abdominal distension	<input type="checkbox"/> > 15 colonies cultured from IV cannula tip using semiquantitative culture method																																																																																														
<input type="checkbox"/> Pain or tenderness			<input type="checkbox"/> Pneumatosis intestinalis by radiograph																																																																																														
<input type="checkbox"/> Drainage or material ⁺			<input type="checkbox"/> Portal venous gas (Hepatobiliary gas) by radiograph																																																																																														
<input type="checkbox"/> Wheezing, rales or rhonchi			<input type="checkbox"/> Pneumoperitoneum by radiograph																																																																																														
<input type="checkbox"/> Diarrhea ⁺			<input type="checkbox"/> Imaging test evidence of infection ⁺																																																																																														
<input type="checkbox"/> Swelling or inflammation			<u>Clinical Diagnosis</u>																																																																																														
<input type="checkbox"/> Occult or gross blood in stools (with no rectal fissure)			<input type="checkbox"/> Physician diagnosis of this event type ⁺																																																																																														
<input type="checkbox"/> Surgical evidence of extensive bowel necrosis (>2 cm of bowel affected)			<input type="checkbox"/> Physician institutes appropriate antimicrobial therapy ⁺																																																																																														
<input type="checkbox"/> Surgical evidence of pneumatosis intestinalis with or without intestinal perforation																																																																																																	
<input type="checkbox"/> Other evidence of infection found on invasive procedure, gross anatomic exam, or histopathologic exam ⁺																																																																																																	
<input type="checkbox"/> Other signs and symptoms ⁺																																																																																																	
* Per specific criteria																																																																																																	
Secondary Bloodstream Infection: Yes No	COVID-19: Yes No If Yes: Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/>																																																																																																
Died: Yes No	Event contributed to death? Yes No																																																																																																
Discharge Date: ___/___/_____	*Pathogens Identified: Yes No If yes, specify on Page 2																																																																																																
<p>Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).</p> <p>Public reporting burden of this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).</p>																																																																																																	
CDC 57.115 (Front) Rev 6 V. 8.6																																																																																																	

Custom Event

Page 2 of 4

Pathogen #	Gram-positive Organisms								
_____	<i>Staphylococcus</i> coagulase-negative (specify species if available):		VANC SIRN						
_____	_____ <i>Enterococcus faecium</i>	DAPTO SNSN		GENTHL [§] SRN	LNZ SIRN	VANC SIRN			
_____	<i>Enterococcus faecalis</i>								
_____	<i>Enterococcus</i> spp. (Only those not identified to the species level)								
_____	<i>Staphylococcus aureus</i>	CIPRO/LEVO/MOXI SIRN	CLIND SIRN	DAPTO SNSN	DOXY/MINO SIRN	ERYTH SIRN	GENT SIRN	LNZ SRN	
_____		OX/CEFOX/METH SIRN	RIF SIRN	TETRA SIRN	TIG SNSN	TMZ SIRN	VANC SIRN		
Pathogen #	Gram-negative Organisms								
_____	<i>Acinetobacter</i> (specify species)	AMK SIRN	AMPSUL SIRN	AZT SIRN	CEFEP SIRN	CEFTAZ SIRN	CIPRO/LEVO SIRN	COL/PB SIRN	
_____		GENT SIRN	IMI SIRN	MERO/DORI SIRN	PIP/PIPTAZ SIRN		TETRA/DOXY/MINO SIRN		
_____		TMZ SIRN	TOBRA SIRN						
_____	<i>Escherichia coli</i>	AMK SIRN	AMP SIRN	AMPSUL/AMXCLV SIRN	AZT SIRN	CEFAZ SIRN	CEFEP S I/S-DD RN	CEFOT/CEFTRX SIRN	
_____		CEFTAZ SIRN	CEFUR SIRN	CEFOX/CETET SIRN	CIPRO/LEVO/MOXI SIRN	COL/PB [†] SRN			
_____		ERTA SIRN	GENT SIRN	IMI SIRN	MERO/DORI SIRN	PIPTAZ SIRN	TETRA/DOXY/MINO SIRN		
_____		TIG SIRN	TMZ SIRN	TOBRA SIRN					
_____	<i>Enterobacter</i> (specify species)	AMK SIRN	AMP SIRN	AMPSUL/AMXCLV SIRN	AZT SIRN	CEFAZ SIRN	CEFEP S I/S-DD RN	CEFOT/CEFTRX SIRN	
_____		CEFTAZ SIRN	CEFUR SIRN	CEFOX/CETET SIRN	CIPRO/LEVO/MOXI SIRN	COL/PB [†] SRN			
_____		ERTA SIRN	GENT SIRN	IMI SIRN	MERO/DORI SIRN	PIPTAZ SIRN	TETRA/DOXY/MINO SIRN		
_____		TIG SIRN	TMZ SIRN	TOBRA SIRN					
_____	_____ <i>Klebsiella pneumoniae</i>	AMK SIRN	AMP SIRN	AMPSUL/AMXCLV SIRN	AZT SIRN	CEFAZ SIRN	CEFEP S I/S-DD RN	CEFOT/CEFTRX SIRN	
_____	_____ <i>Klebsiella oxytoca</i>	CEFTAZ SIRN	CEFUR SIRN	CEFOX/CETET SIRN	CIPRO/LEVO/MOXI SIRN	COL/PB [†] SRN			
_____	_____ <i>Klebsiella aerogenes</i>	ERTA SIRN	GENT SIRN	IMI SIRN	MERO/DORI SIRN	PIPTAZ SIRN	TETRA/DOXY/MINO SIRN		
_____		TIG SIRN	TMZ SIRN	TOBRA SIRN					

Custom Event

Page 3 of 4

Pathogen #	Gram-negative Organisms (<i>continued</i>)									
_____	<i>Pseudomonas aeruginosa</i>	AMK S I R N	AZT S I R N	CEFEP S I R N	CEFTAZ S I R N	CIPRO/LEVO S I R N	COL/PB S I R N	GENT S I R N		
		IMI S I R N	MERO/DORI S I R N		PIP/PIPTAZ S I R N	TOBRA S I R N				
Pathogen #	Fungal Organisms									
_____	<i>Candida</i> (specify species if available)	ANID S I R N	CASPO S NS N	FLUCO S S-DD R N	FLUCY S I R N	ITRA S S-DD R N	MICA S NS N	VORI S S-DD R N		
Pathogen #	Other Organisms									
_____	Organism 1 (specify)	Drug 1 S I R N	Drug 2 S I R N	Drug 3 S I R N	Drug 4 S I R N	Drug 5 S I R N	Drug 6 S I R N	Drug 7 S I R N	Drug 8 S I R N	Drug 9 S I R N
_____	Organism 1 (specify)	Drug 1 S I R N	Drug 2 S I R N	Drug 3 S I R N	Drug 4 S I R N	Drug 5 S I R N	Drug 6 S I R N	Drug 7 S I R N	Drug 8 S I R N	Drug 9 S I R N
_____	Organism 1 (specify)	Drug 1 S I R N	Drug 2 S I R N	Drug 3 S I R N	Drug 4 S I R N	Drug 5 S I R N	Drug 6 S I R N	Drug 7 S I R N	Drug 8 S I R N	Drug 9 S I R N

Result Codes

S = Susceptible I = Intermediate R = Resistant NS = Non-susceptible S-DD = Susceptible-dose dependent N = Not tested

^s GENTHL results: S = Susceptible/Synergistic and R = Resistant/Not Synergistic

[†] Clinical breakpoints have not been set by FDA or CLSI, Sensitive and Resistant designations should be based upon epidemiological cutoffs of Sensitive MIC ≤ 2 and Resistant MIC ≥ 4

Drug Codes:

AMK = amikacin	CEFTRX = ceftriaxone	FLUCY = flucytosine	OX = oxacillin
AMP = ampicillin	CEFUR = cefuroxime	GENT = gentamicin	PB = polymyxin B
AMPSUL = ampicillin/sulbactam	CETET = cefotetan	GENTHL = gentamicin –high level test	PIP = piperacillin
AMXCLV = amoxicillin/clavulanic acid	CIPRO = ciprofloxacin	IMI = imipenem	PIPTAZ = piperacillin/tazobactam
ANID = anidulafungin	CLIND = clindamycin	ITRA = itraconazole	RIF = rifampin
AZT = aztreonam	COL = colistin	LEVO = levofloxacin	TETRA = tetracycline
CASPO = caspofungin	DAPTO = daptomycin	LNZ = linezolid	TIG = tigecycline
CEFAZ = ceftazidime	DORI = doripenem	MERO = meropenem	TMZ = trimethoprim/sulfamethoxazole
CEFEP = cefepime	DOXY = doxycycline	METH = methicillin	TOBRA = tobramycin
CEFOT = cefotaxime	ERTA = ertapenem	MICA = micafungin	VANC = vancomycin
CEFOX = ceftaxime	ERYTH = erythromycin	MINO = minocycline	VORI = voriconazole
CEFTAZ = ceftazidime	FLUCO = fluconazole	MOXI = moxifloxacin	



Custom Fields

--