



## 2023 Extended-Spectrum Beta-Lactamase (ESBL)-Producing Enterobacterales / Invasive *Escherichia coli* Multi-site Gram-Negative Surveillance Initiative (MuGSI) Healthcare-Associated Infections Community Interface (HAIC) Case Report

Form Approved  
OMB No. 0920-0978

Patient's Name:		Phone no.:	
Address:			MRN:
Address Type:			Hospital:
----Patient Identifier information is not transmitted to CDC----			
<b>DEMOGRAPHICS</b>			
1. STATE:	2. COUNTY:	3. STATE ID:	4a. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED:
_____	_____	_____	_____
5. DATE OF BIRTH: (mm/dd/yyyy)		7. SEX AT BIRTH:	8a. ETHNIC ORIGIN:
_____		<input type="radio"/> Male	<input type="radio"/> Hispanic or Latino
6. AGE: _____		<input type="radio"/> Female	<input type="radio"/> Not Hispanic or Latino
_____ Days <input type="radio"/> Mos <input type="radio"/> Yrs		<input type="radio"/> Unknown	<input type="radio"/> Unknown
		<input type="checkbox"/> Check if transgender	8b. RACE: (Check all that apply)
			<input type="checkbox"/> American Indian or Alaska Native
			<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
			<input type="checkbox"/> White
			<input type="checkbox"/> Black or African American
			<input type="checkbox"/> Unknown
9a. DATE OF INCIDENT SPECIMEN COLLECTION (DISC): (mm/dd/yyyy)		10. ORGANISM:	
_____		<input type="radio"/> <i>Escherichia coli</i>	
9b. TIME OF DISC: (HH:MM-Military Format)		If <i>E. coli</i> , select one of the following:      Extended-spectrum cephalosporin-resistant <input type="radio"/> Non-extended spectrum cephalosporin-resistant	
_____		<input type="radio"/> Extended-spectrum cephalosporin-resistant <i>Klebsiella pneumoniae</i>	
		<input type="radio"/> Extended-spectrum cephalosporin-resistant <i>Klebsiella oxytoca</i>	
11. INCIDENT SPECIMEN COLLECTION SITE:			
<input type="checkbox"/> Blood	<input type="checkbox"/> Internal body site (specify): _____	<input type="checkbox"/> Peritoneal fluid	<input type="checkbox"/> Urine
<input type="checkbox"/> Bone	<input type="checkbox"/> Joint/synovial fluid	<input type="checkbox"/> Pericardial fluid	<input type="checkbox"/> Other normally sterile site (specify): _____
<input type="checkbox"/> CSF	<input type="checkbox"/> Muscle	<input type="checkbox"/> Pleural fluid	
12. LOCATION OF SPECIMEN COLLECTION:		13. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC?	
<input type="radio"/> OUTPATIENT	<input type="radio"/> INPATIENT	<input type="radio"/> Private residence	<input type="radio"/> LTACH
Facility ID: _____	Facility ID: _____	<input type="radio"/> LTACH	Facility ID: _____
<input type="radio"/> Emergency room	<input type="radio"/> ICU	<input type="radio"/> Hospital inpatient	<input type="radio"/> Homeless
<input type="radio"/> Clinic/Doctor's office	<input type="radio"/> OR	Facility ID: _____	<input type="radio"/> Incarcerated
<input type="radio"/> Dialysis center	<input type="radio"/> Radiology	<input type="radio"/> Other (specify): _____	<input type="radio"/> Other (specify): _____
<input type="radio"/> Surgery	<input type="radio"/> Other inpatient	Was the patient transferred from this hospital?	<input type="radio"/> Unknown
<input type="radio"/> Observational/Clinical decision unit	<input type="radio"/> Autopsy	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
<input type="radio"/> Other outpatient	<input type="radio"/> Other (Specify): _____		
	<input type="radio"/> Unknown		
14. WAS THE PATIENT HOSPITALIZED ON THE DAY OF OR IN THE 29 CALENDAR DAYS AFTER THE DISC?		15a. WAS THE PATIENT IN AN ICU IN THE 7 DAYS BEFORE THE DISC?	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
IF YES, DATE OF ADMISSION: (mm/dd/yyyy) _____		IF YES, DATE OF ICU ADMISSION: (mm/dd/yyyy) _____ OR <input type="checkbox"/> Date unknown	
		15b. WAS THE PATIENT IN AN ICU ON THE DAY OF INCIDENT SPECIMEN COLLECTION OR IN THE 6 DAYS AFTER THE DISC?	
		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
		IF YES, DATE OF ICU ADMISSION: (mm/dd/yyyy) _____ OR <input type="checkbox"/> Date unknown	
16. PATIENT OUTCOME: <input type="radio"/> Survived <input type="radio"/> Died <input type="radio"/> Unknown			
DATE OF DISCHARGE: (mm/dd/yyyy) _____ OR		DATE OF DEATH: (mm/dd/yyyy) _____ OR <input type="checkbox"/> Date unknown	
<input type="radio"/> Date unknown <input type="radio"/> Left against medical advice (AMA)			
ON THE DAY OF OR IN THE 6 CALENDAR DAYS BEFORE DEATH, WAS THE PATHOGEN OF INTEREST ISOLATED FROM A SITE THAT MEETS THE CASE DEFINITION?			
IF SURVIVED, DISCHARGED TO:		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
<input type="radio"/> Private residence	<input type="radio"/> Other (specify): _____		
<input type="radio"/> LTACH, Facility ID: _____	<input type="radio"/> Unknown		
<input type="radio"/> LTACH, Facility ID: _____			

Public reporting burden of this collection of information is estimated to average 25 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/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

**17a. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S):** (Check all that apply):  None  Colonized  Unknown

<input type="checkbox"/> Abscess, not skin	<input type="checkbox"/> Decubitus/pressure ulcer	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Surgical site infection (internal)
<input type="checkbox"/> AV fistula/graft infection	<input type="checkbox"/> Empyema	<input type="checkbox"/> Pyelonephritis	<input type="checkbox"/> Traumatic wound
<input type="checkbox"/> Bacteremia	<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Septic arthritis	<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Epidural abscess	<input type="checkbox"/> Septic emboli	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Catheter site infection (CVC)	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Septic shock	
<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Skin abscess	
<input type="checkbox"/> Chronic ulcer/wound (not decubitus)	<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Surgical incision infection	

**17b. RECURRENT UTI:**  Yes  No  Unknown

**18. UNDERLYING CONDITIONS:** (Check all that apply)  None  Unknown

<b>CHRONIC LUNG DISEASE</b> <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Chronic pulmonary disease	<b>IMMUNOCOMPROMISED CONDITION</b> <input type="checkbox"/> HIV infection <input type="checkbox"/> AIDS/CD4 count < 200 <input type="checkbox"/> Primary immunodeficiency <input type="checkbox"/> Transplant, hematopoietic stem cell <input type="checkbox"/> Transplant, solid organ	<b>NEUROLOGIC CONDITION</b> <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Chronic cognitive deficit <input type="checkbox"/> Dementia <input type="checkbox"/> Epilepsy/seizure/seizure disorder <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other (specify): _____	<b>SKIN CONDITION</b> <input type="checkbox"/> Burn <input type="checkbox"/> Decubitus/pressure ulcer <input type="checkbox"/> Surgical wound <input type="checkbox"/> Other chronic ulcer or chronic wound <input type="checkbox"/> Other (specify): _____
<b>CHRONIC METABOLIC DISEASE</b> <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> With chronic complications	<b>LIVER DISEASE</b> <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> Ascites <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatic encephalopathy <input type="checkbox"/> Variceal bleeding <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Treated, in SVR <input type="checkbox"/> Current, chronic	<b>PLEGIAS/PARALYSIS</b> <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia	<b>OTHER</b> <input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Obesity or morbid obesity <input type="checkbox"/> Pregnant
<b>CARDIOVASCULAR DISEASE</b> <input type="checkbox"/> CVA/Stroke/TIA <input type="checkbox"/> Congenital heart disease <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Peripheral vascular disease (PVD)	<b>MALIGNANCY</b> <input type="checkbox"/> Malignancy, hematologic <input type="checkbox"/> Malignancy, solid organ (non-metastatic) <input type="checkbox"/> Malignancy, solid organ (metastatic)	<b>RENAL DISEASE</b> <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____ mg/DL <input type="checkbox"/> Unknown or not done	<b>MUGSI CONDITIONS</b> <input type="checkbox"/> Urinary tract problems/abnormalities <input type="checkbox"/> Premature birth <input type="checkbox"/> Spina bifida
<b>GASTROINTESTINAL DISEASE</b> <input type="checkbox"/> Diverticular disease <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Peptic ulcer disease <input type="checkbox"/> Short gut syndrome			

**19. SUBSTANCE USE**

**SMOKING:** (Check all that apply)  None  Unknown

<input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Tobacco <input type="checkbox"/> E-nicotine delivery system <input type="checkbox"/> Marijuana	<b>OTHER SUBSTANCES:</b> (Check all that apply) <input type="radio"/> None <input type="radio"/> Unknown	<b>DUD/ ABUSE</b>	<b>MODE OF DELIVERY</b> (Check all that apply)
<input type="checkbox"/> Marijuana, cannabinoid (other than smoking)	<input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin)	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	<input type="checkbox"/> Opioid, NOS	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Unknown substance	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown
		<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown

**ALCOHOL ABUSE**  
 Yes  No  Unknown

**DURING THE CURRENT HOSPITALIZATION, DID THE PATIENT RECEIVE MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER?**  
 Yes  No  N/A (patient not hospitalized or did not have DUD)

**20. RISK FACTORS:** (Check all that apply)  None  Unknown

**WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?**  Yes  No

**PREVIOUS HOSPITALIZATION IN THE YEAR BEFORE DISC**  Yes  No  Unknown

**IF YES, DATE OF DISCHARGE CLOSEST TO DISC:** (mm/dd/yyyy) \_\_\_\_\_ OR,  DATE UNKNOWN

Facility ID: \_\_\_\_\_

**OVERNIGHT STAY IN LTCF IN THE YEAR BEFORE DISC:**  Yes  No  Unknown

Facility ID: \_\_\_\_\_

**OVERNIGHT STAY IN LTACH IN THE YEAR BEFORE DISC:**  Yes  No  Unknown

Facility ID: \_\_\_\_\_

**SURGERY IN THE YEAR BEFORE DISC:**  Yes  No  Unknown

**CURRENT CHRONIC DIALYSIS:**  Yes  No  Unknown

IF YES, TYPE  
 Hemodialysis  Peritoneal  Unknown

IF HEMODIALYSIS, TYPE OF VASCULAR ACCESS:  
 AV fistula/graft  Hemodialysis central line  Unknown

**CENTRAL LINE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:**  Yes  No  Unknown

Check here if central line in place for > 2 calendar days

**URINARY CATHETER IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC**  
 Yes  No  Unknown

IF YES, CHECK ALL THAT APPLY:  
 Indwelling Urethral Catheter  Condom Catheter  
 Suprapubic Catheter  Other (specify): \_\_\_\_\_

**ANY OTHER INDWELLING DEVICE IN PLACE ON THE DISC UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC:**  
 Yes  No  Unknown

IF YES, CHECK ALL THAT APPLY:  
 ET/NT Tube  Tracheostomy  
 Gastrostomy Tube  Nephrostomy Tube  
 NG Tube  Other (specify): \_\_\_\_\_

**PATIENT TRAVELED INTERNATIONALLY IN THE YEAR BEFORE DISC:**  
 Yes  No  Unknown

COUNTRY(IES): \_\_\_\_\_

**PATIENT HOSPITALIZED WHILE VISITING COUNTRY(IES) ABOVE:**  
 Yes  No  Unknown

**21a. WEIGHT:** \_\_\_\_\_ lbs. \_\_\_\_\_ oz. OR \_\_\_\_\_ kg  Unknown

**21b. HEIGHT:** \_\_\_\_\_ ft. \_\_\_\_\_ in. OR \_\_\_\_\_ cm  Unknown

**21c. BMI:** \_\_\_\_\_  Unknown

**URINE CULTURES ONLY:**

**22. RECORD THE COLONY COUNT:**

\_\_\_\_\_

**URINE CULTURES ONLY:**

**23. SIGNS AND SYMPTOMS ASSOCIATED WITH URINE CULTURE**

Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before through the 2 calendar days after the DISC.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> None                                    | <input type="checkbox"/> Dysuria                                | <input type="checkbox"/> Suprapubic tenderness |
| <input type="checkbox"/> Unknown                                 | <input type="checkbox"/> Fever [temperature ≥ 100.4 °F (38 °C)] | <input type="checkbox"/> Urgency               |
| <input type="checkbox"/> Costovertebral angle pain or tenderness | <input type="checkbox"/> Frequency                              |  |

**Symptoms for patients ≤ 1 year of age only:**

- Apnea
- Bradycardia
- Lethargy
- Vomiting

**24a. IS ANTIMICROBIAL USE (IV OR ORAL) IN THE 30 DAYS BEFORE THE DISC DOCUMENTED?**     Yes     No     Unknown

**24b. IF YES, CHECK ALL ANTIMICROBIALS USED IN THE 30 DAYS BEFORE THE DISC:** (Check all that apply)     Unknown

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> Amikacin                    | <input type="checkbox"/> Cefotaxime             | <input type="checkbox"/> Clarithromycin | <input type="checkbox"/> Imipenem/cilastatin     | <input type="checkbox"/> Polymyxin B                              |
| <input type="checkbox"/> Amoxicillin                 | <input type="checkbox"/> Cefoxitin              | <input type="checkbox"/> Clindamycin    | <input type="checkbox"/> Levofloxacin            | <input type="checkbox"/> Polymyxin E (colistin) Rifaximin         |
| <input type="checkbox"/> Amoxicillin/clavulanic acid | <input type="checkbox"/> Cefepime               | <input type="checkbox"/> Dalbavancin    | <input type="checkbox"/> Linezolid               | <input type="checkbox"/> Tedizolid                                |
| <input type="checkbox"/> Ampicillin                  | <input type="checkbox"/> Ceftazidime            | <input type="checkbox"/> Daptomycin     | <input type="checkbox"/> Meropenem               | <input type="checkbox"/> Telavancin                               |
| <input type="checkbox"/> Ampicillin/sulbactam        | <input type="checkbox"/> Ceftazidime/avibactam  | <input type="checkbox"/> Delafloxacin   | <input type="checkbox"/> Meropenem/vaborbactam   | <input type="checkbox"/> Tigecycline                              |
| <input type="checkbox"/> Azithromycin                | <input type="checkbox"/> Ceftazidime/avibactam  | <input type="checkbox"/> Doripenem      | <input type="checkbox"/> Metronidazole           | <input type="checkbox"/> Tobramycin                               |
| <input type="checkbox"/> Aztreonam                   | <input type="checkbox"/> Cefepime               | <input type="checkbox"/> Doxycycline    | <input type="checkbox"/> Moxifloxacin            | <input type="checkbox"/> Trimethoprim                             |
| <input type="checkbox"/> Cefadroxil                  | <input type="checkbox"/> Ceftolozane/tazobactam | <input type="checkbox"/> Ertapenem      | <input type="checkbox"/> Nitrofurantoin          | <input type="checkbox"/> Trimethoprim/sulfamethoxazole Vancomycin |
| <input type="checkbox"/> Cefazolin                   | <input type="checkbox"/> Ceftriaxone            | <input type="checkbox"/> Eravacycline   | <input type="checkbox"/> Omadacycline            | <input type="checkbox"/> IV                                       |
| <input type="checkbox"/> Cefdinir                    | <input type="checkbox"/> Cefuroxime             | <input type="checkbox"/> Fidaxomicin    | <input type="checkbox"/> Oritavancin             | <input type="checkbox"/> PO                                       |
| <input type="checkbox"/> Cefepime                    | <input type="checkbox"/> Cephalixin             | <input type="checkbox"/> Fosfomicin     | <input type="checkbox"/> Penicillin              | <input type="checkbox"/> Other (specify): _____                   |
| <input type="checkbox"/> Cefiderocol                 | <input type="checkbox"/> Ciprofloxacin          | <input type="checkbox"/> Gentamicin     | <input type="checkbox"/> Piperacillin/tazobactam | <input type="checkbox"/> Other (specify): _____                   |
| <input type="checkbox"/> Cefixime                    |   |   |  |   |

**REMEMINDER:** Any prior antimicrobial use that is not noted above should be documented in the other (specify) field.

**25a. DID THE PATIENT HAVE A POSITIVE TEST(S) FOR SARS-CoV-2 (MOLECULAR ASSAY, ANTIGEN OR OTHER VIRAL TEST, EXCLUDING SEROLOGY) IN THE 90 DAYS BEFORE OR DAY OF THE DISC?**

Yes     No     Unknown

**25b. SPECIMEN COLLECTION DATES FOR POSITIVE TESTS IN THE 90 DAYS BEFORE OR DAY OF DISC:**

<b>First positive test</b>	_____ or <input type="checkbox"/> Date unknown
<b>Most recent positive test:</b>	_____ or <input type="checkbox"/> Date unknown

**25c. COVID-NET CASE ID:** \_\_\_\_\_

**26a. WAS THE INCIDENT SPECIMEN POLYMICROBIAL?**     Yes     No     Unknown

**Complete questions 26b-26d ONLY for ESBL cases:**

**26b. WAS THE INCIDENT SPECIMEN TESTED FOR ESBL PRODUCTION OR OTHER BETA-LACTAMASE GENES?**

- Yes
- No
- Laboratory not testing
- Unknown

**26c. IF TESTED, WHAT TESTING METHOD WAS USED? (Check all that apply):**

- Broth Microdilution (ATI detection)
  - ESBL well
  - Expert rule (ATI flag)
  - Unknown
- Broth Microdilution (Manual)
- Disk Diffusion
- E-test
- Molecular test (specify): \_\_\_\_\_
  - Gene variant (specify): \_\_\_\_\_
- Other non-molecular test (specify): \_\_\_\_\_

**26d. IF TESTED, WHAT WAS THE RESULT?**

- |                           |                           |                           |                           |
|---------------------------|---------------------------|---------------------------|---------------------------|
| <input type="radio"/> Pos | <input type="radio"/> Neg | <input type="radio"/> Ind | <input type="radio"/> Unk |
| <input type="radio"/> Pos | <input type="radio"/> Neg | <input type="radio"/> Ind | <input type="radio"/> Unk |
| <input type="radio"/> Pos | <input type="radio"/> Neg | <input type="radio"/> Ind | <input type="radio"/> Unk |
| <input type="radio"/> Pos | <input type="radio"/> Neg | <input type="radio"/> Ind | <input type="radio"/> Unk |
| <input type="radio"/> Pos | <input type="radio"/> Neg | <input type="radio"/> Ind | <input type="radio"/> Unk |
| <input type="radio"/> Pos | <input type="radio"/> Neg | <input type="radio"/> Ind | <input type="radio"/> Unk |
| <input type="radio"/> Pos | <input type="radio"/> Neg | <input type="radio"/> Ind | <input type="radio"/> Unk |

**27. SUSCEPTIBILITY RESULTS:**

Please complete the table below based on the information found in the indicated data source. (Accelerate Pheno System, E-test, Kirby Bauer, Microscan, Phoenix, Sensititre, Vitek, or Medical Record).

Antibiotic	Data Source	Interpretation	Data Source	Interpretation	Data Source:	Interpretation
	MIC or Zone diameter		MIC or Zone diameter		MIC or Zone diameter	
Amikacin						
Amoxicillin/Clavulanate						
Ampicillin						
Ampicillin/Sulbactam						
Aztreonam						
Cefazolin						
CEFEPIME						
Cefiderocol						
CEFOTAXIME						
Cefoxitin						
CEFTAZIDIME						
Ceftazidime/Avibactam						
Ceftolozane/Tazobactam						
CEFTRIAZONE						
Cephalothin						
Ciprofloxacin						
COLISTIN						
DORIPENEM						
Doxycycline						
Eravacycline						
ERTAPENEM						
Fosfomycin						
Gentamicin						
IMIPENEM						
Imipenem-relebactam						
Levofloxacin						
MEROPENEM						
Meropenem-vaborbactam						
Minocycline						
Nitrofurantoin						
Omadacycline						
Piperacillin/Tazobactam						
Plazomicin						
POLYMYXIN B						
Rifampin						
Tetracycline						
TIGECYCLINE						
Tobramycin						
Trimethoprim-sulfamethoxazole						

**28a. WAS THE CASE FIRST IDENTIFIED THROUGH AN AUDIT?**

- Yes
- No

**28b. CRF STATUS:**

- Complete
- Complete-Pending
- Pending
- Chart unavailable after 3 requests

**28c. SO INITIALS:** \_\_\_\_\_

**28d. DATE OF ABSTRACTION:** (mm/dd/yyyy) \_\_\_\_\_

**28e. COMMENTS:**