



Invasive Methicillin-Resistant Staphylococcus aureus Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2023

Form Approved
OMB No. 0920-0978
Expires xx/xx/xxxx

Patient's Name:			Phone No.: ()		
Address:		Address Type:		MRN:	
City:		State:		ZIP:	
Hospital:					

— PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC —

1. STATE:	2. COUNTY:	2a. PLANNING REGION:	3. STATE ID:	4. PATIENT ID:	5. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED:	6. FACILITY ID WHERE PATIENT TREATED:
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7. SEX AT BIRTH: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Check if transgendered	8. DATE OF BIRTH: ____ - ____ - ____ 9. AGE ____ 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Years	10. RACE: (Check all that apply) 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> Unknown	13. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown
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12. WEIGHT: ____ lbs. ____ oz. OR ____ kg. 1 <input type="checkbox"/> Unknown	13. HEIGHT: ____ ft. ____ in. OR ____ cm. 1 1 <input type="checkbox"/> Unknown	14. BMI (record only if ht. and/or wt. is not available) ____ 1 <input type="checkbox"/> Unknown	15. DATE OF INCIDENT SPECIMEN COLLECTION (DISC): ____ - ____ - ____
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16. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER, THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of admission: ____ - ____ - ____	17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION? 1 <input type="checkbox"/> Yes (HO-MSSA case) 2 <input type="checkbox"/> No (CA-MSSA or HACO-MSSA case)
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18. INCIDENT SPECIMEN COLLECTION SITE: (Check all that apply)

1 Blood 1 Bone 1 CSF 1 Internal body site (specify): _____ 1 Joint/Synovial fluid 1 Muscle

1 Pericardial fluid 1 Peritoneal fluid 1 Pleural fluid 1 Other normally sterile site (specify): _____

<p>19. LOCATION OF SPECIMEN COLLECTION:</p> <p>1 <input type="checkbox"/> Outpatient 1 <input type="checkbox"/> Inpatient 5 <input type="checkbox"/> LTCF</p> <p>Facility ID: _____ Facility ID: _____ Facility ID: _____</p> <p>3 <input type="checkbox"/> Emergency room 1 <input type="checkbox"/> ICU 13 <input type="checkbox"/> LTACH</p> <p>8 <input type="checkbox"/> Clinic/doctor's office 6 <input type="checkbox"/> OR Facility ID: _____</p> <p>15 <input type="checkbox"/> Dialysis center 7 <input type="checkbox"/> Radiology 14 <input type="checkbox"/> Autopsy</p> <p>11 <input type="checkbox"/> Surgery 2 <input type="checkbox"/> Other Inpatient 10 <input type="checkbox"/> Other (specify): _____</p> <p>16 <input type="checkbox"/> Observation/Clinical decision unit 9 <input type="checkbox"/> Unknown</p> <p>4 <input type="checkbox"/> Other outpatient</p>	<p>20. WERE CULTURES OS THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:</p> <p>1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> CSF Date: _____ Date: _____ Date: _____</p> <p>1 <input type="checkbox"/> Internal body site 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> Muscle Date: _____ Date: _____ Date: _____</p> <p>1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Pleural fluid Date: _____ Date: _____ Date: _____</p> <p>1 <input type="checkbox"/> Other normally sterile site (specify): _____ Date: _____</p>
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21. DATE OF FIRST SA BLOOD CULTURE AFTER WHICH SA NOT ISOLATED FOR 14 DAYS: ____ - ____ - ____

22. SUSCEPTIBILITY RESULTS [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)]

Cefazolin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Cefoxitin 1 <input type="checkbox"/> S 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Clindamycin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U
Nafcillin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Oxacillin 1 <input type="checkbox"/> S 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Trimethoprim-Sulfamethoxazole 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U
Vancomycin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U		

<p>23. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC?</p> <p>1 <input type="checkbox"/> Private residence 1 <input type="checkbox"/> LTACH Facility ID: _____</p> <p>1 <input type="checkbox"/> LTCF Facility ID: _____ 1 <input type="checkbox"/> Homeless</p> <p>1 <input type="checkbox"/> Hospital Inpatient Facility ID: _____ 1 <input type="checkbox"/> Incarcerated</p> <p>1 <input type="checkbox"/> Other (specify): _____</p> <p>Was patient transferred from this hospital? _____</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Unknown</p>	<p>24. IF CASE IS ≤12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION: 1 <input type="checkbox"/> NICU/SCN 2 <input type="checkbox"/> Well Baby Nursery 9 <input type="checkbox"/> Unknown</p> <p>25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>IF YES, birth weight: ____ lbs. ____ oz. OR ____ g. OR 1 <input type="checkbox"/> Unknown birth weight</p> <p>IF YES, estimated gestational age: ____ weeks OR 1 <input type="checkbox"/> Unknown gestational age</p>
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Public reporting burden of this collection of information is estimated to average 28 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 Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of ICU admission: ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown	27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of ICU admission: ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown
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28. TYPES OF MSSA INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply) 1 None 1 Unknown

1 <input type="checkbox"/> Abscess (not skin)	1 <input type="checkbox"/> Cellulitis	1 <input type="checkbox"/> Epidural Abscess	1 <input type="checkbox"/> Septic Arthritis	1 <input type="checkbox"/> Surgical Site (Internal)
1 <input type="checkbox"/> AV Fistula/Graft Infection	1 <input type="checkbox"/> Chronic Ulcer/Wound (non-decubitus)	1 <input type="checkbox"/> Meningitis	1 <input type="checkbox"/> Septic Emboli	1 <input type="checkbox"/> Traumatic Wound
1 <input type="checkbox"/> Bacteremia	1 <input type="checkbox"/> Decubitus/Pressure Ulcer	1 <input type="checkbox"/> Peritonitis	1 <input type="checkbox"/> Septic Shock	1 <input type="checkbox"/> Urinary Tract
1 <input type="checkbox"/> Bursitis	1 <input type="checkbox"/> Empyema	1 <input type="checkbox"/> Pneumonia	1 <input type="checkbox"/> Skin Abscess	1 <input type="checkbox"/> Other: (specify)
1 <input type="checkbox"/> Catheter Site Infection	1 <input type="checkbox"/> Endocarditis	1 <input type="checkbox"/> Osteomyelitis	1 <input type="checkbox"/> Surgical Incision	_____

29. UNDERLYING CONDITIONS: (Check all that apply) 1 None 1 Unknown

CHRONIC LUNG DISEASE 1 <input type="checkbox"/> Cystic fibrosis 1 <input type="checkbox"/> Chronic pulmonary disease CHRONIC METABOLIC DISEASE 1 <input type="checkbox"/> Diabetes mellitus 1 <input type="checkbox"/> With chronic complications CARDIOVASCULAR DISEASE 1 <input type="checkbox"/> CVA/Stroke/TIA 1 <input type="checkbox"/> Congenital heart disease 1 <input type="checkbox"/> Congestive heart failure 1 <input type="checkbox"/> Myocardial infarction 1 <input type="checkbox"/> Peripheral vascular disease (PVD) GASTROINTESTINAL DISEASE 1 <input type="checkbox"/> Diverticular disease 1 <input type="checkbox"/> Inflammatory bowel disease 1 <input type="checkbox"/> Peptic ulcer disease 1 <input type="checkbox"/> Short gut syndrome	IMMUNOCOMPROMISED CONDITION 1 <input type="checkbox"/> HIV infection 1 <input type="checkbox"/> AIDS/CD4 count <200 1 <input type="checkbox"/> Primary immunodeficiency 1 <input type="checkbox"/> Transplant, hematopoietic stem cell 1 <input type="checkbox"/> Transplant, solid organ LIVER DISEASE 1 <input type="checkbox"/> Chronic liver disease 1 <input type="checkbox"/> Ascites 1 <input type="checkbox"/> Cirrhosis 1 <input type="checkbox"/> Hepatic encephalopathy 1 <input type="checkbox"/> Variceal bleeding 1 <input type="checkbox"/> Hepatitis C 1 <input type="checkbox"/> Treated, in SVR 1 <input type="checkbox"/> Current, chronic	MALIGNANCY 1 <input type="checkbox"/> Malignancy, hematologic 1 <input type="checkbox"/> Malignancy, solid organ (non-metastatic) 1 <input type="checkbox"/> Malignancy, solid organ (metastatic) NEUROLOGIC CONDITION 1 <input type="checkbox"/> Cerebral palsy 1 <input type="checkbox"/> Chronic cognitive deficit 1 <input type="checkbox"/> Dementia 1 <input type="checkbox"/> Epilepsy/seizure/seizure disorder 1 <input type="checkbox"/> Multiple sclerosis 1 <input type="checkbox"/> Neuropathy 1 <input type="checkbox"/> Parkinson's Disease 1 <input type="checkbox"/> Other (specify): _____ _____ PLEGIAS/PARALYSIS 1 <input type="checkbox"/> Hemiplegia 1 <input type="checkbox"/> Paraplegia 1 <input type="checkbox"/> Quadriplegia	RENAL DISEASE 1 <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____mg/DL 1 <input type="checkbox"/> Unknown or not done SKIN CONDITION 1 <input type="checkbox"/> Burn 1 <input type="checkbox"/> Decubitus/pressure ulcer 1 <input type="checkbox"/> Surgical wound 1 <input type="checkbox"/> Other chronic ulcer or chronic wound 1 <input type="checkbox"/> Other skin condition (specify): _____ _____ OTHER 1 <input type="checkbox"/> Connective tissue disease 1 <input type="checkbox"/> Obesity or morbid obesity 1 <input type="checkbox"/> Pregnant 1 <input type="checkbox"/> Other (specify only for cases ≤12 months of age): _____ _____
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30. WAS THE PATIENT HOMELESS IN THE YEAR BEFORE DISC? 1 Yes 2 No 9 Unknown

31. SUBSTANCE USE:

SMOKING: 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Tobacco 1 <input type="checkbox"/> E-nicotine delivery system 1 <input type="checkbox"/> Marijuana	ALCOHOL ABUSE: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
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OTHER SUBSTANCES (CHECK ALL THAT APPLY): 1 None 1 Unknown

	DOCUMENTED USE DISORDER (DUD/ABUSE):	MODE OF DELIVERY (Check all that apply):
1 <input type="checkbox"/> Marijuana, cannabinoid (other than smoking)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, DEA schedule I (e.g., Heroin)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, NOS	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Cocaine	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Methamphetamine	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Other (specify): _____	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown

1 <input type="checkbox"/> Unknown substance	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown

DURING THE CURRENT HOSPITALIZATION DID THE PATIENT RECEIVE MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER? 1 Yes 2 No 9 N/A (patient not hospitalized or did not have DUD)

32. PRIOR HEALTHCARE EXPOSURE(S):

PREVIOUS DOCUMENTED MRSA INFECTION OR COLONIZATION

1 Yes 2 No 9 Unknown

If YES: _____ OR previous STATE I.D.: _____
Month Year

OVERNIGHT STAY IN LTACH IN THE YEAR BEFORE DISC

1 Yes 2 No 9 Unknown

Facility ID: _____

PREVIOUS HOSPITALIZATION IN THE YEAR BEFORE DISC

1 Yes 2 No 9 Unknown

If YES, DATE OF DISCHARGE CLOSEST TO DISC: ____ - ____ - ____

OR, 1 Date unknown

Facility ID: _____

OVERNIGHT STAY IN LTCF IN THE YEAR BEFORE DISC

1 Yes 2 No 9 Unknown

Facility ID: _____

SURGERY IN THE YEAR BEFORE DISC 1 Yes 2 No 9 Unknown

IF YES, list the surgeries and dates of surgery that occurred within 90 days prior to the DISC:

Surgery Date

1. _____
2. _____
3. _____
4. _____

CENTRAL LINE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC

1 Yes 2 No 9 Unknown

CHECK HERE if central line in place for >2 calendar days 1

DIALYSIS IN THE YEAR BEFORE DISC (Hemodialysis or Peritoneal dialysis)

1 Yes 2 No 9 Unknown

CURRENT CHRONIC DIALYSIS 1 Yes 2 No 9 Unknown

TYPE: 1 Hemodialysis 1 Peritoneal 1 Unknown

IF HEMODIALYSIS, type of vascular access:

1 AV fistula/graft 1 Hemodialysis central line 1 Unknown

33. PATIENT OUTCOME 1 Survived

DATE OF DISCHARGE: ____ - ____ - ____ OR 1 Date Unknown

1 Left against medical advice (AMA)

IF SURVIVED, DISCHARGED TO:

- 1 Private Residence 4 Other (specify): _____
- 2 LTCF Facility ID: _____
- 3 LTACH Facility ID: _____ 9 Unknown

2 Died 9 Unknown

DATE OF DEATH: ____ - ____ - ____ OR 1 Date Unknown

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?

1 Yes 2 No 9 Unknown

34a. DID THE PATIENT HAVE A POSITIVE TEST(S) FOR SARS-CoV-2 (MOLECULAR ASSAY, SEROLOGY OR OTHER CONFIRMATORY TEST) IN THE 90 DAYS BEFORE OR DAY OF THE DISC?

1 Yes 2 No 9 Unknown

COVID-NET CASE ID: _____

SPECIMEN COLLECTION DATES FOR POSITIVE TESTS IN THE 90 DAYS BEFORE OR DAY OF DISC

First positive test: ____ - ____ - ____ 1 Unknown

Most recent positive test: ____ - ____ - ____ 1 Unknown

34. WAS CASE FIRST IDENTIFIED THROUGH AUDIT?

1 Yes 2 No
9 Unknown

35. CRF STATUS:

- 1 Complete
2 Incomplete
3 Edited & Correct
4 Chart unavailable after 3 requests

36. DOES THIS CASE HAVE RECURRENT MRSA DISEASE?

1 Yes 2 No
9 Unknown

IF YES, PREVIOUS (1ST) STATE I.D.

37. DATE REPORTED TO EIP SITE:

____ - ____ - ____

38. DATE ABSTRACTION:

____ - ____ - ____

39. S.O. INITIALS:

40. COMMENTS:
