Form Approved
OMB Control No.: 0920-XXXX
Expiration Date: XX/XX/XXXX

Burkholderia multivorans
Outbreak Investigation Case Report Form

Jurisdiction:

Local Epi ID:

Local Lab ID:

Facility ID:

Burden statement:

Public reporting burden of this collection of information is estimated to average 3 hours 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 H21-8, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX

Form Approved
OMB Control No.: 0920-XXXX
Expiration Date: XX/XX/XXXX

Burkholderia multivorans
Case Report Form

Record ID: _____
(NOTE: This is autogenerated by REDCap and does not need to be completed on paper forms)

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SECTION 1. ID NUMBERS

CDC will assign the CDC Epi ID and CDC Lab ID numbers. The Local Epi ID, Local Lab ID, and Facility ID are numbers that are assigned and entered by the health department. The Local Epi ID will correspond to the patient and the Local Lab ID number will correspond to the patient's isolate. The Facility ID will correspond to the healthcare facility associated with the patient's index specimen and where the patient's medical record information will be abstracted from. For Local Epi, Local Lab, and Facility IDs, use the same numbers you have created for your records or sent in previous communications to CDC.

State: _____

Local Epi ID: _____
(Please ensure this ID matches any previously communicated information on this patient)

Local Lab ID: _____
(Please ensure this ID matches any previously communicated information on this patient)

Facility ID: _____
(Healthcare facility associated with the patient's index specimen)
(Please ensure this ID matches any previously communicated information on this patient)

CDC Epi ID: _____

CDC Lab ID: _____

Date chart abstraction was completed: ____ /____ /_____
MM DD YYYY

Abstractor's initials: _____

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SECTION 2. PATIENT DEMOGRAPHICS

Patient age: _____
(Patient age at date of index specimen collection [first specimen where *B. multivorans* was isolated])

Patient age: ○ Years ○ Months (select only if patient is less than 1 year of age) ○ Days (select only if patient is less than 1 month of age)

Patient sex (biological sex assigned at birth): ○ Male ○ Female ○ Unknown/Not reported

Patient race and/or ethnicity (select all that apply):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other, specify: _____

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SECTION 3. MICROBIOLOGY

Index specimen is the first specimen where *B. multivorans* was isolated. Count specimens from the same source collected on the same day as a single specimen. Count specimens separately if collected on different days or from different specimen sources.

Date of index specimen collection: ____ /____ /_____
MM DD YYYY

Index specimen source (culture 1):

- ○ Blood
- ○ Cerebrospinal fluid
- ○ Cutaneous/skin (e.g., abscess, bullae, purulent cellulitis, vesicles, pustules), specify: _____
- ○ Intra-abdominal fluid/aspirate (e.g., ascitic fluid, peritoneal fluid, biliary fluid, abscess aspirate), specify: _____
- ○ Joint/synovial fluid
- ○ Respiratory (e.g., sputum, bronchial brush/wash/lavage, endotracheal aspirate, pleural fluid, nasopharyngeal), specify: _____
- ○ Tissue, specify: _____
- ○ Urine (e.g., midstream, suprapubic aspiration, indwelling catheter urine, nephrostomy tube), specify: _____
- ○ Wound, specify: _____
- ○ Other, specify: _____

What was the type of unit/location the patient was on at the time of index specimen collection (culture 1)?

- ○ Bone marrow transplant unit
- ○ Burn unit
- ○ Emergency department
- ○ Interventional radiology room
- ○ Labor/delivery

- Medical intensive care unit (ICU)
- Medical/surgical unit, specify: _____
- Not admitted/outpatient clinic
- Observation unit
- Oncology unit
- Operating room
- Other ICU, specify: _____
- Solid organ transplant unit
- Step down unit
- Surgical/trauma ICU
- Urgent care
- Other, specify: _____

Were other organisms isolated from the index specimen source (culture 1)? ○ Yes ○ No

If yes, which other organisms were isolated from the index specimen source (culture 1)?
_____

Was *B. multivorans* isolated from a different specimen source collected <u>on the same day</u> as the index specimen source (culture 1)? ○ Yes ○ No

If yes, from what other specimen source(s) (Select all that apply)

- ☐ Blood
- ☐ Cerebrospinal fluid
- ☐ Cutaneous/skin (e.g., abscess, bullae, purulent cellulitis, vesicles, pustules), specify: _____
- ☐ Intra-abdominal fluid/aspirate (e.g., ascitic fluid, peritoneal fluid, biliary fluid, abscess aspirate), specify: _____
- ☐ Joint/synovial fluid
- ☐ Respiratory (e.g., sputum, bronchial brush/wash/lavage, endotracheal aspirate, pleural fluid, nasopharyngeal), specify: _____
- ☐ Tissue, specify: _____
- ☐ Urine (e.g., midstream, suprapubic aspiration, indwelling catheter urine, nephrostomy tube), specify: _____
- ☐ Wound, specify: _____
- ☐ Other, specify: _____

Was *B. multivorans* isolated from additional specimen sources collected <u>after the date</u> that the index specimen source (culture 1) was obtained? ○ Yes ○ No

If yes, from what specimen source(s)? (Select all that apply and list the date(s) of collection)

- ☐ Blood, list the date(s) of specimen collection (mm-dd-yyyy): _____
- ☐ Cerebrospinal fluid, list the date(s) of specimen collection (mm-dd-yyyy): _____

- ☐ Cutaneous/skin (e.g., abscess, bullae, purulent cellulitis, vesicles, pustules), specify site and list the date(s) of specimen collection (mm-dd-yyyy) next to each site: _____
- ☐ Intra-abdominal fluid/aspirate (e.g., ascitic fluid, peritoneal fluid, biliary fluid, abscess aspirate), specify site and list the date(s) of specimen collection (mm-dd-yyyy) next to each site: _____
- ☐ Joint/synovial fluid, specify site and list the date(s) of specimen collection (mm-dd-yyyy) next to each site: _____
- ☐ Respiratory (e.g., sputum, bronchial brush/wash/lavage, endotracheal aspirate, pleural fluid, nasopharyngeal), specify site and list the date(s) of specimen collection (mm-dd-yyyy) next to each site: _____
- ☐ Tissue, specify site and list the date(s) of specimen collection (mm-dd-yyyy) next to each site: _____
- ☐ Urine (e.g., midstream, suprapubic aspiration, indwelling catheter urine, nephrostomy tube), specify site and list the date(s) of specimen collection (mm-dd-yyyy) next to each site: _____
- ☐ Wound, specify site and list the date(s) of specimen collection (mm-dd-yyyy) next to each site: _____
- ☐ Other, specify site and list the date(s) of specimen collection (mm-dd-yyyy) next to each site: _____

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SECTION 4. PAST MEDICAL HISTORY

The patient's past medical history information may be obtained either from a "Problem List" section of the medical record (if available) and/or the past medical history section in the hospital admission note corresponding to admission where the index specimen was collected.

Did the patient have any underlying medical conditions present at the time of index specimen collection? ○ Yes ○ No

If yes, which of the following underlying conditions? (Select all that apply)

- ☐ Cancer (any malignancy, including lymphoma, leukemia, and metastatic skin cancer)
  - If yes, what type of cancer? _____
    - Receiving chemotherapy or radiation therapy at time of index culture collection? ○ Yes ○ No ○ Unknown
- ☐ Cirrhosis
- ☐ Cystic fibrosis
- ☐ Diabetes mellitus
- ☐ End-stage renal disease/dialysis-dependent
  - If yes, type of dialysis
    - Hemodialysis
    - Peritoneal dialysis
- ☐ HIV with prior history of AIDS or AIDS-defining illness? ○ Yes ○ No ○ Unknown
  Examples: candidiasis, cryptococcosis, coccidioidomycosis, histoplasmosis, Kaposi sarcoma, Burkitt lymphoma, cytomegalovirus retinitis with loss of vision, wasting syndrome, tuberculosis, disseminated or extrapulmonary infection due to Mycobacterium sp., Pneumocystis jirovecii pneumonia, etc.

☐ Other treatments that may result in moderate-to-severe immunosuppression, specify: _____

Examples: receipt of chimeric antigen receptor (CAR)-T-cell therapy, active treatment with high-dose systemic corticosteroids (i.e., 20 or more mg of prednisone or equivalent per day for 2 or more week), biologic agents that are immunosuppressive or immunomodulatory, etc.

☐ Transplant recipient

If yes, type of transplant (e.g., liver, stem cell, etc.): _____

Receiving immunosuppressive therapy at the time of index specimen collection?

○ Yes ○ No ○ Unknown

☐ Other, specify: _____

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SECTION 5. ACUTE CARE HOSPITAL ADMISSION

List all acute care hospital admissions in the 14 days prior to the date of index specimen collection. When determining timeframes, please consider the date of index specimen collection as day 0. Please, list admissions from most recent to oldest.

PLEASE, REFER TO THE SUPPLEMENTARY MATERIALS SECTION IN THIS CASE REPORT FORM IF YOU NEED TO COMPLETE THIS SECTION FOR ADDITIONAL HOSPITAL ADMISSIONS.

How many admissions to an acute care hospital did the patient have in the 14 days prior to the date of index specimen collection (day 0)? _____

Admission # ___

Facility ID: _____

Facility street address: _____

Facility city: _____

Facility state (two letter code): _____

Facility ZIP code: _____

Admit date: ____ /____ /_____

MM DD YYYY

Primary diagnosis at admission: _____

Admitted/transferred from:

- o Home/residence
- o Residential care setting (e.g., assisted living facility, group home, intermediate care, etc.)
- o Acute care hospital
- o Critical access hospital
- o Emergency department
- o Long-term acute care hospital
- o Skilled nursing facility
- o Ventilator-capable skilled nursing facility
- o Inpatient/resident rehabilitation facility
- o Other, specify: _____

What unit was the patient admitted to? _____

During this hospital admission, did the patient move or change locations in the hospital in the 14 days prior to the date of index specimen collection (day 0)? ○ Yes ○ No ○ Unknown

If yes, list all locations, including locations where the patient spent less than 24 hours (e.g., operating room, observation area, post-acute care unit, etc.), and the range of dates that the patient spent at these locations (include locations on day 0 as well:

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

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SECTION 6. HISTORY OF MEDICAL DEVICES, LINES, AND PROCEDURES OR SURGERIES

Which of the following invasive **medical devices or lines** did the patient have in the 14 days prior to the date of index specimen collection (day 0) (including day 0)? (Select all that apply)

- ☐ Central venous catheter (e.g., peripherally inserted central catheter [PICC], tunneled catheter, implanted port, etc.)
- ☐ Arterial line
- ☐ BiPAP/CPAP (non-invasive ventilation)
- ☐ Endotracheal tube (intubation)
- ☐ Tracheostomy tube
- ☐ Gastrostomy feeding tube (e.g., PEG tube, J tube, G tube)
- ☐ Biliary drainage catheter
- ☐ Invasive or indwelling urinary catheter (e.g., foley catheter)
- ☐ Suprapubic urinary catheter
- ☐ Nephrostomy tube
- ☐ Other, specify: _____

Which of the following **procedures or surgeries** did the patient receive in the 14 days prior to the date of index specimen collection (day 0) (including day 0) (Select all that apply)

- ☐ Bronchoscopy
- ☐ Endoscopy
- ☐ Colonoscopy
- ☐ Hemodialysis
- ☐ Peritoneal dialysis
- ☐ Invasive urological procedure (e.g., cystoscopy), specify: _____
- ☐ Paracentesis
- ☐ Endoscopic retrograde cholangiopancreatography (ERCP)
- ☐ Surgical procedure, specify: _____
- ☐ Other, specify: _____

Did the patient receive wound care in the 14 days prior to the date of index specimen collection (day 0) (including day 0)? ○ Yes ○ No

Did the patient receive occupational therapy evaluations (e.g., swallow and speech evaluations) in the 14 days prior to the date of index specimen collection (day 0) (including day 0)? ○ Yes ○ No

If yes, please describe: _____

Did the patient receive physical therapy evaluations in the 14 days prior to the date of index specimen collection (day 0) (including day 0)? ○ Yes ○ No

If yes, please describe: _____

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SECTION 7. PATIENT OUTCOMES

Was the patient treated for the *B. multivorans*? ○ Yes ○ No

Local Epi ID _____ / Local Lab ID _____

If yes, what was the primary infection type? (Select only one)

- Urinary tract infection
- Pneumonia
- Bloodstream infection (with no source of infection documented)
- Skin/wound/tissue infection
- Other, specify: _____

Any additional clinical details, if relevant: _____

Patient outcome at time of medical record review? ○ Death ○ Discharged ○ Still admitted

If deceased, was *B. multivorans* considered the primary cause of death?

○ Yes ○ No ○ Unknown

Form Approved
OMB Control No.: 0920-XXXX
Expiration Date: XX/XX/XXXX

Supplementary Materials for *Burkholderia multivorans* Case Report Form

Local Epi ID _____ / Local Lab ID _____

Additional forms for SECTION 5. ACUTE CARE HOSPITAL ADMISSION

List all acute care hospital admissions in the 14 days prior to the date of index specimen collection. When determining timeframes, please consider the date of index specimen collection as day 0. Please, list admissions from most recent to oldest.

Admission # ___

Facility ID: _________________________________
Facility street address: _________________________________
Facility city: _________________________________
Facility state (two letter code): ___________
Facility ZIP code: ___________
Admit date: ____ /____ /______
MM DD YYYY
Primary diagnosis at admission: _________________________________
Admitted/transferred from:

- o Home/residence
- o Residential care setting (e.g., assisted living facility, group home, intermediate care, etc.)
- o Acute care hospital
- o Critical access hospital
- o Emergency department
- o Long-term acute care hospital
- o Skilled nursing facility
- o Ventilator-capable skilled nursing facility
- o Inpatient/resident rehabilitation facility
- o Other, specify: _________________________________

What unit was the patient admitted to? _________________________________

During this hospital admission, did the patient move or change locations in the hospital in the 14 days prior to the date of index specimen collection (day 0)? ◯ Yes ◯ No ◯ Unknown

If yes, list all locations, including locations where the patient spent less than 24 hours (e.g., operating room, observation area, post-acute care unit, etc.), and the range of dates that the patient spent at these locations (please, include locations on day 0 as well:

Unit: __________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY
Unit: __________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY
Unit: __________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY
Unit: __________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY
Unit: __________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY
Unit: __________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY
Unit: __________________ From: ___ / ___ / _____ To: ___ / ___ / _____

MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Unit: ___________________ From: ___ / ___ / _____ To: ___ / ___ / _____
MM DD YYYY MM DD YYYY

Form Approved
OMB Control No.: 0920-XXXX
Expiration Date: XX/XX/XXXX

Burkholderia multivorans
Facility-Level Form

Record ID: _____
(NOTE: This is autogenerated by REDCap and does not need to be completed on paper forms)

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SECTION 1. ID NUMBERS

This section can be completed by the health department staff prior to the interview. CDC will assign the CDC Epi ID numbers. The Local Epi ID and the Facility ID numbers are assigned and entered by the health department. The Local Epi ID will correspond to the patient. For Local Epi and Facility IDs, use the same numbers you have created for your records or sent in previous communications to CDC.

- **If the patient was admitted to more than one hospital for more than 48 hours in the 14 days prior to the date of index specimen collection:** PLEASE, COMPLETE A NEW FACILITY-LEVEL FORM FOR EACH ACUTE CARE HOSPITAL (FACILITY ID) ASSOCIATED WITH THIS CASE-PATIENT.

- **If the patient had multiple admissions to the same acute care hospital in the 14 days prior to the date of index specimen collection:** Complete the facility-level form only once but reference the list of locations/units where the patient was placed during all admissions to this hospital when completing the questions on ice machines.

-

State: _____

Facility ID: _____
(Please ensure this ID matches any previously communicated information on this patient)

Is there more than one case-patient associated with this facility? ○ Yes ○ No
If yes, how many case-patients are associated with this facility? _____

Local Epi ID: _____
(Please ensure this ID matches any previously communicated information on this patient)

CDC Epi ID: _____

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SECTION 2. USE OF NONSTERILE ICE OR WATER FROM ICE MACHINES FOR CLINICAL CARE ACTIVITIES

How was the information obtained to complete this form? (Select all that apply)
☐ Onsite visit with direct observation

Local Epi ID _____ / Local Lab ID _____

- ☐ Onsite visit without direct observation
- ☐ Remote phone consultation
- ☐ Email correspondence
- ☐ Other, please specify: _____

For what patient care activities is **ice** from ice machines used at the hospital? (Select all that apply)

- ☐ Consumption/hydration
- ☐ Bathing
- ☐ Reducing fever
- ☐ Reducing pain
- ☐ Reducing inflammation
- ☐ Occupational therapy evaluations (e.g., swallow and speech evaluations), specify: _____
- ☐ Physical therapy evaluations, specify: _____
- ☐ Other, specify: _____
- ☐ None

How are ice packs or bags cleaned and disinfected after using on a patient? Describe.

_____

For what patient care activities is **water** from ice machines used at the hospital? (Select all that apply)

- ☐ Consumption/hydration
- ☐ Bathing
- ☐ Reducing fever
- ☐ Reducing pain
- ☐ Reducing inflammation
- ☐ Occupational therapy evaluations (e.g., swallow and speech evaluations), specify: _____
- ☐ Physical therapy evaluations, specify: _____
- ☐ Other, specify: _____
- ☐ None

Is ice or water from ice machines used to cool medications or products prior to patient administration (e.g., albuterol nebulizer solution, etc.)? ○ Yes ○ No ○ Unknown

If yes, describe types of medications or products. _____

If yes, where is the ice or water obtained from (e.g., unit/location of ice machine)?

_____

Is ice or water from ice machines used to actively cool endoscopes (e.g., bronchoscopes) during a procedure? ○ Yes ○ No ○ Unknown

If yes, where is the ice or water obtained from (e.g., unit/location of ice machine)?

_____

Is ice or water from ice machines used during other procedures or surgeries? ○ Yes ○ No ○ Unknown

If yes, describe types of procedures or surgeries. _____

Local Epi ID _____ / Local Lab ID _____

If yes, describe how ice or water is used during each of these procedures or surgeries.
_____
If yes, where is the ice or water obtained from (e.g., unit/location of ice machine)?
_____

SECTION 3. ICE MACHINES AND USE OF NONSTERILE ICE/WATER FROM ICE MACHINES

Facility ID: _____
(Please ensure this ID matches any previously communicated information on this patient)

Describe the frequency of cleaning/descaling and sanitizing the following of all ice machines of the same brand and model at the hospital. **Please, complete a new table for <u>each different brand/model</u> of ice machine located in a unit/area where the patient might have spent time during their hospital admission.**

Brand								
Model								
Component	**Frequency**							
Drain line	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Bi-monthly	☐ Quarterly	☐ Bi-annually	☐ Annually	☐ Other, specify:
Drain pain/drip pan	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Bi-monthly	☐ Quarterly	☐ Bi-annually	☐ Annually	☐ Other, specify:
Condenser	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Bi-monthly	☐ Quarterly	☐ Bi-annually	☐ Annually	☐ Other, specify:
Dispenser and components	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Bi-monthly	☐ Quarterly	☐ Bi-annually	☐ Annually	☐ Other, specify:
Ice machine	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Bi-monthly	☐ Quarterly	☐ Bi-annually	☐ Annually	☐ Other, specify:
Transport tube	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Bi-monthly	☐ Quarterly	☐ Bi-annually	☐ Annually	☐ Other, specify:
Ice storage area/bin	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Bi-monthly	☐ Quarterly	☐ Bi-annually	☐ Annually	☐ Other, specify:
Pressurized water line sanitizing	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Bi-monthly	☐ Quarterly	☐ Bi-annually	☐ Annually	☐ Other, specify:

Are ice machines part of the facility's water management plan?

- o Yes, ice machines are part of the facility's water management plan and testing of the ice or water from ice machines is included in the plan.
  If yes, what testing or monitoring of ice machines is part of the water management plan? (Select all that apply)
  - ☐ *Legionella* sp. testing
  - ☐ Coliform testing (e.g., total coliform, fecal coliform, *Escherichia coli*, etc.)
  - ☐ Heterotrophic plate count (HPC)
  - ☐ Other, specify: _____
- o Yes, ice machines are part of the facility's water management plan, but the plan does not include testing of the ice or water from ice machines.
- o No, ice machines are not part of the facility's water management plan.
- o No, the facility does not have a water management plan.
- o Unknown

Reference the list of locations/units where the patient was placed during the hospital admission (see SECTION 5. ACUTE CARE HOSPITAL ADMISSION from the medical record abstraction form).

Facility ID: _____
(Please ensure this ID matches any previously communicated information on this patient)

Did the patient spend time at a unit/location with an ice machine during the hospital admission?
○ Yes ○ No ○ Unknown
If no, **STOP HERE**
If yes, continue with the following questions.

Complete the following questions for <u>all ice machines located in units/locations where the patient was placed</u> during <u>admission to this acute care hospital</u>. If the patient had <u>multiple admissions to the same acute care hospital</u> and <u>spent time in the same units/locations</u> in the 14 days prior to index specimen collection, <u>list those units/locations only once</u>.

PLEASE, REFER TO THE SUPPLEMENTARY MATERIALS SECTION IN THIS FACILITY-LEVEL FORM IF YOU NEED TO COMPLETE THIS SECTION FOR ADMISSIONS TO MORE THAN ONE UNIT/LOCATION AND FOR A DIFFERENT FACILITY IDs.

Facility ID: _____
(Please ensure this ID matches any previously communicated information on this patient)

Unit/location: _____

How many ice machines are located in this unit/location? _____

Please, complete the following information for all ice machines in this unit/location. Use a new form for each ice machine.

Brand of ice machine: _____

Local Epi ID _____ / Local Lab ID _____

Model of ice machine: _____

Serial number of ice machine: _____

Purchase date of ice machine: ___ / _____
MM YYYY

Date when ice machine was put into use: ___ / _____
MM YYYY

Was the ice machine connected to the facility's water supply and checked for leaks during installation?
○ Yes ○ No ○ Unknown
If yes, unit/location of the hospital where it was connected and checked for leaks: _____

Was the ice machine cleaned/descaled and sanitized during installation and prior to putting into use?
○ Yes ○ No ○ Unknown

Date of last periodic cleaning/descaling and sanitizing prior to the date of index specimen collection for the first case-patient identified at this hospital: ___ / ___ /_____
MM DD YYYY

Please, list the following information for all cleaning/descaling products used in this ice machine:
Brand of cleaning/descaling product #1: _____
Name of cleaning/descaling product #1: _____
Lot number of cleaning/descaling product #1 used during the routine cleaning/descaling closest to the date of index specimen collection for the first case-patient identified at this hospital (if available): _____
Does this product need to be mixed with water prior to use? ○ Yes ○ No ○ Unknown
If yes, is tap water used? ○ Yes ○ No ○ Unknown
If yes, where is this tap water obtained from? _____
If yes, is hot tap water used (100°F or 38°C)? ○ Yes ○ No ○ Unknown

Is another cleaning/descaling product used in this ice machine? ○ Yes ○ No
Brand of cleaning/descaling product #2: _____
Name of cleaning/descaling product #2: _____
Lot number of cleaning/descaling product #2 used during the routine cleaning/descaling closest to the date of index specimen collection for the first case-patient identified at this hospital (if available): _____
Does this product need to be mixed with water prior to use? ○ Yes ○ No ○ Unknown
If yes, is tap water used? ○ Yes ○ No ○ Unknown
If yes, where is this tap water obtained from? _____
If yes, is hot tap water used (100°F or 38°C)? ○ Yes ○ No ○ Unknown

Brand of sanitizing product #1: _____
Name of sanitizing product #1: _____
Lot number of sanitizing product #1 used during the routine sanitizing closest to the date of index specimen collection for the first case-patient identified at this hospital (if available):
_____
Does this product need to be mixed with water prior to use? ○ Yes ○ No ○ Unknown
If yes, is tap water used? ○ Yes ○ No ○ Unknown
If yes, where is this tap water obtained from? _____
If yes, is hot tap water used (100°F or 38°C)? ○ Yes ○ No ○ Unknown

Is another sanitizing product used in this ice machine? ○ Yes ○ No
Brand of sanitizing product #2: _____
Name of sanitizing product #2: _____
Lot number of sanitizing product #2 used during the routine sanitizing closest to the date of index specimen collection for the first case-patient identified at this hospital (if available):
_____
Does this product need to be mixed with water prior to use? ○ Yes ○ No ○ Unknown
If yes, is tap water used? ○ Yes ○ No ○ Unknown
If yes, where is this tap water obtained from? _____
If yes, is hot tap water used (100°F or 38°C)? ○ Yes ○ No ○ Unknown

Is there a carbon filter attached to the water line that connects to this ice machine? ○ Yes ○ No ○ Unknown
If yes, how frequent is this filter changed? _____
Date when filter was last changed prior to the date of index specimen collection for the first case-patient identified at this hospital: ___ / ___ / ___
MM DD YYYY
Brand of carbon filter: _____
Lot number of carbon filter installed at the time of index specimen collection for the first case-patient identified at this hospital: _____

Is there a non-carbon filter (e.g., ultrafiltration filter) attached to the water line that connects to this ice machine? ○ Yes ○ No ○ Unknown
If yes, how frequent is this filter changed? _____
Date when filter was last changed prior to the date of index specimen collection for the first case-patient identified at this hospital: ___ / ___ / ___
MM DD YYYY
Brand of non-carbon filter: _____
Type of non-carbon filter: _____
Lot number of non-carbon filter installed at the time of index specimen collection for the first case-patient identified at this hospital: _____
Is this filter located after the carbon filter (i.e., closer to the water inlet of the ice machine)?
○ Yes ○ No ○ Unknown

Form Approved
OMB Control No.: 0920-XXXX
Expiration Date: XX/XX/XXXX

Supplementary Materials for *Burkholderia multivorans* Facility-Level Form

Local Epi ID _____ / Local Lab ID _____

Complete the following questions for all ice machines located in units/locations where the patient was placed during the hospital admission.

Facility ID: _____
(Please ensure this ID matches any previously communicated information on this patient)

Unit/location: _____

How many ice machines are located in this unit/location? _____

Please, complete the following information for all ice machines in this unit/location. Use a new form for each ice machine.

Brand of ice machine: _____

Model of ice machine: _____

Serial number of ice machine: _____

Purchase date of ice machine: ___ / _____
MM YYYY

Date when ice machine was put into use: ___ / _____
MM YYYY

Was the ice machine connected to the facility's water supply and checked for leaks during installation?
○ Yes ○ No ○ Unknown
If yes, unit/location of the hospital where it was connected and checked for leaks: _____

Was the ice machine cleaned/descaled and sanitized during installation and prior to putting into use?
○ Yes ○ No ○ Unknown

Date of last periodic cleaning/descaling and sanitizing prior to the date of index specimen collection for the first case-patient identified at this hospital: ___ / ___ /_____
MM DD YYYY

Please, list the following information for all cleaning/descaling products used in this ice machine:
Brand of cleaning/descaling product #1: _____
Name of cleaning/descaling product #1: _____
Lot number of cleaning/descaling product #1 used during the routine cleaning/descaling closest to the date of index specimen collection for the first case-patient identified at this hospital (if available): _____
Does this product need to be mixed with water prior to use? ○ Yes ○ No ○ Unknown
If yes, is tap water used? ○ Yes ○ No ○ Unknown

Local Epi ID _____ / Local Lab ID _____

If yes, where is this tap water obtained from? _____
If yes, is hot tap water used (100°F or 38°C)? ○ Yes ○ No ○ Unknown

Is another cleaning/descaling product used in this ice machine? ○ Yes ○ No
Brand of cleaning/descaling product #2: _____
Name of cleaning/descaling product #2: _____
Lot number of cleaning/descaling product #2 used during the routine cleaning/descaling closest to the date of index specimen collection for the first case-patient identified at this hospital (if available): _____
Does this product need to be mixed with water prior to use? ○ Yes ○ No ○ Unknown
If yes, is tap water used? ○ Yes ○ No ○ Unknown
If yes, where is this tap water obtained from? _____
If yes, is hot tap water used (100°F or 38°C)? ○ Yes ○ No ○ Unknown

Brand of sanitizing product #1: _____
Name of sanitizing product #1: _____
Lot number of sanitizing product #1 used during the routine sanitizing closest to the date of index specimen collection for the first case-patient identified at this hospital (if available): _____
Does this product need to be mixed with water prior to use? ○ Yes ○ No ○ Unknown
If yes, is tap water used? ○ Yes ○ No ○ Unknown
If yes, where is this tap water obtained from? _____
If yes, is hot tap water used (100°F or 38°C)? ○ Yes ○ No ○ Unknown

Is another sanitizing product used in this ice machine? ○ Yes ○ No
Brand of sanitizing product #2: _____
Name of sanitizing product #2: _____
Lot number of sanitizing product #2 used during the routine sanitizing closest to the date of index specimen collection for the first case-patient identified at this hospital (if available): _____
Does this product need to be mixed with water prior to use? ○ Yes ○ No ○ Unknown
If yes, is tap water used? ○ Yes ○ No ○ Unknown
If yes, where is this tap water obtained from? _____
If yes, is hot tap water used (100°F or 38°C)? ○ Yes ○ No ○ Unknown

Is there a carbon filter attached to the water line that connects to this ice machine? ○ Yes ○ No ○ Unknown
If yes, how frequent is this filter changed? _____
Date when filter was last changed prior to the date of index specimen collection for the first case-patient identified at this hospital: ___ / ___ / ___
MM DD YYYY
Brand of carbon filter: _____
Lot number of carbon filter installed at the time of index specimen collection for the first case-patient identified at this hospital: _____

Local Epi ID _____ / Local Lab ID _____

Is there a non-carbon filter (e.g., ultrafiltration filter) attached to the water line that connects to this ice machine? ○ Yes ○ No ○ Unknown

If yes, how frequent is this filter changed? _____

Date when filter was last changed prior to the date of index specimen collection for the first case-patient identified at this hospital: ___ / ___ / ___
MM DD YYYY

Brand of non-carbon filter: _____

Type of non-carbon filter: _____

Lot number of non-carbon filter installed at the time of index specimen collection for the first case-patient identified at this hospital: _____

Is this filter located after the carbon filter (i.e., closer to the water inlet of the ice machine)?
○ Yes ○ No ○ Unknown

Local Epi ID _____ / Local Lab ID _____