

# *Burkholderia multivorans*

## Outbreak Investigation Case Report Form

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**Jurisdiction:**

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**Local Epi ID:**

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**Local Lab ID:**

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**Facility ID:**

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**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

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

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# *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])

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

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

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

- 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 on the same day 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 after the date 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): \_\_\_\_\_

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

- 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.*

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

- 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:

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

What unit was the patient admitted to? \_\_\_\_\_

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

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: \_\_\_/\_\_\_/\_\_\_  
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Unit: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_  
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Unit: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_  
MM DD YYYY MM DD YYYY

Unit: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_  
MM DD YYYY MM DD YYYY

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Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

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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

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

**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:

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

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

|             |                                 |                               |
|-------------|---------------------------------|-------------------------------|
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |
| Unit: _____ | MM DD YYYY<br>From: ___/___/___ | MM DD YYYY<br>To: ___/___/___ |

# *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 each different brand/model 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                        | <input type="checkbox"/> Weekly | <input type="checkbox"/> Bi-weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-annually | <input type="checkbox"/> Annually | <input type="checkbox"/> Other, specify: |
| Drain pan/drip pan                | <input type="checkbox"/> Weekly | <input type="checkbox"/> Bi-weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-annually | <input type="checkbox"/> Annually | <input type="checkbox"/> Other, specify: |
| Condenser                         | <input type="checkbox"/> Weekly | <input type="checkbox"/> Bi-weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-annually | <input type="checkbox"/> Annually | <input type="checkbox"/> Other, specify: |
| Dispenser and components          | <input type="checkbox"/> Weekly | <input type="checkbox"/> Bi-weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-annually | <input type="checkbox"/> Annually | <input type="checkbox"/> Other, specify: |
| Ice machine                       | <input type="checkbox"/> Weekly | <input type="checkbox"/> Bi-weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-annually | <input type="checkbox"/> Annually | <input type="checkbox"/> Other, specify: |
| Transport tube                    | <input type="checkbox"/> Weekly | <input type="checkbox"/> Bi-weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-annually | <input type="checkbox"/> Annually | <input type="checkbox"/> Other, specify: |
| Ice storage area/bin              | <input type="checkbox"/> Weekly | <input type="checkbox"/> Bi-weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-annually | <input type="checkbox"/> Annually | <input type="checkbox"/> Other, specify: |
| Pressurized water line sanitizing | <input type="checkbox"/> Weekly | <input type="checkbox"/> Bi-weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-annually | <input type="checkbox"/> Annually | <input type="checkbox"/> Other, specify: |

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_



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

- 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: \_\_\_\_\_
- 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.
- No, ice machines are not part of the facility's water management plan.
- No, the facility does not have a water management plan.
- 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 all ice machines located in units/locations where the patient was placed during admission to this acute care hospital. If the patient had multiple admissions to the same acute care hospital and spent time in the same units/locations in the 14 days prior to index specimen collection, list those units/locations only once.**

**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

Local Epi ID \_\_\_\_\_ / Local Lab ID \_\_\_\_\_

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

**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

