# Invasive *Staphylococcus aureus*
# Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2024

Form Approved
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| 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: | 2.a PLANNING REGION: | 3. STATE ID: | 4. PATIENT ID: | 5. LABORATORY ID WHERE INCIDENT SPECIMEN INDENTIFIED: | 6. FACILITY ID WHERE PATIENT TREATED: |
|---|---|---|---|---|---|---|
| ____ ____ | | | | | | |

**7. SEX AT BIRTH:**
1 ☐ Male 2 ☐ Female
9 ☐ Unknown
1 ☐ Check if transgendered

**8. DATE OF BIRTH:** ___ ___ - ___ ___ - ___ ___ ___ ___

**9. AGE** ___ ___ ___
1 ☐ Days 2 ☐ Mos. 3 ☐ Years

**10. RACE: (Check all that apply)**
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ White
1 ☐ Unknown

**13. ETHNIC ORIGIN:**
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

**12. WEIGHT:**
_____ lbs. _____ oz. OR _____ kg.
1 ☐ Unknown

**13. HEIGHT:**
_____ ft. _____ in. OR _____ cm. 1
1 ☐ Unknown

**14. BMI (record only if ht. and/or wt. is not available)**
_____ 1 ☐ Unknown

**15. DATE OF INCIDENT SPECIMEN COLLECTION (DISC):**
___ ___ - ___ ___ - ___ ___ ___ ___

**15a. IS THE ISOLATE MRSA OR MSSA?**
☐ MRSA ☐ MSSA
☐ Unknown

**16. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER, THE DISC?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown **IF YES, date of admission:** ___ ___ - ___ ___ - ___ ___ ___ ___

**17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?**
1 ☐ Yes (HO-MRSA case) 2 ☐ No (CA-MRSA or HACO-MRSA case)

**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): _____

**19. LOCATION OF SPECIMEN COLLECTION:**

**1 ☐ Outpatient**
Facility ID: _____
3 ☐ Emergency room
8 ☐ Clinic/doctor's office
15 ☐ Dialysis center
11 ☐ Surgery
16 ☐ Observation/Clinical decision unit
4 ☐ Other outpatient

**1 ☐ Inpatient**
Facility ID: _____
1 ☐ ICU
6 ☐ OR
7 ☐ Radiology
2 ☐ Other Inpatient

**5 ☐ LTCF**
Facility ID: _____

**13 ☐ LTACH**
Facility ID: _____

**14 ☐ Autopsy**

**10 ☐ Other (specify):** _____

9 ☐ Unknown

**20. WERE CULTURES OF THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:**

| | | |
|---|---|---|
| 1 ☐ Blood | 1 ☐ Bone | 1 ☐ CSF |
| Date: _____ | Date: _____ | Date: _____ |
| 1 ☐ Internal body site | 1 ☐ Joint/Synovial fluid | 1 ☐ Muscle |
| Date: _____ | Date: _____ | Date: _____ |
| 1 ☐ Peritoneal fluid | 1 ☐ Pericardial fluid | 1 ☐ Pleural fluid |
| Date: _____ | Date: _____ | Date: _____ |

1 ☐ Other normally sterile site (specify): _____
Date: _____

**21. DATE OF FIRST SA BLOOD CULTURE AFTER WHICH SA NOT ISOLATED FOR 13 DAYS:** ___ ___ - ___ ___ - ___ ___ ___ ___

**22. SUSCEPTIBILITY RESULTS [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), NS=Non-susceptible (4), SDD=Susceptible dose-dependent (5), U=Unknown/Not Reported (9)]**

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cefazolin | 1 ☐ S | 2 ☐ I | 3 ☐ R | 9 ☐ U | Cefoxitin | 1 ☐ S | 3 ☐ R | 9 ☐ U | Ceftaroline | 1 ☐ S | 5 ☐ SDD | 3 ☐ R | 9 ☐ U | Clindamycin | 1 ☐ S | 2 ☐ I | 3 ☐ R | 9 ☐ U |
| Daptomycin | 1 ☐ S | 4 ☐ NS | 9 ☐ U | | Doxycycline | 1 ☐ S | 2 ☐ I | 3 ☐ R | 9 ☐ U | Linezolid | 1 ☐ S | 3 ☐ R | 9 ☐ U | Nafcillin | 1 ☐ S | 2 ☐ I | 3 ☐ R | 9 ☐ U | | | | |
| Oxacillin | 1 ☐ S | 3 ☐ R | 9 ☐ U | | Tetracycline | 1 ☐ S | 2 ☐ I | 3 ☐ R | 9 ☐ U | TMP-SMX | 1 ☐ S | 2 ☐ I | 3 ☐ R | 9 ☐ U | Vancomycin | 1 ☐ S | 2 ☐ I | 3 ☐ R | 9 ☐ U | | | | |

**23. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC?**
1 ☐ Private residence
1 ☐ LTCF Facility ID: _____
1 ☐ Hospital Inpatient Facility ID: _____
Was patient transferred from this hospital?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
1 ☐ LTACH Facility ID: _____
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Other (specify): _____
1 ☐ Unknown

**24. IF CASE IS ≤12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION:**
1 ☐ NICU/SCN 2 ☐ Well Baby Nursery 9 ☐ Unknown

**25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**IF YES, birth weight:** _____ **lbs.** _____ **oz. OR** _____ **g.** OR 1 ☐ Unknown birth weight

**IF YES, estimated gestational age:** _____ weeks OR 1 ☐ Unknown gestational age



***— IMPORTANT — PLEASE COMPLETE THE BACK OF THIS FORM —***

**26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
**IF YES, date of ICU admission:** __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

**27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
**IF YES, date of ICU admission:** __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

**28. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S):** (Check all that apply) 1 ☐ None 1 ☐ Unknown

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

**28a. DOES THE PATIENT HAVE:**

| | | | | ***IF YES,*** is it associated with the MRSA/MSSA infection? | | |
|---|---|---|---|---|---|---|
| Implanted cardiac device (e.g., prosthetic heart valve, pacemaker, AICD, LVAD)? | 1 ☐ Yes | 2 ☐ No | 9 ☐ Unknown | 1 ☐ Yes, specify: _____ | 2 ☐ No | 9 ☐ Unknown |
| Implanted orthopedic device (e.g., prosthetic joint or orthopedic hardware)? | 1 ☐ Yes | 2 ☐ No | 9 ☐ Unknown | 1 ☐ Yes, specify: _____ | 2 ☐ No | 9 ☐ Unknown |
| Non-dialysis vascular graft? | 1 ☐ Yes | 2 ☐ No | 9 ☐ Unknown | 1 ☐ Yes | 2 ☐ No | 9 ☐ Unknown |

**28b. Does the patient have another type of implanted prosthetic device associated with the infection?** 1 ☐ Yes, specify: _____ 2 ☐ No 9 ☐ Unknown

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

**CHRONIC LUNG DISEASE**
1 ☐ Cystic fibrosis
1 ☐ Chronic pulmonary disease

**CHRONIC METABOLIC DISEASE**
1 ☐ Diabetes mellitus
1 ☐ With chronic complications

**CARDIOVASCULAR DISEASE**
1 ☐ CVA/Stroke/TIA
1 ☐ Congenital heart disease
1 ☐ Congestive heart failure
1 ☐ Myocardial infarction
1 ☐ Peripheral vascular disease (PVD)

**GASTROINTESTINAL DISEASE**
1 ☐ Diverticular disease
1 ☐ Inflammatory bowel disease
1 ☐ Peptic ulcer disease
1 ☐ Short gut syndrome

**IMMUNOCOMPROMISED CONDITION**
1 ☐ HIV infection
1 ☐ AIDS/CD4 count <200
1 ☐ Primary immunodeficiency
1 ☐ Transplant, hematopoetic stem cell
1 ☐ Transplant, solid organ: _____

**LIVER DISEASE**
1 ☐ Chronic liver disease
1 ☐ Ascites
1 ☐ Cirrhosis
1 ☐ Hepatic encephalopathy
1 ☐ Variceal bleeding
1 ☐ Hepatitis C
1 ☐ Treated, in SVR
1 ☐ Current, chronic

**MALIGNANCY**
1 ☐ Malignancy, hematologic
1 ☐ Malignancy, solid organ (non-metastatic)
1 ☐ Malignancy, solid organ (metastatic)

**NEUROLOGIC CONDITION**
1 ☐ Cerebral palsy
1 ☐ Chronic cognitive deficit
1 ☐ Dementia
1 ☐ Epilepsy/seizure/seizure disorder
1 ☐ Multiple sclerosis
1 ☐ Neuropathy
1 ☐ Parkinson's Disease
1 ☐ Other (specify): _____

**PLEGIAS/PARALYSIS**
1 ☐ Hemiplegia
1 ☐ Paraplegia
1 ☐ Quadriplegia

**RENAL DISEASE**
1 ☐ Chronic kidney disease
Lowest serum creatinine: _____ mg/DL
1 ☐ Unknown or not done

**SKIN CONDITION**
1 ☐ Burn
1 ☐ Decubitus/pressure ulcer
1 ☐ Surgical wound
1 ☐ Other chronic ulcer or chronic wound
1 ☐ Other skin condition (specify): _____

**OTHER**
1 ☐ Connective tissue disease
1 ☐ Obesity or morbid obesity
1 ☐ Pregnant
1 ☐ Other (specify only for cases ≤12 months of age): _____

**30. WAS THE PATIENT HOMELESS IN THE YEAR BEFORE DISC?** 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**31. SUBSTANCE USE:**

**SMOKING:** 1 ☐ None 1 ☐ Unknown 1 ☐ Tobacco 1 ☐ E-nicotine delivery system 1 ☐ Marijuana

**ALCOHOL ABUSE:** 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**OTHER SUBSTANCES (CHECK ALL THAT APPLY):** 1 ☐ None 1 ☐ Unknown

| | DOCUMENTED USE DISORDER (DUD/ABUSE): | MODE OF DELIVERY (Check all that apply): |
|---|---|---|
| 1 ☐ Marijuana, cannabinoid (other than smoking) | 1 ☐ DUD or abuse | 1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown |
| 1 ☐ Opioid, DEA schedule I (e.g., Heroin) | 1 ☐ DUD or abuse | 1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown |
| 1 ☐ Opioid, DEA schedule II-IV (e.g., methadone, oxycodone) | 1 ☐ DUD or abuse | 1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown |
| 1 ☐ Opioid, NOS | 1 ☐ DUD or abuse | 1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown |
| 1 ☐ Cocaine | 1 ☐ DUD or abuse | 1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown |
| 1 ☐ Methamphetamine | 1 ☐ DUD or abuse | 1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown |
| 1 ☐ Other (specify): _____ | 1 ☐ DUD or abuse | 1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown |
| 1 ☐ Unknown substance | 1 ☐ DUD or abuse | 1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ 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/MSSA INFECTION OR COLONIZATION**

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

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

**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 LTACH IN THE YEAR BEFORE DISC**

1 ☐ Yes 2 ☐ No 9 ☐ 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 2 ☐ Died 9 ☐ Unknown

DATE OF DISCHARGE: __ __ - __ __ - __ __ __ __ OR 1 ☐ Date Unknown

1 ☐ Left against medical advice (AMA)

IF SURVIVED, DISCHARGED TO:

1 ☐ Private Residence

2 ☐ LTCF Facility ID: _____

3 ☐ LTACH Facility ID: _____

4 ☐ Other (specify): _____

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, ANTIGEN OR OTHER VIRAL TEST; EXCLUDING SEROLOGY) IN THE 90 DAYS BEFORE OR DAY OF THE DISC?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

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

COVID-NET CASE ID in the year before or day of the DISC: _____ ☐ None or N/A

**34. WAS CASE FIRSTIDENTIFIED 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/MSSA 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:**