Form Approved
OMB No. 0920-0978
Expires xx/xx/xxxx
January, 2024

Invasive *Staphylococcus aureus* Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2025

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 transgender

8. DATE OF BIRTH: __ __ - __ __ - __ __ __ __

9. AGE __ __ __
1 ☐ Days 2 ☐ Mos. 3 ☐ Years

10. RACE AND/OR ETHNICITY: (Check all that apply)
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Hispanic or Latino
1 ☐ Middle Eastern or North African
1 ☐ Native Hawaiian or Pacific Islander
1 ☐ White
1 ☐ Unknown

11. WEIGHT: ______ **lbs.** ______ **oz. OR** ______ **kg.**
1 ☐ Unknown

12. HEIGHT: ______ **ft.** ______ **in. OR** ______ **cm.** 1
1 ☐ Unknown

13. BMI (record only if ht. and/or wt. is not available)
______ 1 ☐ Unknown

14. DATE OF INCIDENT SPECIMEN COLLECTION (DISC):
__ __ - __ __ - __ __ __ __

15. 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 case) 2 ☐ No (CA or HACO 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
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 Date: ________ 1 ☐ Bone Date: ________ 1 ☐ CSF Date: ________
1 ☐ Internal body site Date: ________ 1 ☐ Joint/Synovial fluid Date: ________ 1 ☐ Muscle Date: ________
1 ☐ Peritoneal fluid Date: ________ 1 ☐ Pericardial fluid Date: ________ 1 ☐ Pleural fluid 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)]

Drug					Drug				
Cefazolin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ U	Cefoxitin	1 ☐ S		3 ☐ R	9 ☐ U
Daptomycin	1 ☐ S	4 ☐ NS		9 ☐ U	Doxycycline	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ U
Oxacillin	1 ☐ S		3 ☐ R	9 ☐ U	Tetracycline	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ U
Ceftaroline	1 ☐ S	5 ☐ SDD	3 ☐ R	9 ☐ U	Clindamycin	1 ☐ S	2 ☐ I	3 ☐ R	9 ☐ U
Linezolid	1 ☐ S		3 ☐ R	9 ☐ U	Nafcillin	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 ☐ Correctional or detention facility
1 ☐ Drug/alcohol rehabilitation
1 ☐ Other
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

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— 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?

		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 ☐ Paresis
1 ☐ Parkinson's Disease
1 ☐ Spinal cord injury

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 ☐ Blistering disease
1 ☐ Burn
1 ☐ Decubitus/pressure ulcer
1 ☐ Eczema
1 ☐ Psoriasis
1 ☐ Surgical wound
1 ☐ Other chronic ulcer or chronic wound

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 documented 1 ☐ Unknown 1 ☐ Tobacco 1 ☐ E-nicotine delivery system 1 ☐ Marijuana

ALCOHOL ABUSE: 1 ☐ Yes 2 ☐ None documented 9 ☐ Unknown

OTHER SUBSTANCES (CHECK ALL THAT APPLY): 1 ☐ None documented 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 3 ☐ Hospitalized >1 year 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: ____________
☐ Homeless
☐ Correctional or detention facility
☐ Drug/alcohol rehabilitation
4 ☐ Other
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: