NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn

Laboratory-identified MDRO or CDI Event for LTCF

*Required for saving *Facility ID:	Event #:
*Resident ID:	
Medicare number (or comparable railroad insurance number):	
Resident Name: Last: First: Middle:	
*Gender: M F Other	*Date of Birth: ___/___/____
Sex at Birth: M F Other	Gender Identity (Specify): Gender Identity (Specify): Male Female Male-to-female transgender Female-to-male transgender Identifies as non-conforming Other Asked but unknown
*Ethnicity (Specify): Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Declined to respond	*Race (Specify Race (Select all that apply): American Indian or Alaska Native Asian Black or African American Middle Eastern or North African Native Hawaiian or Pacific Islander White Unknown Declined to respond
Preferred Language: (Specify)	Interpreter Needed: (Specify) Yes No Declined to Respond Unknown
*Date of First Admission to Facility: __/__/____	*Date of Current Admission to Facility: __/__/____
Event Details	
*Event Type: **LabID**	*Date Specimen Collected: __/__/____
*Specific Organism Type: (check one) ☐ MRSA ☐ MSSA ☐ VRE ☐ *C. difficile* ☐ CephR-*Klebsiella* ☐ CRE-*E. coli* ☐ CRE-*Enterobacter* ☐ CRE-*Klebsiella* ☐ MDR-*Acinetobacter*	
*Specimen Body Site/System:	*Specimen Source:
*Resident Care Location:	
*Primary Resident Service Type: (check one) ☐ Long-term general nursing ☐ Long-term dementia ☐ Long-term psychiatric ☐ Skilled nursing/Short-term rehab (subacute) ☐Ventilator ☐ Bariatric ☐ Hospice/Palliative	
*Has resident been transferred from an acute care facility in the past 4 weeks? Yes No	
If Yes, <u>date of last transfer</u> from acute care to your facility: __/__/____ If Yes, was the resident on antibiotic therapy for this specific organism type at the time of transfer to your facility? Yes No	
Custom Fields	
Label ________________ ____/____/_____ ________________ ______________ ________________ ______________ ________________ ______________ ________________ ______________	Label ________________ ____/____/_____ ________________ ______________ ________________ ______________ ________________ ______________ ________________ ______________
Comments	

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Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 23 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

CDC 57.138, rev 7, v 13.0