



Invasive Methicillin-Sensitive Staphylococcus aureus
Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2023

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

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 IDENTIFIED: 6. FACILITY ID WHERE PATIENT TREATED:

7. SEX: 8. DATE OF BIRTH: 9. AGE: 10. RACE: (Check all that apply) 13. ETHNIC ORIGIN:

12. WEIGHT: 13. HEIGHT: 14. BMI (record only if ht. and/or wt. is not available) 15. DATE OF INCIDENT SPECIMEN COLLECTION (DISC):

16. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER THE DISC? 17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?

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: 20. WERE CULTURES OS THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?
IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:

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), U=Unknown/Not Reported (9)]
Cefazolin 1 S 2 I 3 R 9 U Cefoxitin 1 S 3 R 9 U Clindamycin 1 S 2 I 3 R 9 U
Nafcillin 1 S 2 I 3 R 9 U Oxacillin 1 S 3 R 9 U Trimethoprim-Sulfamethoxazole 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? 24. IF CASE IS <12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION:
25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)?

Public reporting burden of this collection of information is estimated to average 28 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/ ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

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 MRSA INFECTION ASSOCIATED WITH CULTURE(S): (Check all that apply) 1 None 1 Unknown

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

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, hematopoietic 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 <input type="checkbox"/> Marijuana, cannabinoid (other than smoking)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, DEA schedule I (e.g., Heroin)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, NOS	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Cocaine	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Methamphetamine	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Other (specify): _____	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown

1 <input type="checkbox"/> Unknown substance	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> 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 INFECTION OR COLONIZATION

1 Yes 2 No 9 Unknown

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

OVERNIGHT STAY IN LTACH IN THE YEAR BEFORE DISC

1 Yes 2 No 9 Unknown

Facility ID: _____

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 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

DATE OF DISCHARGE: ____ - ____ - ____ OR 1 Date Unknown

1 Left against medical advice (AMA)

IF SURVIVED, DISCHARGED TO:

- 1 Private Residence 4 Other (specify): _____
- 2 LTCF Facility ID: _____
- 3 LTACH Facility ID: _____ 9 Unknown

2 Died 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

COVID-NET CASE ID: _____

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

34. WAS CASE FIRST IDENTIFIED 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 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: