Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2027
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:	
*Sex: F M	*Date of Birth: ___/___/____
*Ethnicity (specify): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to respond ☐ Unknown	*Race (specify): ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Middle Eastern or North African ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ 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, date of last transfer 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

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 20 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 H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).

CDC 57.138, v 13.0 January 2025