



# Invasive *Staphylococcus aureus* Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2026

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

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: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Missing Value	8. DATE OF BIRTH: ____ - ____ - ____		10. RACE AND/OR ETHNICITY: (Check all that apply)				
9 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Years	9. AGE	1 <input type="checkbox"/> American Indian or Alaska Native	1 <input type="checkbox"/> Hispanic or Latino	1 <input type="checkbox"/> White	1 <input type="checkbox"/> Asian	1 <input type="checkbox"/> Middle Eastern or North African	1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Black or African American	1 <input type="checkbox"/> Native Hawaiian or Pacific Islander	11. WEIGHT: ____ lbs. ____ oz. OR ____ kg. 1 <input type="checkbox"/> Unknown	12. HEIGHT: ____ ft. ____ in. OR ____ cm. 1 1 <input type="checkbox"/> Unknown		13. BMI (record only if ht. and/or wt. is not available) ____ 1 <input type="checkbox"/> Unknown	14. DATE OF INCIDENT SPECIMEN COLLECTION (DISC): ____ - ____ - ____	15. IS THE ISOLATE MRSA OR MSSA? 1 <input type="checkbox"/> MRSA 1 <input type="checkbox"/> MSSA 1 <input type="checkbox"/> Unknown
16. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER, THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of admission: ____ - ____ - ____				17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION? 1 <input type="checkbox"/> Yes (HO case) 2 <input type="checkbox"/> No (CA or HACO case)			
18. INCIDENT SPECIMEN COLLECTION SITE: (Check all that apply)							
1 <input type="checkbox"/> Blood	1 <input type="checkbox"/> Bone	1 <input type="checkbox"/> CSF	1 <input type="checkbox"/> Internal body site (specify): _____			1 <input type="checkbox"/> Joint/Synovial fluid	1 <input type="checkbox"/> Muscle
1 <input type="checkbox"/> Pericardial fluid	1 <input type="checkbox"/> Peritoneal fluid	1 <input type="checkbox"/> Pleural fluid	1 <input type="checkbox"/> Other normally sterile site (specify): _____				
19. LOCATION OF SPECIMEN COLLECTION:				20. WERE CULTURES OF THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?			
1 <input type="checkbox"/> Outpatient	1 <input type="checkbox"/> Inpatient	5 <input type="checkbox"/> LTCF	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				
Facility ID: _____	Facility ID: _____	Facility ID: _____	IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:				
3 <input type="checkbox"/> Emergency room	1 <input type="checkbox"/> ICU	13 <input type="checkbox"/> LTACH	1 <input type="checkbox"/> Blood	1 <input type="checkbox"/> Bone	1 <input type="checkbox"/> CSF	Date: _____	Date: _____
8 <input type="checkbox"/> Clinic/doctor's office	6 <input type="checkbox"/> OR	Facility ID: _____	1 <input type="checkbox"/> Internal body site	1 <input type="checkbox"/> Joint/Synovial fluid	1 <input type="checkbox"/> Muscle	Date: _____	Date: _____
15 <input type="checkbox"/> Dialysis center	7 <input type="checkbox"/> Radiology	14 <input type="checkbox"/> Autopsy	1 <input type="checkbox"/> Peritoneal fluid	1 <input type="checkbox"/> Pericardial fluid	1 <input type="checkbox"/> Pleural fluid	Date: _____	Date: _____
11 <input type="checkbox"/> Surgery	2 <input type="checkbox"/> Other Inpatient	10 <input type="checkbox"/> Other	1 <input type="checkbox"/> Other normally sterile site (specify): _____	Date: _____			
16 <input type="checkbox"/> Observation/Clinical decision unit	9 <input type="checkbox"/> Unknown						
4 <input type="checkbox"/> Other outpatient							
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 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Cefoxitin 1 <input type="checkbox"/> S 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Ceftaroline 1 <input type="checkbox"/> S 5 <input type="checkbox"/> SDD 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Clindamycin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Daptomycin 1 <input type="checkbox"/> S 4 <input type="checkbox"/> NS 9 <input type="checkbox"/> U	Doxycycline 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Linezolid 1 <input type="checkbox"/> S 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Nafcillin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U
Oxacillin 1 <input type="checkbox"/> S 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Tetracycline 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	TMP-SMX 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Vancomycin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> 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:			
1 <input type="checkbox"/> Private residence	1 <input type="checkbox"/> LTACH Facility ID: _____	1 <input type="checkbox"/> Homeless	1 <input type="checkbox"/> NICU/SCN	2 <input type="checkbox"/> Well Baby Nursery	9 <input type="checkbox"/> Unknown		
1 <input type="checkbox"/> LTCF Facility ID: _____	1 <input type="checkbox"/> Hospital Inpatient Facility ID: _____	1 <input type="checkbox"/> Correctional or detention facility	25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)?				
1 <input type="checkbox"/> Drug/alcohol rehabilitation	1 <input type="checkbox"/> Other	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					
Was patient transferred from this hospital?	1 <input type="checkbox"/> Other	IF YES, birth weight: ____ lbs. ____ oz. OR ____ g. OR 1 <input type="checkbox"/> Unknown birth weight					
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Unknown	IF YES, estimated gestational age: ____ weeks OR 1 <input type="checkbox"/> Unknown gestational age					

Public reporting burden of this collection of information is estimated to average 29 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).

<b>26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>IF YES, date of ICU admission:</b> ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown	<b>27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>IF YES, date of ICU admission:</b> ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown												
<b>28. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S):</b> (Check all that apply) 1 <input type="checkbox"/> None 1 <input type="checkbox"/> 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 _____													
<b>28a. DOES THE PATIENT HAVE:</b> Implanted cardiac device (e.g., prosthetic heart valve, pacemaker, AICD, LVAD)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>IF YES, is it associated with the MRSA/MSSA infection?</b> 1 <input type="checkbox"/> Yes, specify: _____ 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown Implanted orthopedic device (e.g., prosthetic joint or orthopedic hardware)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Yes, specify: _____ 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown Non-dialysis prosthetic vascular graft? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>28b. Does the patient have another type of implanted prosthetic device associated with the infection?</b> 1 <input type="checkbox"/> Yes, specify: _____ 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown													
<b>29. UNDERLYING CONDITIONS:</b> (Check all that apply) 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown <table style="width:100%; border: none;"> <tr> <td style="width:25%; vertical-align: top;"> <b>CHRONIC LUNG DISEASE</b>  1 <input type="checkbox"/> Cystic fibrosis  1 <input type="checkbox"/> Chronic pulmonary disease </td> <td style="width:25%; vertical-align: top;"> <b>IMMUNOCOMPROMISED CONDITION</b>  1 <input type="checkbox"/> HIV infection  1 <input type="checkbox"/> AIDS/CD4 count &lt;200  1 <input type="checkbox"/> Primary immunodeficiency  1 <input type="checkbox"/> Transplant, hematopoietic stem cell  1 <input type="checkbox"/> Transplant, solid organ: _____ </td> <td style="width:25%; vertical-align: top;"> <b>MALIGNANCY</b>  1 <input type="checkbox"/> Malignancy, hematologic  1 <input type="checkbox"/> Malignancy, solid organ (non-metastatic)  1 <input type="checkbox"/> Malignancy, solid organ (metastatic) </td> <td style="width:25%; vertical-align: top;"> <b>RENAL DISEASE</b>  1 <input type="checkbox"/> Chronic kidney disease  Lowest serum creatinine: _____ mg/DL  1 <input type="checkbox"/> Unknown or not done </td> </tr> <tr> <td style="vertical-align: top;"> <b>CHRONIC METABOLIC DISEASE</b>  1 <input type="checkbox"/> Diabetes mellitus  1 <input type="checkbox"/> With chronic complications </td> <td style="vertical-align: top;"> <b>LIVER DISEASE</b>  1 <input type="checkbox"/> Chronic liver disease  1 <input type="checkbox"/> Ascites  1 <input type="checkbox"/> Cirrhosis  1 <input type="checkbox"/> Hepatic encephalopathy  1 <input type="checkbox"/> Variceal bleeding  1 <input type="checkbox"/> Hepatitis C  1 <input type="checkbox"/> Treated, in SVR  1 <input type="checkbox"/> Current, chronic </td> <td style="vertical-align: top;"> <b>NEUROLOGIC CONDITION</b>  1 <input type="checkbox"/> Cerebral palsy  1 <input type="checkbox"/> Chronic cognitive deficit  1 <input type="checkbox"/> Dementia  1 <input type="checkbox"/> Epilepsy/seizure/seizure disorder  1 <input type="checkbox"/> Multiple sclerosis  1 <input type="checkbox"/> Neuropathy  1 <input type="checkbox"/> Paresis  1 <input type="checkbox"/> Parkinson's Disease  1 <input type="checkbox"/> Spinal cord injury </td> <td style="vertical-align: top;"> <b>SKIN CONDITION</b>  1 <input type="checkbox"/> Blistering disease  1 <input type="checkbox"/> Burn  1 <input type="checkbox"/> Decubitus/pressure ulcer  1 <input type="checkbox"/> Eczema  1 <input type="checkbox"/> Psoriasis  1 <input type="checkbox"/> Surgical wound  1 <input type="checkbox"/> Other chronic ulcer or chronic wound </td> </tr> <tr> <td style="vertical-align: top;"> <b>CARDIOVASCULAR DISEASE</b>  1 <input type="checkbox"/> CVA/Stroke/TIA  1 <input type="checkbox"/> Congenital heart disease  1 <input type="checkbox"/> Congestive heart failure  1 <input type="checkbox"/> Myocardial infarction  1 <input type="checkbox"/> Peripheral vascular disease (PVD) </td> <td 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<b>30. WAS THE PATIENT HOMELESS IN THE YEAR BEFORE DISC?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown													
<b>31. SUBSTANCE USE:</b> <b>SMOKING:</b> 1 <input type="checkbox"/> None documented 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Tobacco 1 <input type="checkbox"/> E-nicotine delivery system 1 <input type="checkbox"/> Marijuana <b>ALCOHOL ABUSE:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> None documented 9 <input type="checkbox"/> Unknown <b>OTHER SUBSTANCES (CHECK ALL THAT APPLY):</b> 1 <input type="checkbox"/> None documented 1 <input type="checkbox"/> Unknown <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top;"> <b>DOCUMENTED USE DISORDER (DUD/ABUSE):</b>  1 <input type="checkbox"/> Marijuana, cannabinoid (other than smoking)  1 <input type="checkbox"/> Opioid, DEA schedule I (e.g., Heroin)  1 <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)  1 <input type="checkbox"/> Opioid, NOS  1 <input type="checkbox"/> Cocaine  1 <input type="checkbox"/> Methamphetamine  1 <input type="checkbox"/> Other (specify): _____  _____  1 <input type="checkbox"/> Unknown substance </td> <td style="width:33%; vertical-align: top;"> 1 <input type="checkbox"/> DUD or abuse  1 <input type="checkbox"/> DUD or abuse </td> <td style="width:33%; vertical-align: top;"> <b>MODE OF DELIVERY (Check all that apply):</b>  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"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown  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"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown  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"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown  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"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown </td> </tr> </table>		<b>DOCUMENTED USE DISORDER (DUD/ABUSE):</b> 1 <input type="checkbox"/> Marijuana, cannabinoid (other than smoking) 1 <input type="checkbox"/> Opioid, DEA schedule I (e.g., Heroin) 1 <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone) 1 <input type="checkbox"/> Opioid, NOS 1 <input type="checkbox"/> Cocaine 1 <input type="checkbox"/> Methamphetamine 1 <input type="checkbox"/> Other (specify): _____ _____ 1 <input type="checkbox"/> Unknown substance	1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse	<b>MODE OF DELIVERY (Check all that apply):</b> 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"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 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"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 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"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown 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"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown									
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<b>DURING THE CURRENT HOSPITALIZATION DID THE PATIENT RECEIVE MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> 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

**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 2  Died

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: \_\_\_\_\_
- 5  Homeless
- 6  Correctional or detention facility
- 7  Drug/alcohol rehabilitation
- 4  Other
- 9  Unknown

3  Hospitalized >1 year

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 in the year before or day of the DISC: \_\_\_\_\_  None or N/A

**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/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:**