



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

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:	
_____	_____	_____	_____	_____	_____	
7. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Missing Value		8. DATE OF BIRTH: ____ - ____ - ____ 9. AGE: ____ 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Years		10. RACE AND/OR ETHNICITY: (Check all that apply) 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? <input type="checkbox"/> MRSA <input type="checkbox"/> MSSA <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: 1 <input type="checkbox"/> Outpatient 1 <input type="checkbox"/> Inpatient 5 <input type="checkbox"/> LTCF Facility ID: _____ Facility ID: _____ Facility ID: _____ 3 <input type="checkbox"/> Emergency room 1 <input type="checkbox"/> ICU 13 <input type="checkbox"/> LTACH 8 <input type="checkbox"/> Clinic/doctor's office 6 <input type="checkbox"/> OR Facility ID: _____ 15 <input type="checkbox"/> Dialysis center 7 <input type="checkbox"/> Radiology 14 <input type="checkbox"/> Autopsy 11 <input type="checkbox"/> Surgery 2 <input type="checkbox"/> Other Inpatient 10 <input type="checkbox"/> Other 16 <input type="checkbox"/> Observation/Clinical decision unit 9 <input type="checkbox"/> Unknown 4 <input type="checkbox"/> Other outpatient			20. WERE CULTURES OF THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE: 1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> CSF Date: _____ Date: _____ Date: _____ 1 <input type="checkbox"/> Internal body site 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> Muscle Date: _____ Date: _____ Date: _____ 1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Pleural fluid Date: _____ Date: _____ Date: _____ 1 <input type="checkbox"/> 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)] 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? 1 <input type="checkbox"/> Private residence 1 <input type="checkbox"/> LTACH Facility ID: _____ 1 <input type="checkbox"/> LTCF Facility ID: _____ 1 <input type="checkbox"/> Hospital Inpatient Facility ID: _____ Was patient transferred from this hospital? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			24. IF CASE IS ≤12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION: 1 <input type="checkbox"/> NICU/SCN 2 <input type="checkbox"/> Well Baby Nursery 9 <input type="checkbox"/> Unknown 25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, birth weight: _____ lbs. _____ oz. OR _____ g. OR 1 <input type="checkbox"/> Unknown birth weight 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).						

26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of ICU admission: ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown		27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of ICU admission: ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown	
28. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S): (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"/> AV Fistula/Graft Infection 1 <input type="checkbox"/> Chronic Ulcer/Wound (non-decubitus) 1 <input type="checkbox"/> Bacteremia 1 <input type="checkbox"/> Decubitus/Pressure Ulcer 1 <input type="checkbox"/> Bursitis 1 <input type="checkbox"/> Empyema 1 <input type="checkbox"/> Catheter Site Infection 1 <input type="checkbox"/> Endocarditis		1 <input type="checkbox"/> Epidural Abscess 1 <input type="checkbox"/> Septic Arthritis 1 <input type="checkbox"/> Meningitis 1 <input type="checkbox"/> Septic Emboli 1 <input type="checkbox"/> Peritonitis 1 <input type="checkbox"/> Septic Shock 1 <input type="checkbox"/> Pneumonia 1 <input type="checkbox"/> Skin Abscess 1 <input type="checkbox"/> Osteomyelitis 1 <input type="checkbox"/> Surgical Incision	
28a. DOES THE PATIENT HAVE: 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 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 Non-dialysis vascular graft? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		IF YES, is it associated with the MRSA/MSSA infection? 1 <input type="checkbox"/> Yes, specify: _____ 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 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	
28b. Does the patient have another type of implanted prosthetic device associated with the infection? 1 <input type="checkbox"/> Yes, specify: _____ 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			
29. UNDERLYING CONDITIONS: (Check all that apply) 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown			
CHRONIC LUNG DISEASE 1 <input type="checkbox"/> Cystic fibrosis 1 <input type="checkbox"/> Chronic pulmonary disease		IMMUNOCOMPROMISED CONDITION 1 <input type="checkbox"/> HIV infection 1 <input type="checkbox"/> AIDS/CD4 count <200 1 <input type="checkbox"/> Primary immunodeficiency 1 <input type="checkbox"/> Transplant, hematopoietic stem cell 1 <input type="checkbox"/> Transplant, solid organ: _____	
CHRONIC METABOLIC DISEASE 1 <input type="checkbox"/> Diabetes mellitus 1 <input type="checkbox"/> With chronic complications		MALIGNANCY 1 <input type="checkbox"/> Malignancy, hematologic 1 <input type="checkbox"/> Malignancy, solid organ (non-metastatic) 1 <input type="checkbox"/> Malignancy, solid organ (metastatic)	
CARDIOVASCULAR DISEASE 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)		NEUROLOGIC CONDITION 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	
GASTROINTESTINAL DISEASE 1 <input type="checkbox"/> Diverticular disease 1 <input type="checkbox"/> Inflammatory bowel disease 1 <input type="checkbox"/> Peptic ulcer disease 1 <input type="checkbox"/> Short gut syndrome		LIVER DISEASE 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	
		RENAL DISEASE 1 <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____ mg/DL 1 <input type="checkbox"/> Unknown or not done	
		SKIN CONDITION 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	
		OTHER 1 <input type="checkbox"/> Connective tissue disease 1 <input type="checkbox"/> Obesity or morbid obesity 1 <input type="checkbox"/> Pregnant 1 <input type="checkbox"/> Other (specify only for cases ≤12 months of age): _____	
30. WAS THE PATIENT HOMELESS IN THE YEAR BEFORE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			
31. SUBSTANCE USE:			
SMOKING: 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		ALCOHOL ABUSE: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> None documented 9 <input type="checkbox"/> Unknown	
OTHER SUBSTANCES (CHECK ALL THAT APPLY): 1 <input type="checkbox"/> None documented 1 <input type="checkbox"/> 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"/> 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 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 1 <input type="checkbox"/> DUD or abuse 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"/> 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	
DURING THE CURRENT HOSPITALIZATION DID THE PATIENT RECEIVE MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER?		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 ☐ UnknownIf 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 DISC1 ☐ Yes 2 ☐ No 9 ☐ UnknownCHECK 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 ☐ UnknownCURRENT CHRONIC DIALYSIS 1 ☐ Yes 2 ☐ No 9 ☐ UnknownTYPE: 1 ☐ Hemodialysis 1 ☐ Peritoneal 1 ☐ Unknown

IF HEMODIALYSIS, type of vascular access:

1 ☐ AV fistula/graft 1 ☐ Hemodialysis central line 1 ☐ Unknown33. PATIENT OUTCOME 1 ☐ Survived2 ☐ Died3 ☐ Hospitalized >1 year9 ☐ UnknownDATE OF DISCHARGE: ____ - ____ - ____ OR 1 ☐ Date UnknownDATE OF DEATH: ____ - ____ - ____ OR 1 ☐ Date Unknown1 ☐ Left against medical advice (AMA)

IF SURVIVED, DISCHARGED TO:

1 ☐ Private Residence6 ☐ Correctional or detention facility2 ☐ LTCF Facility ID: _____7 ☐ Drug/alcohol rehabilitation3 ☐ LTACH Facility ID: _____4 ☐ Other5 ☐ Homeless9 ☐ UnknownON 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 ☐ Unknown34a. 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 ☐ UnknownCOVID-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 ☐ UnknownMost recent positive test: ____ - ____ - ____ 1 ☐ Unknown34. WAS CASE FIRST IDENTIFIED
THROUGH AUDIT?1 ☐ Yes 2 ☐ No9 ☐ Unknown

35. CRF STATUS:

1 ☐ Complete2 ☐ Incomplete3 ☐ Edited & Correct4 ☐ Chart unavailable
after 3 requests36. DOES THIS CASE
HAVE RECURRENT
MRSA/MSSA
DISEASE?1 ☐ Yes 2 ☐ No9 ☐ UnknownIF YES, PREVIOUS
(1ST) STATE I.D.

37. DATE REPORTED TO EIP SITE:

____ - ____ - ____

38. DATE ABSTRACTION:

____ - ____ - ____

39. S.O. INITIALS:

40. COMMENTS: