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

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

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 INDENTIFIED:	6. FACILITY ID WHERE PATIENT TREATED:
____ ____	_____	_____	_____	_____	_____	_____

7. SEX:
1 ☐ Male 2 ☐ Female
9 ☐ Missing value

8. DATE OF BIRTH:
__ __ - __ __ - __ __ __ __

9. AGE __ __ __
1 ☐ Days 2 ☐ Mos. 3 ☐ Years

10. RACE: (Check all that apply)
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ White
1 ☐ Unknown

13. ETHNIC ORIGIN:
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

12. WEIGHT:
_____ lbs. _____ oz. OR _____ kg.
1 ☐ Unknown

13. HEIGHT:
_____ ft. _____ in. OR _____ cm. 1
1 ☐ Unknown

14. BMI (record only if ht. and/or wt. is not available)
_____ 1 ☐ Unknown

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?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown **IF YES, date of admission:** __ __ - __ __ - __ __ __ __

17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION?
1 ☐ Yes (HO-MRSA case) 2 ☐ No (CA-MRSA or HACO-MRSA case)

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:

1 ☐ Outpatient
Facility ID: _____
3 ☐ Emergency room
8 ☐ Clinic/doctor's office
15 ☐ Dialysis center
11 ☐ Surgery
16 ☐ Observation/Clinical decision unit
4 ☐ Other outpatient

1 ☐ Inpatient
Facility ID: _____
1 ☐ ICU
6 ☐ OR
7 ☐ Radiology
2 ☐ Other Inpatient

5 ☐ LTCF
Facility ID: _____

13 ☐ LTACH
Facility ID: _____

14 ☐ Autopsy

10 ☐ Other (specify): _____

9 ☐ Unknown

20. WERE CULTURES OS THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:

1 ☐ Blood Date: _____	1 ☐ Bone Date: _____	1 ☐ CSF Date: _____
1 ☐ Internal body site Date: _____	1 ☐ Joint/Synovial fluid Date: _____	1 ☐ Muscle Date: _____
1 ☐ Peritoneal fluid Date: _____	1 ☐ Pericardial fluid Date: _____	1 ☐ Pleural fluid Date: _____

1 ☐ 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), 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?
1 ☐ Private residence
1 ☐ LTCF Facility ID: _____
1 ☐ Hospital Inpatient Facility ID: _____
Was patient transferred from this hospital?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
1 ☐ LTACH Facility ID: _____
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Other (specify): _____
1 ☐ Unknown

24. IF CASE IS ≤12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION:
1 ☐ NICU/SCN 2 ☐ Well Baby Nursery 9 ☐ Unknown

25. IF PATIENT <2 YEARS OF AGE WERE THEY BORN PREMATURE (<37 WEEKS GESTATION)?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

IF YES, birth weight: _____ **lbs.** _____ **oz. OR** _____ **g.** OR 1 ☐ Unknown birth weight

IF YES, estimated gestational age: _____ weeks OR 1 ☐ Unknown gestational age

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).

— IMPORTANT — PLEASE COMPLETE THE BACK OF THIS FORM —

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

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, hematopoetic 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 ☐ Marijuana, cannabinoid (other than smoking)	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Opioid, DEA schedule I (e.g., Heroin)	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Opioid, NOS	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Cocaine	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Methamphetamine	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Other (specify): _____	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ Unknown
1 ☐ Unknown substance	1 ☐ DUD or abuse	1 ☐ IDU 1 ☐ Skin popping 1 ☐ Non-IDU 1 ☐ 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

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 LTACH IN THE YEAR BEFORE DISC

1 ☐ Yes 2 ☐ No 9 ☐ 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 9 ☐ Unknown

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: _____

4 ☐ Other (specify): _____

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 FIRSTIDENTIFIED 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: