

## MDRO or CDI Infection Event

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\*required for saving \*\*required for completion

|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                              |                                                |                                                                                                           |
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| *Required for saving<br>Facility ID:                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                              | **Required for completion<br>Event #:          |                                                                                                           |
| *Patient ID:                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                              | Social Security #:                             |                                                                                                           |
| Secondary ID:                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                              | Medicare #:                                    |                                                                                                           |
| Patient Name, Last:                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                              | First:                                         | Middle:                                                                                                   |
| *Sex: F M                                                                                                                                                                                                                                                                                                                                                                               | *Date of Birth:                                                                                                                                                                                                              |                                                |                                                                                                           |
| Ethnicity (Specify):<br>Hispanic or Latino<br>Not Hispanic or Latino<br>Unknown<br>Declined to respond                                                                                                                                                                                                                                                                                  | Race (Select all that apply):<br>American Indian or Alaska Native<br>Asian<br>Black or African American<br>Middle Eastern or North African<br>Native Hawaiian or Pacific Islander<br>White<br>Unknown<br>Declined to respond |                                                |                                                                                                           |
| Language: (Specify)                                                                                                                                                                                                                                                                                                                                                                     | Interpreter Needed: Yes No Declined to Respond Unknown                                                                                                                                                                       |                                                |                                                                                                           |
| <b>Event Details</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                              |                                                |                                                                                                           |
| *Event Type:<br>[For Event Type = BSI, PNEU, SSI, or UTI use the event specific from]                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                              | *Date of Event:                                |                                                                                                           |
| Post Procedure Event: Yes No                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                              | Date of Procedure:                             |                                                                                                           |
| MDRO/CDI Infection<br>Surveillance: Yes                                                                                                                                                                                                                                                                                                                                                 | NHSN Procedure Code:                                                                                                                                                                                                         | ICD-10-PCS or CPT Procedure Code:              |                                                                                                           |
| *Specific Organism Type: (Select up to 3) <input type="checkbox"/> MRSA <input type="checkbox"/> MSSA <input type="checkbox"/> VRE <input type="checkbox"/> CephR-Klebsiella<br><input type="checkbox"/> CRE-E. coli <input type="checkbox"/> CRE-Enterobacter <input type="checkbox"/> CRE-Klebsiella <input type="checkbox"/> MDR-Acinetobacter <input type="checkbox"/> C. difficile |                                                                                                                                                                                                                              |                                                |                                                                                                           |
| *Date Admitted to Facility:                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                              | *Location:                                     |                                                                                                           |
| *Specific Event Type (used only for CDC defined events):                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                              |                                                |                                                                                                           |
| Specify Criteria Used (check all that apply)                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                              |                                                |                                                                                                           |
| <u>Signs and Symptoms</u>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                              | <u>Laboratory or Diagnostic Testing</u>        |                                                                                                           |
| <input type="checkbox"/> Abscess                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Heat                                                                                                                                                                                                | <input type="checkbox"/> Dysuria               | <input type="checkbox"/> Organism(s) identified                                                           |
| <input type="checkbox"/> Apnea                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Hypotension                                                                                                                                                                                         | <input type="checkbox"/> Fever                 | <input type="checkbox"/> Not cultured                                                                     |
| <input type="checkbox"/> Bradycardia                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Hypothermia                                                                                                                                                                                         | <input type="checkbox"/> Bilious aspirate      | <input type="checkbox"/> Organism(s) identified from blood specimen*                                      |
| <input type="checkbox"/> Cough                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Lethargy                                                                                                                                                                                            | <input type="checkbox"/> Erythema or redness   | <input type="checkbox"/> Other positive laboratory tests*                                                 |
| <input type="checkbox"/> Vomiting                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Nausea                                                                                                                                                                                              | <input type="checkbox"/> Suprapubic tenderness | <input type="checkbox"/> > 15 colonies cultured from IV cannula tip using semiquantitative culture method |
| <input type="checkbox"/> Abdominal distension                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                              |                                                |                                                                                                           |
| <input type="checkbox"/> Pain or tenderness                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Pneumatosis intestinalis by radiograph                                                                                                                                                              |                                                |                                                                                                           |
| <input type="checkbox"/> Drainage or material*                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Portal venous gas (Hepatobiliary gas) by radiograph                                                                                                                                                 |                                                |                                                                                                           |
| <input type="checkbox"/> Wheezing, rales or rhonchi                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Pneumoperitoneum by radiograph                                                                                                                                                                      |                                                |                                                                                                           |
| <input type="checkbox"/> Diarrhea*                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Imaging test evidence of infection*                                                                                                                                                                 |                                                |                                                                                                           |
| <input type="checkbox"/> Swelling or inflammation                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                              |                                                |                                                                                                           |
| <input type="checkbox"/> Occult or gross blood in stools (with no rectal fissure)                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                              |                                                |                                                                                                           |
| <input type="checkbox"/> Surgical evidence of extensive bowel necrosis (>2 cm of bowel affected)                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                              |                                                |                                                                                                           |
| <input type="checkbox"/> Surgical evidence of pneumatosis intestinalis with or without intestinal perforation                                                                                                                                                                                                                                                                           | <u>Clinical Diagnosis</u>                                                                                                                                                                                                    |                                                |                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Physician diagnosis of this event type*                                                                                                                                                             |                                                |                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Physician institutes appropriate antimicrobial therapy*                                                                                                                                             |                                                |                                                                                                           |
| <input type="checkbox"/> Other evidence of infection found on invasive procedure, gross anatomic exam, or histopathologic exam *                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                              |                                                |                                                                                                           |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|
| *Required for saving<br>Facility ID:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | **Required for completion<br>Event #:                         |  |
| <input type="checkbox"/> Other signs and symptoms*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                               |  |
| * Per specific site criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                               |  |
| <b><i>Clostridioides difficile</i> Infection</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                               |  |
| *Admitted to ICU for CDI complications: Yes    No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | *Surgery for CDI complications: Yes    No                     |  |
| * Secondary Bloodstream Infection: Yes    No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | *COVID-19 Yes    No                                           |  |
| **Died: Yes    No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Event contributed to death? Yes    No                         |  |
| Discharge Date: ____ / ____ / ____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | *Pathogens Identified: Yes    No    If yes, specify on Page 2 |  |
| <p>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)).</p> <p>Public reporting burden of this collection of information is estimated to average 34 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).</p> <p>CDC 57.126 (Front) Rev 6 V. 8.6</p> |  |                                                               |  |

## MDRO or CDI Infection Event

| Pathogen #                                                                                                                                                      | Gram-positive Organisms |                            |                         |                             |                            |                         |                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------|-------------------------|-----------------------------|----------------------------|-------------------------|-------------------------|--|
| <i>Staphylococcus</i><br>coagulase-negative<br><br>(specify species if available):                                                                              | CEFOX/OX<br>SRN         | VANC<br>SIRN               |                         |                             |                            |                         |                         |  |
| ---- <i>Enterococcus faecium</i><br><br>---- <i>Enterococcus faecalis</i><br><br>---- <i>Enterococcus</i> spp. (Only those not identified to the species level) | DAPTO<br>SI/S-DD NSRN   | GENTHL <sup>§</sup><br>SRN | LNZ<br>SIRN             | VANC<br>SIRN                |                            |                         |                         |  |
| <i>Staphylococcus aureus</i>                                                                                                                                    | CEFOX/METH/OX<br>SRN    | CEFTAR<br>SS-DDIRN         | CIPRO/LEVO/MOXI<br>SIRN | CLIND<br>SIRN               | DAPTO<br>SNSN              | DOXY/MINO<br>SIRN       | GENT<br>SIRN            |  |
|                                                                                                                                                                 | LNZ<br>SRN              | RIF<br>SIRN                | TETRA<br>SIRN           | TMZ<br>SIRN                 | VANC<br>SIRN               |                         |                         |  |
| Pathogen #                                                                                                                                                      | Gram-negative Organisms |                            |                         |                             |                            |                         |                         |  |
| <i>Acinetobacter</i><br>(specify species)<br><br>_____                                                                                                          | AMK<br>SIRN             | AMPSUL<br>SIRN             | CEFEP<br>SIRN           | CEFTAZ/CEFOT/CEFTRX<br>SIRN | CIPRO/LEVO<br>SIRN         | COL/PB<br>SRN           | DORI/MERO<br>SIRN       |  |
|                                                                                                                                                                 | DOXY/MINO<br>SIRN       | GENT<br>SIRN               | IMI<br>SIRN             | PIPTAZ<br>SIRN              | TMZ<br>SIRN                | TOBRA<br>SIRN           |                         |  |
| <i>Escherichia coli</i>                                                                                                                                         | AMK<br>SIRN             | AMP<br>SIRN                | AMPSUL/AMXCLV<br>SIRN   | AZT<br>SIRN                 | CEFAZ<br>SIRN              | CEFEP<br>SI/S-DDRN      | CEFOT/CEFTRX<br>SIRN    |  |
|                                                                                                                                                                 | CEFTAVI<br>SRN          | CEFTAZ<br>SIRN             | CEFTOTAZ<br>SIRN        | CIPRO/LEVO/MOXI<br>SIRN     | COL/PB <sup>†</sup><br>IRN | DORI/IMI/MERO<br>SIRN   | DOXY/MINO/TETRA<br>SIRN |  |
|                                                                                                                                                                 | ERTA<br>SIRN            | GENT<br>SIRN               | IMIREL<br>SIRN          | MERVAB<br>SIRN              | PIPTAZ<br>SIRN             | TIG<br>SIRN             | TMZ<br>SIRN             |  |
|                                                                                                                                                                 | TOBRA<br>SIRN           |                            |                         |                             |                            |                         |                         |  |
| <i>Enterobacter</i><br>(specify species)<br><br>_____                                                                                                           | AMK<br>SIRN             | AZT<br>SIRN                | CEFEP<br>SI/S-DDRN      | CEFOT/CEFTRX<br>SIRN        | CEFTAVI<br>SRN             | CEFTAZ<br>SIRN          | CEFTOTAZ<br>SIRN        |  |
|                                                                                                                                                                 | CIPRO/LEVO/MOXI<br>SIRN | COL/PB <sup>†</sup><br>IRN | DORI/IMI/MERO<br>SIRN   | DOXY/MINO/TETRA<br>SIRN     | ERTA<br>SIRN               | GENT<br>SIRN            | IMIREL<br>SIRN          |  |
|                                                                                                                                                                 | MERVAB<br>SIRN          | PIPTAZ<br>SIRN             | TIG<br>SIRN             | TMZ<br>SIRN                 | TOBRA<br>SIRN              |                         |                         |  |
| ---- <i>Klebsiella pneumoniae</i><br><br>---- <i>Klebsiella oxytoca</i><br><br>---- <i>Klebsiella aerogenes</i>                                                 | AMK<br>SIRN             | AMPSUL/AMXCLV<br>SIRN      | AZT<br>SIRN             | CEFAZ<br>SIRN               | CEFEP<br>SI/S-DDRN         | CEFOT/CEFTRX<br>SIRN    | CEFTAVI<br>SRN          |  |
|                                                                                                                                                                 | CEFTAZ<br>SIRN          | CEFTOTAZ<br>SIRN           | CIPRO/LEVO/MOXI<br>SIRN | COL/PB <sup>†</sup><br>IRN  | DORI/IMI/MERO<br>SIRN      | DOXY/MINO/TETRA<br>SIRN | ERTA<br>SIRN            |  |
|                                                                                                                                                                 | GENT<br>SIRN            | IMIREL<br>SIRN             | MERVAB<br>SIRN          | PIPTAZ<br>SIRN              | TIG<br>SIRN                | TMZ<br>SIRN             | TOBRA<br>SIRN           |  |



| Pathogen # | Gram-Negative Organisms (continued)                    |                |                       |                   |                |                |                  |                    |                |                |
|------------|--------------------------------------------------------|----------------|-----------------------|-------------------|----------------|----------------|------------------|--------------------|----------------|----------------|
|            | <i>Pseudomonas aeruginosa</i>                          | AMK<br>SIRN    | AZT<br>SIRN           | CEFEP<br>SIRN     | CEFTAVI<br>SRN | CEFTAZ<br>SIRN | CEFTOTAZ<br>SIRN | CIPRO/LEVO<br>SIRN |                |                |
|            |                                                        | COL/PB<br>SIRN | DORI/IMI/MERO<br>SIRN | GENT<br>SIRN      | PIPTAZ<br>SIRN | TOBRA<br>SIRN  |                  |                    |                |                |
| Pathogen # | Fungal Organisms                                       |                |                       |                   |                |                |                  |                    |                |                |
|            | <i>Candida</i> (specify species if available)<br>_____ | ANID<br>SIRN   | CASPO<br>SIRN         | FLUCO<br>SS-DD RN | MICA<br>SIRN   | VORI<br>SIRN   |                  |                    |                |                |
| Pathogen # | Other Organisms                                        |                |                       |                   |                |                |                  |                    |                |                |
|            | Organism 1 (specify)<br>_____                          | Drug 1<br>SIRN | Drug2<br>SIRN         | Drug3<br>SIRN     | Drug 4<br>SIRN | Drug 5<br>SIRN | Drug 6<br>SIRN   | Drug 7<br>SIRN     | Drug 8<br>SIRN | Drug 9<br>SIRN |
|            | Organism 1 (specify)<br>_____                          | Drug 1<br>SIRN | Drug2<br>SIRN         | Drug3<br>SIRN     | Drug 4<br>SIRN | Drug 5<br>SIRN | Drug 6<br>SIRN   | Drug 7<br>SIRN     | Drug 8<br>SIRN | Drug 9<br>SIRN |
|            | Organism 1 (specify)<br>_____                          | Drug 1<br>SIRN | Drug2<br>SIRN         | Drug3<br>SIRN     | Drug 4<br>SIRN | Drug 5<br>SIRN | Drug 6<br>SIRN   | Drug 7<br>SIRN     | Drug 8<br>SIRN | Drug 9<br>SIRN |

### Result Codes

S = Susceptible I = Intermediate R = Resistant NS = Non-susceptible S-DD = Susceptible-dose dependent  
N = Not tested

§ GENTHL results: S = Susceptible/Synergistic and R = Resistant/Not Synergistic

† Clinical breakpoints are based on CLSI M100-ED30:2020, Intermediate MIC ≤ 2 and Resistant MIC ≥ 4

| Drug Codes:                          |                                   |                                      |                                     |
|--------------------------------------|-----------------------------------|--------------------------------------|-------------------------------------|
| AMK = amikacin                       | CEFTAR = ceftaroline              | GENT = gentamicin                    | OX = oxacillin                      |
| AMP = ampicillin                     | CEFTAVI = ceftazidime/avibactam   | GENTHL = gentamicin -high level test | PB = polymyxin B                    |
| AMPSUL = ampicillin/sulbactam        | CEFTOTAZ = ceftolozane/tazobactam | IMI = imipenem                       | PIPTAZ = piperacillin/tazobactam    |
| AMXCLV = amoxicillin/clavulanic acid | CEFTRX = ceftriaxone              | IMIREL = imipenem/relebactam         | RIF = rifampin                      |
| ANID = anidulafungin                 | CIPRO = ciprofloxacin             | LEVO = levofloxacin                  | TETRA = tetracycline                |
| AZT = aztreonam                      | CLIND = clindamycin               | LNZ = linezolid                      | TIG = tigecycline                   |
| CASPO = caspofungin                  | COL = colistin                    | MERO = meropenem                     | TMZ = trimethoprim/sulfamethoxazole |
| CEFAZ = ceftazolin                   | DAPTO = daptomycin                | MERVAB = meropenem/vaborbactam       | TOBRA = tobramycin                  |
| CEFEP = cefepime                     | DORI = doripenem                  | METH = methicillin                   | VANC = vancomycin                   |
| CEFOT = cefotaxime                   | DOXY = doxycycline                | MICA = micafungin                    | VORI = voriconazole                 |
| CEFOX = ceftoxitin                   | ERTA = ertapenem                  | MINO = minocycline                   |                                     |
| CEFTAZ = ceftazidime                 | FLUCO = fluconazole               | MOXI = moxifloxacin                  |                                     |



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## Comments

**Custom Fields**