Form Approved
OMB Control No.: 0920-XXXX
Expiration date: XX/XX/XXXX

Form 1: Medical Tourism Case Intake Form

Instructions:
Health departments may use this form to notify the Centers for Disease Control and Prevention (CDC) of patients who have suffered an adverse health outcome(s) related to medical tourism. The form is divided into two parts.

Part A collects basic information about the patient, their travel history, the surgeries, treatments, or procedures received outside the United States, and the adverse health outcome(s) experienced related to the surgeries, treatments, or procedures received outside the United States. The interviewer should complete the form by speaking directly with the patient when possible. Alternatively, interviewing someone familiar with the circumstances surrounding the adverse health outcome (e.g., medical provider, relative, friend) or medical chart abstraction are acceptable. The medical chart review may be done in consultation with the patient interview. Verbal consent should be obtained from patients, and participation is voluntary.

Part B collects pertinent laboratory and radiology results obtained after the patient presents for medical care in the United States for the adverse health outcome(s). The interviewer should obtain this information from medical chart abstraction. When this is not possible, obtaining information from the treating medical provider or patient is acceptable. Additionally, you may include or refer to any previously completed health forms associated with the patient's adverse health outcome(s) with this intake form. Please ensure any personally identifiable information (PII) is removed before submitting.

Key Definitions:
Medical Tourism:
Travel by a U.S. resident outside of the United States for the purpose of receiving healthcare or a U.S. resident presenting to a U.S. healthcare facility after receiving medical care outside the United States.

Adverse health outcome:
An unexpected problem, complication, or undesirable health outcome resulting from medical or dental surgeries, treatments, or other procedures. Examples include infections, blood clots, and other undesired post-treatment complications. Adverse health outcomes relevant to this data collection are those occurring after medical tourism.

PART A (interview to be completed by clinician or state/local health department)

Medical Tourism Case Intake Form

Case ID (CDC to complete):_____
Local Case ID (Local Health Jurisdiction to complete): _____
State Case ID (State/Territorial Health Jurisdiction to complete): _____
Patient Initials: _____
Date form completed (MM/DD/YYYY): _____
If the interview was conducted in a language other than "English" please specify the name of the language here: _____

Who did you interview to complete this form? (*Select all that apply*).

- ☐ Patient
- ☐ Friend or family member (*specify* relationship): _____
- ☐ Healthcare provider
- ☐ Medical chart review
- ☐ Other (*please specify*):_____

Name of person completing the form: _____
Title: _____
Organization: _____
Contact phone number: _____
Contact email: _____

If you are transferring data from an earlier interview with the patient, list the interviewers' names, contact number, and interview date for these interviews:
Interview A: Name: _____ Tel: _____ Date: _ _/ _/
Interview B: Name: _____ Tel: _____ Date: _ _/ _/
Interview C: Name: _____ Tel: _____ Date: _ _/ _/___

How did you find out about this medical tourist? *Select all that apply*.

- ☐ Patient volunteered information about recent medical or dental surgery, treatment or procedure(s) received abroad when presenting for care in the United States
- ☐ The clinician at the reporting US hospital/clinic identified the patient as a medical tourist when asking the patient about recent international travel history
- ☐ US hospital/clinic's laboratory
- ☐ Laboratory surveillance system
- ☐ Notification by domestic or international public health partner
- ☐ Other (please specify):_____

Patient interview/chart abstraction

1. How old were you (the patient) at time of surgery / treatment / procedure? *Please report age in years.* _____

2. Sex:
- ☐ Male
- ☐ Female

3. What is your (the patient's) race/ethnicity? *Select all that apply*.
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian/Pacific Islander
- ☐ White

4. What is your (the patient's) current state of residence? _____

5. What is your (the patient's) county of residence? _____

Travel Information

6. When did you (the patient) depart from the United States? (MM/DD/YYYY):
_____

7. What was your (the patient's) primary method of travel from the United States to the country where the surgery/treatment/procedure(s) was received? *Select best answer*.
- ☐ Air (e.g., plane, helicopter)
- ☐ Land (e.g., train, automobile, or bus)
- ☐ Sea (e.g., cruise travel, boat, or ferry)

8. When did you (the patient) return to the United States? (MM/DD/YYYY):
_____

9. After the surgery/treatment/procedure, what was your (the patient's) primary method of travel back to the United States? *Select best answer*.
- ☐ Air (e.g., plane, helicopter)
- ☐ Land (e.g., train, automobile, or bus)

☐ Sea (e.g., cruise travel, boat, or ferry)

Surgery/treatment/procedure received outside the United States

10. What surgery/treatment/procedure(s) did you (the patient) have outside the United States. *Select all that apply.*

- ☐ Bariatric or weight loss surgery
- ☐ Cancer treatment
- ☐ Cardiac surgery or procedure
- ☐ Cosmetic surgery or procedure
    - o Abdominoplasty (tummy tuck)
    - o Breast augmentation
    - o Buttock augmentation (e.g., "Brazilian butt lift")
    - o Liposuction
    - o Rhinoplasty
    - o Other (please specify): _____
- ☐ Dental surgery or procedure
- ☐ Induced abortion (medical or surgical)
- ☐ In vitro fertilization or other fertility procedure
- ☐ Ophthalmologic surgery or procedure
- ☐ Organ transplant
- ☐ Orthopedic surgery
- ☐ Stem cell therapy (distinct from stem cell transplant; e.g., stem cell injections)
- ☐ Stem cell transplant
- ☐ Other_____

11. What type of healthcare professional(s) performed the surgery/treatment/procedure? *Check all that apply.*

- ☐ Medical Doctor *Please specify type.*
    - o Surgeon
    - o Pain specialist
    - o Primary care physician
    - o Dermatologist
    - o Anesthesiologist
    - o Other (please specify): _____
- ☐ Nurse Practitioner
- ☐ Nurse

- ☐ Physician Assistant
- ☐ Dentist
- ☐ Other: _____
- ☐ Prefer not to answer
- ☐ Not sure/don't know

12a. When and where was the procedure(s) done? *If any answer is unknown, please indicate this by writing "unknown". If patient received procedures at multiple facilities outside the U.S., enter the narrative (details in question 12a, 12b, 12c) in the space at the end of Form 1 Part A.*

- ☐ Procedure(s) received:_____
- ☐ Date(s) of procedure(s): _____
- ☐ Name of the person(s) who did the procedure(s): _____
- ☐ Facility name/address/city/country: _____
- ☐ Facility or Healthcare provider phone number: _____
- ☐ Facility discharge date: _____

12b.Do you know of somebody else who experienced an adverse health outcome resulting from the surgery, treatment or procedures at this facility?

- ☐ Yes
- ☐ No
- ☐ Declined to answer

12c. If yes, can you (the patient) provide the contact information for that person to the state/local health department? (NOTE: Personally Identifiable Information should not be transmitted to CDC)

- ☐ Yes
- ☐ No
- ☐ Not Sure/Don't Know
- ☐ Declined to Answer

Adverse health outcome related to surgery/treatment/procedure received outside the United States

13. What adverse health outcome(s) did you (the patient) experience? *Select all that apply. If an infection is present, please indicate the type of infection. Please include ICD-10 codes, if known. Additional space is provided if needed at the end of the section.*

- ☐ Infection type *(Select all that apply).*
  - o Bloodstream
  - o Skin/soft tissue (e.g., cellulitis, abscess, wound infection)
  - o CNS (e.g., meningitis, brain abscess)
  - o Bone (i.e., osteomyelitis)
  - o Wound at site of procedure
  - o Joint (i.e., septic arthritis)
  - o Urinary tract
  - o Sepsis
  - o Other infection-related diagnosis, specify_____
- ☐ Deep venous thrombosis
- ☐ Pulmonary embolism
- ☐ Death (cause of death): _____ Date of death (MM/DD/YYYY):_____
- ☐ Other adverse health outcome: _____

14. What date did you (the patient) start noticing symptoms related to the adverse health outcome? (MM/DD/YYYY): _____

15. What is your (the patient's) current health status related to the adverse health outcome?

- ☐ Recovered
- ☐ Hospitalized/receiving inpatient care
  - o Type of care (e.g., antibiotics, surgical revision, wound care): _____
- ☐ Resident of long-term care facility or subacute rehabilitation center receiving care
  - o Type of care (e.g., antibiotics, wound care): _____
- ☐ At home of residence receiving outpatient care
  - o Type of care: (e.g., antibiotics, wound care): _____
- ☐ Deceased

18. Additional Space for PART A Answer(s) *(if needed)*

_____

_____

_____

_____
_____
_____
_____
_____
_____

PART B (Medical Chart Abstraction)

19. **Laboratory Results**

Please note any results from labs completed as a result of the adverse health outcome. You may attach deidentified laboratory reports with this form. Alternatively, please describe the results below; extra space at the end of the form can be used if necessary. Please describe identified microorganisms, antimicrobial susceptibility results, and resistance mechanisms, if relevant. Options to enter additional results will be available in the electronic form.

	Result1	*Result2*	*Result3*
Date of test			
Name of laboratory			
Site of sample (*Select one*)	o *Blood* o *Wound* o *Tissue* o *CSF*	o *Blood* o *Wound* o *Tissue* o *CSF*	o *Blood* o *Wound* o *Tissue* o *CSF*

	o *Joint* o *Bone* o *Urinary Tract* o *Other (please specify)_____ __*	o *Joint* o *Bone* o *Urinary Tract* o *Other (please specify)_____ __*	o *Joint* o *Bone* o *Urinary Tract* o *Other (please specify)____ ___*
Type of result or test name	o *Culture* o *PCR* o *Serology* o *Antigen* o *Other (please specify)_____ __*	o *Culture* o *PCR* o *Serology* o *Antigen* o *Other (please specify)_____ __*	o *Culture* o *PCR* o *Serology* o *Antigen* o *Other (please specify)____ ___*
Organism identified			
Resistance mechanisms			
Antimicrobial Susceptibility Test results			

20. If an isolate is available, has it been submitted for Whole Genome Sequencing?

- ☐ Yes, (name of laboratory: _____, date submitted (MM/DD/YYYY):_____
- ☐ No
- ☐ Not sure/Don't Know
- ☐ N/A

21. **Radiology Results.** *Please note any types of imaging procedures performed. If using paper form, attach deidentified imaging results here. Add additional details as necessary in the space provided at the end of the form. If using electronic form, may upload deidentified laboratory results here. Options to include multiple entries for each variable will be available in the electronic form.*

	Result1	*Result2*	*Result3*
Date of test			
Type of test (X-ray, CT, MRI, US, other: specify)			
Body Site			
Results			

22. Additional Space for PART B Answer(s) *(if needed)*