Form Approved
OMB No. 0920-0978
Expires xx/xx/xxxx
June 2025

Invasive *Staphylococcus aureus*
Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2027

Patient's Name:			Phone No.: ( )
Address:	Address Type:	MRN:	
City:	State:	ZIP:	Hospital:

— PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC —

1. STATE:	2. COUNTY:	2.a PLANNING REGION:	3. STATE ID:	4. PATIENT ID:	5. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED:	6. FACILITY ID WHERE PATIENT TREATED:
____ ____						

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

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

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

10. RACE AND/OR ETHNICITY: (Check all that apply)
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Black or African American
1 ☐ Hispanic or Latino
1 ☐ Middle Eastern or North African
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ White
1 ☐ Unknown

10a. WHAT TYPE OF HEALTH INSURANCE DID THE PATIENT HAVE AT THE TIME OF THE DISC? (Check all that apply)
1 ☐ Medicaid 1 ☐ Medicare 1 ☐ Private Insurance (including TRICARE) 1 ☐ VA Care 1 ☐ Self-pay (includes uninsured) 1 ☐ No charge 1 ☐ Other (specify): _____
9 ☐ Unknown

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

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

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

14. DATE OF INCIDENT SPECIMEN COLLECTION (DISC):
__ __ - __ __ - __ __ __ __

15. IS THE ISOLATE MRSA OR MSSA?
☐ MRSA ☐ MSSA
☐ Unknown

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 case) 2 ☐ No (CA or HACO 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

9 ☐ Unknown

20. WERE CULTURES OF 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 RESLULTS [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☐S	2☐I	3☐R	9☐U	Cefoxitin	1☐S		3☐R	9☐U	Ceftaroline	1☐S	5☐SDD	3☐R	9☐U	Clindamycin	1☐S	2☐I	3☐R	9☐U
Daptomycin	1☐S		4☐NS	9☐U	Doxycycline	1☐S	2☐I	3☐R	9☐U	Linezolid	1☐S		3☐R	9☐U	Nafcillin	1☐S	2☐I	3☐R	9☐U
Oxacillin	1☐S		3☐R	9☐U	Tetracycline	1☐S	2☐I	3☐R	9☐U	TMP-SMX	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 hosptial?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
1 ☐ LTACH
Facility ID: _____
1 ☐ Homeless
1 ☐ Correctional or detention facility
1 ☐ Drug/alcohol rehabilitation
1 ☐ Other
1 ☐ Unknown

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

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 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) _____

28a. DOES THE PATIENT HAVE:

IMPLANTED CARDIAC DEVICE (E.G., PROSTHETIC HEART VALVE, PACEMAKER, AICD, LVAD)?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, is it associated with the MRSA/MSSA infection?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If associated with the infection, specify type (check all that apply):
1 ☐ CIED pocket/generator infection
1 ☐ CIED lead infection
1 ☐ CIED unspecified infection location
1 ☐ Prosthetic heart valve
1 ☐ LVAD driveline infection
1 ☐ LVAD pump/pump pocket infection
1 ☐ LVAD unspecified infection location
1 ☐ Other, specify: _____

IMPLANTED ORTHOPEDIC DEVICE (E.G., PROSTHETIC JOINT OR ORTHOPEDIC HARDWARE)?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, is it associated with the MRSA/MSSA infection?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If associated with the infection, specify type (check all that apply):
1 ☐ Prosthetic joint, hip
1 ☐ Prosthetic joint, knee
1 ☐ Prosthetic joint, other
1 ☐ Hardware, spine
1 ☐ Hardware, other
1 ☐ Other, specify: _____

NON-DIALYSIS PROSTHETIC VASCULAR GRAFT? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, is it associated with the MRSA/MSSA infection? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

28b. DOES THE PATIENT HAVE ANOTHER TYPE OF IMPLANTED PROSTHETIC DEVICE ASSOCIATED WITH THE INFECTION?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
IF YES, specify type (check all that apply):
1 ☐ CSF shunt/drain 1 ☐ Percutaneous drain/tube (non-CSF) 1 ☐ Urinary catheter or stent 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 ☐ Paresis
1 ☐ Parkinson's Disease
1 ☐ Spinal cord injury

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 ☐ Blistering disease
1 ☐ Burn
1 ☐ Decubitus/pressure ulcer
1 ☐ Eczema
1 ☐ Psoriasis
1 ☐ Surgical wound
1 ☐ Other chronic ulcer or chronic wound

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 documented 1 ☐ Unknown 1 ☐ Tobacco 1 ☐ E-Nicotine delivery system 1 ☐ Marijuana

ALCOHOL ABUSE: 1 ☐ Yes 2 ☐ None documented 9 ☐ Unknown

INJECTION DRUG USE (IDU): 1 ☐ Yes 2 ☐ None documented 9 ☐ Unknown

If IDU, which substance(s) (check all that apply)
1 ☐ Opioid, schedule I
1 ☐ Opioid, schedule II-IV
1 ☐ Opioid, NOS
1 ☐ Cocaine
1 ☐ Methamphetamine
1 ☐ Other (specify): _____
1 ☐ Unknown substance

If IDU, did the patient receive medication assisted treatment (MAT)/ medication for opioid use disorder (MOUD) during the current hospitalization?
1 ☐ Yes 2 ☐ No 9 ☐ NA (not hospitalized or does not inject opioids)

32. PRIOR HEALTHCARE EXPOSURE(S):

PREVIOUS DOCUMENTED MRSA/MSSA INFECTION OR COLONIZATION

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

IF YES: _____ _____ OR previous STATE I.D.: _____
Month Year

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 3 ☐ Hospitalized > 1 year 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: _____
5 ☐ Homeless
6 ☐ Correctional or detention facility
7 ☐ Drug/alcohol rehabilitation
4 ☐ Other
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

34. WAS CASE FIRST IDENTIFIED THROUGH AUDIT?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

35. CRF STATUS:

1 ☐ Complete
2 ☐ Incomplete
3 ☐ Edited & Correct
4 ☐ Chart unavailable after 3 requests

37. DATE REPORTED TO EIP SITE:

__ __ - __ __ - __ __ __ __

38. DATE ABSTRACTION:

__ __ - __ __ - __ __ __ __

39. S.O. INITIALS:

_____

40. COMMENTS: